MetLife

RECOVERY BENEFIT PLAN
CLAIM FORM

POLICY NO. ....

PART A. INSURED'S STATMENT

Name of insured ....

Insured's Address :

Street .... **P.O.Box** ....

City .... **Country** ....

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1. Nature of Disease ....

2. Date of First Consultation ....

3. Date of Diagnosis of Disease ....

4. Has disease been caused by :

a. Acquired Immune Deficiency (AIDS) ? ....

b. Misuse of drugs or alcohol ? ....

5. Cardiac Bypass Surgery (if applicable)

a. Date of surgery ....

b. Misuse of drugs or alcohol ? ....

6. a. Name of treating Physician ....

b. Physician's adderss ....

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AUTHORIZATION

I hereby authorize all doctors or other persons and all hospitals or other institutions to furnish all information (including full copies of thier records) regarding myself, my medical history in general and this claim in particular to MetLife (Life Insurance Company).

A photo copy of this authorization shall be as considered as Original.

Signature of Insured .... **Date** ....

COMPLETE FOR DIAGNOSED DISEASE

1. Date you were first consulted for the symptoms of this condition :

Month ..... Day ..... Year .....

2. Date patient had previous medical attention for this condition :

Month ..... Day ..... Year .....

Physician .....

Addres : Street ..... City .....

3. Date confined to Hospital :

From: ..... To: .....

From: ..... To: .....

4. Hospital Name .....

Address .....

5. Has disease been caused by : (Give Details)

a. Acquired Immune Deficiency Disease virus (HIV) Or is it an AIDS related complex of infection by HIV virus ?

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b. Misuse of Drugs or Alcohol?

Name of Attending Physician .....

Signature Date

PART B - PHYSICIAN'S STATEMENT

Name of Patient _____ Date of Birth _____

Height _____ Weight _____

1. COMPLETE FOR MYOCARDAL INFORMATION

a. Final diagnosis _____

_____

b. Date of Diagnosis _____

c. Was there history of chest pain ? Yes _____ No _____
If yes. give details.

_____

d. Did EKG reveal new Electrocardiographic changes ? Yes _____ No _____
If yes. give details.

_____

e. Was there elevation of Cardiac Enzymes ? Yes _____ No _____

(Company requires all laboratory tests. EKGS and X-RAYS done)

2. COMPLETE FOR CORONARY ARTERY DISEASE REQUIRING SURGERY

a. Date of Diagnosis _____

b. Nature of Surgery _____

_____

c. Date of Surgery _____

d. No of coronary Arteries involved _____

(Company requires all laboratory tests, EKGS and Catheterization Film & Diagram)

3. COMPLETE FOR CEREBRAL STROKE

a. Final Diagnosis _____

_____

b. Date of Diagnosis _____

c. Did EEG reveal permanent neurological deficit ? _____

(Company requires all laboratory tests. EEGS and Neurologist Opinion Confirming diagnosis)

4. COMPLETE FOR CANCER

a. Detailed final diagnosis including location _____

_____

_____

b. Date of Diagnosis _____

c. Medical History _____

_____

(Company requires all laboratory and Tissue Biopsy Pathology Tests)

* 5. COMPLETE FOR CHRONIC, IRREVERSIBLE RENAL FAILURE

a. Detailed Diagnosis _____

_____

_____

b. Date of Diagnosis _____

c. Medical History _____

_____

d. Nature of Treatment _____

(Company requires all laboratory Tests)

* 6. COMPLETE FOR BLINDNESS CAUSED BY SICKNESS

a. Nature of sickness _____

_____

b. Is blindness total, permanent and irrevocable ? Yes _____ No _____

_____

c. Date of Diagnosis _____

d. Medical History _____

_____

(Company requires all laboratory Tests)
*Applicable to RBP contracts issued in december 1990 and later