

# Accident & Health

## Application Form

### Circles of Protection

# MetLife®

Policy No.

Consultant's Name:

IFA Name:

Consultant's Code:

IFA Code:

▶ Please complete all relevant information Completely and Legibly.  
Changes and corrections must be initialed and dated by Proposed Insured.

THIS FORM / RECEIPT IS VALID ONLY IF COMPLETED  
AND RECEIVED AT THE COMPANY'S GULF  
OPERATIONS IN DUBAI ON OR BEFORE

#### PART 1

#### A. NAME OF PROPOSED INSURED (As shown in the Identification document)

First Name

Middle Name

Last Name

#### IDENTIFICATION

I.D. Type

I.D. No.

Expiry Date

Gender

 Male  Female

Marital Status

 Single  Married  Divorced / Separated  Widowed

Date of Birth

Age Last Birthday

City of Birth

Country of Birth

Please list all Nationalities: 1)

2)

3)

#### RESIDENCY\*

1)  2)  3)

\* "Residency" is any place where you may be obliged to file income tax returns as a resident of that jurisdiction.

#### OCCUPATION

Position / Title

Exact Daily Duties

Company Name

Nature of Business

Earned Annual Income in the past 3 years

Currency

Current Year

Last Year

The Year Before

#### PERSONAL BANKING DETAILS

Name of Bank

Address

#### CURRENT BUSINESS ADDRESS

Country

City / Town

P.O. Box

Area / Street

Building

Flat / Villa No.

Telephone

 -  - 

E-mail

#### CURRENT RESIDENCE ADDRESS

Country

City / Town

P.O. Box

Area / Street

Building

Flat / Villa No.

Telephone

 -  - 

Mobile

 -  - 

#### SEND CORRESPONDENCE TO

Residence

Work

Other

If Other, please provide

**BENEFICIARY DETAILS (for Proposed Insured)**

Full Name of Beneficiary	Relationship	Date of Birth								Nationality	Country of Residence	Percentage
		D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y			

"Unless otherwise requested, Proceeds( shares) will be distributed equally among multiple Beneficiaries and the right to change the Beneficiary is reserved with the applicant"

**B. NAME OF PROPOSED SPOUSE (to be Insured - Applicable to Circles of Protection & Olympic Plan only)**

First Name  Middle Name  Last Name

**IDENTIFICATION**

I.D. Type  I.D. No.  Expiry Date

Gender  Male  Female Marital Status  Single  Married  Divorced / Separated  Widowed

Date of Birth         Age Last Birthday

City of Birth  Country of Birth

Please list all Nationalities: 1)  2)  3)

**RESIDENCY\***

1)  2)  3)

\* **"Residency"** is any place where you may be obliged to file income tax returns as a resident of that jurisdiction.

**OCCUPATION**

Position / Title  Exact Daily Duties

Company Name  Nature of Business

**Earned** Annual Income in the past 3 years  Currency  Current Year  Last Year  The Year Before

**CURRENT BUSINESS ADDRESS**

Country  City / Town  P.O. Box

Area / Street  Building  Flat / Villa No.

Telephone  Country Code  - Area Code  -  E-mail

**CURRENT RESIDENCE ADDRESS**

Country  City / Town  P.O. Box

Area / Street  Building  Flat / Villa No.

Telephone  Country Code  - Area Code  -  Mobile  Country Code  - Area Code  -

Full Name of Beneficiary for Proposed Spouse	Relationship	Date of Birth								Nationality	Country of Residence	Percentage
		D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y			
		D	D	M	M	Y	Y	Y	Y			

"Unless otherwise requested, Proceeds( shares) will be distributed equally among multiple Beneficiaries and the right to change the Beneficiary is reserved with the applicant"

**C. NAME OF PROPOSED DEPENDENT (Applicable to Circles of Protection & Olympic Plan only)**

Full Name of Child	Gender	Date of Birth								Nationality	Country of Residence	Height	Weight
Full Name of Child		D	D	M	M	Y	Y	Y	Y				
Full Name of Child		D	D	M	M	Y	Y	Y	Y				
Full Name of Child		D	D	M	M	Y	Y	Y	Y				
Full Name of Child		D	D	M	M	Y	Y	Y	Y				

**PLEASE NOTE: ANY CHANGE IN THE ELIGIBILITY OF A NAMED INSURED MUST BE IMMEDIATELY NOTIFIED TO THE COMPANY.**

**D. APPLICANT / OWNER DETAILS (if other than Proposed Insured)**

First Name  Middle Name  Last Name

**IDENTIFICATION**

I.D. Type  I.D. No.  Expiry Date

Gender  Male  Female Marital Status  Single  Married  Divorced / Separated  Widowed

Date of Birth         Age Last Birthday

City of Birth  Country of Birth

Please list all Nationalities: 1)  2)  3)

**RESIDENCY\***

1)  2)  3)

\* **"Residency"** is any place where you may be obliged to file income tax returns as a resident of that jurisdiction.

Relationship to Proposed Insured

**OCCUPATION**

Position / Title  Exact Daily Duties

Company Name  Nature of Business

**Earned** Annual Income in the past 3 years  Currency  Current Year  Last Year  The Year Before

**PERSONAL BANKING DETAILS**

Name of Bank  Address

**CURRENT BUSINESS ADDRESS**

Country  City / Town  P.O. Box   
 Area / Street  Building  Flat / Villa No.   
 Telephone  -  -  E-mail

**CURRENT RESIDENCE ADDRESS**

Country  City / Town  P.O. Box   
 Area / Street  Building  Flat / Villa No.   
 Telephone  -  -  Mobile  -  -

**DOES ANY PROPOSED INSURED AND / OR APPLICANT HAVE ANY EXISTING INSURANCE?**

If 'YES', please provide full details on the table below:

**YES**  **NO**

Name	Policy No.	Company	Effective Date	Status	Amount	Annual Premium	Life/A&H/Group

**PART II - Details of Plan selected**

**CIRCLES OF PROTECTION PLAN**

Currency <input type="text"/> <input type="text"/> <input type="text"/>	Proposed Insured Occupational Class <input type="text"/>		Proposed Spouse Occupational Class <input type="text"/>		Proposed Dependent(s)	
Benefits	Amount	Premium	Amount	Premium	Amount	Premium
Accidental Death, Dismemberment, and Permanent Total Disability						

**Mode of Premium Payment**  
 Annual  
 Other

**Totals**  
 Insured  Spouse  Each Child   
 Spouse +  Number of Children x   
 Children +  =   
 =  +  =

**Note: For Excess amount/refund (if any), please provide the following bank details:**

**IBAN / Account Number**   
**Swift Code**  **Name of the Bank**   
 (if A/C is provided)

**PART III - GENERAL HEALTH DETAILS**

Questions pertain to all Proposed insureds named on the application. If the answer is "YES" to any question, give details including physician's names and dates.

	Yes	No	
1. Has any person been treated for or told they had diabetes, abnormal blood pressure, any disorder or disease of the heart, lung, back, or spine; a mental, weight, or nervous condition; cancer, leukemia, kidney or liver disease; alcoholism or drug abuse or any other disease, disorder, injury, or congenital anomalies; or has any person consulted a physician for any other reason?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/>
2. Have you smoked cigarettes or used any other type of tobacco within the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>	
If 'YES', please indicate: The year in which you started smoking: <input style="width: 100px;" type="text"/> Type: <input style="width: 150px;" type="text"/> Quantity per day: <input style="width: 80px;" type="text"/>			
3. Do you intend to seek medical advice, treatment, or have any medical tests performed? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>
4. AIDS (Acquired Immunodeficiency Syndrome) Questions – Describe in details any affirmative answer:			
a. Have you received medical advice, or treatment, in connection with AIDS or AIDS related condition or sexually transmitted disease? Have you been told you had AIDS or AIDS related complex? Have you had or been told you have a positive blood test for antibodies to the AIDS virus (Human Immunodeficiency Virus)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/>
b. Do you have any of the following which are unexplained: fatigue, weight loss, diarrhea, enlarged lymph nodes, or unusual skin lesions? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/>
5. Does the disability income insurance under all policies in force or applied for exceed 75% of that person's earnings? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/>
6. What is your Height <input style="width: 80px;" type="text"/> Weight <input style="width: 80px;" type="text"/> Your Spouse's Height <input style="width: 80px;" type="text"/> Weight <input style="width: 80px;" type="text"/>			
7. Does any of the Proposed Persons named above undertake / participate or expect to undertake / participate in any hazardous sport or undertaking (Examples: skydiving, underwater diving, hang-gliding, parachuting, private flying, mountain climbing, auto, cycle, or boat racing, surfing or skiing on land or water, etc.)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/>
Additional Information, if any	<input style="width: 100%; height: 15px;" type="text"/> <input style="width: 100%; height: 15px;" type="text"/>		

**DECLARATION**

- (a) I hereby declare that I and my family members proposed for insurance are in good health and I agree that, except as provided in a duly executed Conditional Receipt bearing the same date and printed number as this application, there shall be no contract of insurance unless a policy is issued and delivered on this application and the full first premium is actually paid thereon provided no change shall have occurred in the insurability of the Proposed Insured(s) since the completion of the application.
- (b) I hereby declare that all statements and answers in this application together with those in any required medical examination, questionnaires, or amendments are full, complete, and true and bind all parties in interest under the policy herein applied for.
- (c) I understand that no agent or medical examiner or other person except an authorized officer of the Company is permitted to make or discharge contracts or waive or change any of the conditions or provisions of any application, policy, or receipt, or to accept or pass upon insurability; that notice to or knowledge of any agent or medical examiner is not notice to or knowledge of the Company unless stated in either this application or in any medical examination considered as part of it.
- (d) I understand that no right to borrow, surrender, or assign or other privilege of ownership may be exercised by a minor and that acceptance of any policy issued on this application that shall be a ratification of any correction or changes to this application which the Company may make in the space entitled "Company Endorsement Only".
- (e) I hereby exonerate any physician and / or hospital and / or clinic and / or insurance company and / or other organization that has any records or knowledge of me and / or my family members proposed for insurance (if any) from professional secrecy and hereby authorize such person(s) and / or entity to give to MetLife any and all information about me and / or my family members proposed for insurance and copy of records with reference to health and / or medical history and / or any hospitalization, medical advice, diagnosis, treatment, disease, and / or ailment.

- (f) I understand that all contributions to the policy are subject to any applicable anti-money laundering rules and regulations that are in force at the time the contributions are received by MetLife.
- (g) I also authorize MetLife to obtain, from any source it deems appropriate, information concerning my financial and / or professional and / or personal status, as well as information related to my driving history.
- (h) I hereby provide MetLife my unambiguous consent to process, share, and transfer my personal data to a recipient outside the country (e.g. to the Company Headquarters in the USA and / or to other branches or affiliates of the Insurer's Group) where the transfer, sharing, is necessary for the performance of the contract or for the compliance with any legal obligation to which the Company is subject and where necessary transfer, share any such information with the regulators and other law enforcement agencies for the performance of its obligations related to the international sanctions and other regulations applicable to the Company.
- (i) I understand that Coverage and/or Payment under the insurance contract will NOT be made if: (i) the policyholder, insured, or person entitled to receive such payment is residing in a sanctioned country; or (ii) the policyholder, the insured or person entitled to receive such payment is listed on the Office of Foreign Assets Control (OFAC) Specially Designated Nationals (SDN) list, the OFAC Sectorial Sanctions Identifications list or any international or local sanctions list; or (iii) the payment is claimed for services received in any sanctioned country

I also understand that the Company shall not be liable to pay any claim or provide any coverage or Benefit to the extent that the provision of such coverage or Benefit would expose the Company to any sanction under any applicable laws.

- (j) I hereby authorize MetLife to send me notifications and notices via short message service "SMS" and I accept receiving SMS and understand that MetLife makes no warranty that the SMS will be uninterrupted or error free and any such error or interruption shall not be deemed or treated in any way whatsoever to create any liability on MetLife and I acknowledge that I shall not file any complaint or claim against MetLife for any SMS error or interruption or for any reason related to receiving / not receiving SMS.

**E-mail authorization:**

By providing your E-mail address and signing this application you agree to receive from MetLife the policy document, certificate and/or any other documents and to send to MetLife all types of documents and information related to the policy ["Documents"] via electronic mail ["E-mail"]. Please be aware that having chosen this electronic means of sending or receiving information & Documents, it is your responsibility to ensure that the E-mail address you have provided us in this application is correct at all times, and that it is your responsibility to inform MetLife immediately should your E-mail address changes or should you cease to receive the Documents. You agree that all information & Documents sent to or received from your E-mail address as stated in this application will be considered valid and originated from you or sent to you personally.

MetLife is not responsible for non-receipt of E-mails due to invalid E-mail addresses or other technical problems related to your E-mail service.

If you would like to change your E-mail address with MetLife, or if you would like a paper copy of the Documents, or if you believe that you have not received your Documents, please notify us immediately.

By signing this application, you understand and agree that if you wish to discontinue receiving Documents electronically it is your obligation to revoke this Authorization by another written document. By signing this application also, you declare that you have read and understood MetLife's privacy policies and Terms of Use on [www.metlife.com/about/privacy](http://www.metlife.com/about/privacy) and you will review any Terms of Use or Privacy Statement of any future service providers used by MetLife. You understand that although MetLife take every precaution to protect the privacy of members' information, MetLife cannot guarantee safety of your information. You consent to provide your E-mail address to be included in MetLife's E-mail list and accept any inherent risks involved with E-mail communications.

**FREE LOOK PERIOD**

MetLife offers 30 - days free-look period. In the event where the Policyholder wishes to cancel the plan within 30 days of the issuance of the policy, he/she may write to: Customer Service Department, MetLife, P.O.Box 371916 Dubai, United Arab Emirates. Please note that full Premium will be refunded without any interest.

**IMPORTANT :**

- **BEFORE SIGNING THIS APPLICATION MAKE SURE ALL ANSWERS ARE CORRECT AND ALL DECLARATIONS ABOVE ARE FULLY UNDERSTOOD.**
- **AN INCORRECT OR INCOMPLETE DECLARATION MAY INVALIDATE THE POLICY.**
- **NO AGENT HAS THE AUTHORITY TO MODIFY THE TERMS AS WRITTEN IN THE APPLICATION FORM, OR TO OVERRIDE THE REQUIREMENTS OF THE COMPANY.**

**SIGNATURES**

Proposed Insured's Signature  
(In his own capacity and on behalf of his family members under legal age proposed for insurance)

Signature of Spouse and Dependent(s)  
(above legal age proposed for insurance)

Applicant Owner's Signature  
(if other than the Proposed Insured)

**Dated at** [City] [Country] on this [D] [D] day of [M] [M] 20 [Y] [Y]

**Witness /Representative / Consultant**

I certify that the information supplied by the Proposed Insured(s) / Owner has been truthfully recorded on this application.

Name of Witness [ ] [D] [D] [M] [M] [Y] [Y] [Y] [Y] [Signature]

Name of IFA [ ]

To be filled in by the IFA's Compliance / Operations Manager

By ticking this box you confirm that the welcome call to the client has been done and recorded before submitting the application to MetLife.  
 During the welcome call, the client has been made aware of the Product Features and Benefits.

**Note: In case the above box has not been ticked, MetLife will be Contacting the customer to conduct the welcome call before issuing the policy.**

**MetLife, Inc. (NYSE: MET), through its subsidiaries and affiliates ("MetLife"), is one of the largest life insurance companies in the world. Founded in 1868, MetLife is a global provider of life insurance, annuities, employee benefits and asset management. Serving approximately 100 million customers, MetLife has operations in nearly 50 countries and holds leading market positions in the United States, Japan, Latin America, Asia, Europe and the Middle East. For more information, visit [www.metlife.com](http://www.metlife.com)**

**MetLife is a pioneer of life insurance with a presence of nearly 65 years in the Gulf. Through its branches in Bahrain, Kuwait, Oman, Qatar and the United Arab Emirates, MetLife offers life, accident and health insurance along with retirement and savings products to individuals and corporations.**

For more information, visit [www.metlife-gulf.com](http://www.metlife-gulf.com)