

MetLife[®] Individual Protection

1 of 12

MetLife Claims Invicta House Trafalgar Place Brighton BN1 4FR

0800 917 1333 www.metlife.co.uk claims@metlife.uk.com

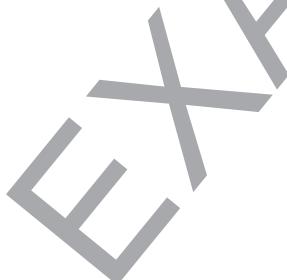
Claim form

In order to make a claim under MetLife MultiProtect or Accident Protection, please complete this form in full. Should you have any queries completing the form, please contact your claims team on the telephone number above.

Please note that the issue of this claim form by MetLife Europe d.a.c. ('MetLife') does not constitute an admission of any liability by MetLife in respect of your claim under your policy. You are under a duty to provide true, accurate and complete information in this claim form and when providing information to MetLife in order for us to assess your claim. If you provide misleading information it may result in your claim being rejected. If the requirements under our claims procedures are not complied with, we may not pay your claim. Please refer to the policy Terms and Conditions for claim that are excluded from cover.

Before submitting your claim form, please ensure you have:

- Signed the declaration and consent
- Filled out your bank details (if the claim is not being paid to the account we collect premiums from)
- Filled out your section of your claim form
- Asked a Doctor to fill out the Medical Statement
- Provided a copy of the hospital discharge summary (if relevant)
- Provided proof of your main occupation (in the case of sports-related injuries please see notes on page 6)



Policy Number:

BPA number:

Section 1 - Declaration and consent

Access to medical reports

It may be necessary for us to ask any Doctor who has attended to you to provide us with a medical report, but before we can do this, we need your consent. Before signing the declaration below, you should know that you have certain rights under the Access to Medical Reports Act 1988 and or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. You do not have to give your consent, but if you do not, we may be unable to proceed with processing your claim. You can say whether you wish to see the report before it is sent to us. We will then tell you if we request a report from your Doctor. We will also inform your Doctor that you wish to see the report before it is sent to us. You will then have 21 days to contact your Doctor to arrange to see this report. If you choose not to see the report before it is sent, you can ask your Doctor for a copy within 6 months of it being supplied to us. If you consider any part of the report to be misleading, you can ask your Doctor to amend it. If your Doctor refuses, you may add your own written comments. Your Doctor does not have to let you see any part of the report if, in their opinion, you or others would be harmed by it, or if the report contains information about another person, unless that person consents to you seeing the report. You will be informed if any part of the report is affected in this way. If the whole report is affected, your Doctor will not send it to us unless you agree.

Please note that if you do wish to see any report before it is sent to us then this may cause the processing of your claim to take longer than would otherwise be the case.

Data protection

MetLife is the data controller in respect of any personal data you provide to us. The ways in which MetLife may collect, share or process your personal data are explained in MetLife's Privacy Notice. MetLife's Privacy Notice also explains your rights regarding your personal data. A copy of MetLife's Privacy Notice is available on our website, www.metlife.co.uk.

Should you have any questions or concerns, please contact the MetLife Data Protection Officer at DataProtectionUK@MetLife.com.

Policyholder Name:

Policy Number:

BPA number:

Declaration and consent

Name of claimant

Please sign here



Please note: You are under a duty to provide true, accurate and complete information in this claim form and when providing information to MetLife in order for us to assess your claim. If you provide misleading information it may result in your claim being rejected.

By signing above, I confirm that I have read and I understand the explanation above of my rights under the Access to Medical Reports Act 1988 and or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. I consent to MetLife applying to my treating Doctors or medical practitioners to obtain medical reports and my medical notes and records.

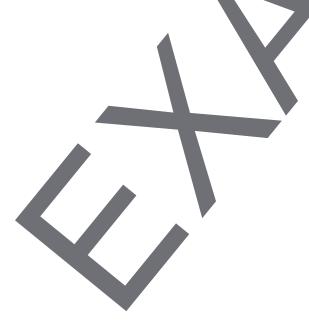
I do want to see any report before it is sent to MetLife

I do not want to see any report before it is sent to MetLife.

I consent to MetLife requesting information from any Doctor or medical practitioner who has treated me in respect of any medical condition affecting my physical or mental health. I authorise my treating Doctor and my treating medical practitioner to release copies of my medical notes and records to MetLife and I authorise my Doctor or medical practitioner to provide a report on production by MetLife of a copy of this consent. I confirm that a copy or electronic copy of this form and the signed consent shall have the same validity as the original.

I confirm that I have read the Data Protection section above and understand how to access MetLife's Privacy Notice.

I declare that the information disclosed by me in this claim form is true, accurate and complete. I understand that if I have provided misleading information it may result in my claim being rejected.



Policy Number:

BPA number:

Section 2 - Bank account details - to be completed by you

Following our assessment of your claim, any claim payment would automatically be made direct to the bank account we collect premiums from. Payment should clear within 3 working days of MetLife confirming payment has been made.

If you prefer that we pay the benefit into a different bank account to your premium bank account, please complete the details below. Please note, you do not need to complete this section if we are paying the benefit into your premium bank account.

Name of Bank/Building society			
Address			
City	Postcode		
Bank account number		Sort code	
Name of bank account Holder			

If you request we make payment to a bank account that is not yours we will require proof of identification (Driving License, Passport or National Identity card) from the bank account holder.

Policyholder Name:

Policy Number:

BPA number:

Section 3 - Details of Claim

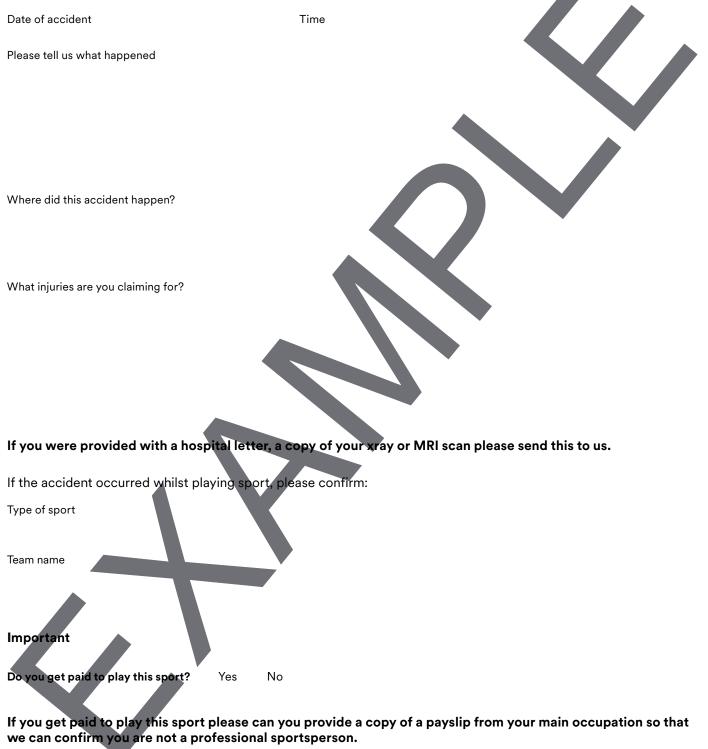
Please only complete your address here if you have moved since taking out your policy and we don't have your new address.

Address									
				Tov	vn/City			Postcode	
Email									
(Please n processe		by giving us	s your ema	il address	, you agre	e to us updating	you on yo	ur claim by email and contacting you abou	ut our
Mobile n	umber					Home telep	hone numl	ber	
What is y	vour prefe	erred meth	od of conta	act?	Email	Telephone	Post	SMS Text	
General	Practitio	ner (GP)							
Title									
Dr	Mr	Mrs	Miss	Ms	Other -	· please specify			
First nam	ne(s)					Surname			
Address									
City			Pc	stcode			Telepl	hone number	
Name(s)	of any ot	her treati	na medica	professi	onal (for y	our injury or illne	ess vou are	e claiming for)	
Title							,		
Dr	Mr	Mrs	Miss	Ms	Other -	please specify			
First nam	ne(s)					Surname			
Address									
City			Pc	stcode			Telen	hone number	
Oity				stedue			Telepi		
Please c	onfirm w	ho you hav	ve asked to	o comple	te the me	dical statement			
Policyho	lder Nam	e:			Policy Nu	umber:		BPA number:	

Accident Claims

If you are claiming for an accidental injury please complete this section.

If you are only claiming for UK Hospitalisation benefit due to sickness, please move to page 7 and complete that section.



Policyholder Name:

Policy Number:

BPA number:

For accidents reported to the police

If the accident was reported to the police, please state the address of the police station, and any crime reference number you may have been given:

Address			
City	Country		Postcode
Police Officer first name(s)		Surname	
Telephone number		•	
Crime reference No.			

UK Hospitalisation claims – Accident and Sickness

Admission date	Admission time	Discharge date	Discharge time	Hospital name and town	Ward name

Why were you admitted to hospital?

Policyholder Name:

Policy Number:

BPA number:

To be completed by you:

Claiming for Section 4 - Medical Statement - to be completed by the Doctor Full name of the patient Date of birth Date of first consultation Date of first consultation Date diagnosed the diagnosed Date d	Full name			
Section 4 - Medical Statement - to be completed by the Doctor Full name of the patient Dete of birth Dete of birth Dete of birst consultation Last consultation Date diagnosis Control Control Consultation Date diagnosed Date diagnosis? How was the diagnosis made? If the diagnosis was made via clinical examination rather than a diagnostic tool such as test, xray, scan, what symptoms supported the diagnosis? What treatment has your patient received? If surgery has taken place/is planned please include details of the surgery.				
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Date of first consultation Last consultation Total number of consultations Date symptoms first appeared Date diagnosed Date diagnosed Dom M Y Y Y Dom M Y Y Y Dom M Y Y Y Who made the diagnosis? Dom M Y Y Y Dom M Y Y Y How was the diagnosis made? If the diagnosis was made via clinical examination rather than a diagnostic tool such as test, xray, scan, what symptoms supported the diagnosis? What treatment has your patient received? If surgery has taken place/is planned please include details of the surgery.	Full name of the patient			Date of birth
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diagnosis? What treatment has your patient received? If surgery has taken place/is planned please include details of the surgery.	How was the diagnosis made?			
		amination rather than a dia	gnostic tool such	as test, xray, scan, what symptoms supported the
If this was an accidental injury please advise how the accident happened and all the injuries sustained.	What treatment has your patient receive	ed? If surgery has taken pla	ce/is planned ple	ase include details of the surgery.
If this was an accidental injury please advise how the accident happened and all the injuries sustained.				
	If this was an accidental injury please ac	lvise how the accident hap	pened and all the	injuries sustained.

Policyholder Name:

Policy Number:

BPA number:

No

Has the patient been admitted to hospital for 24 hours or more in relation to this illness or injury? Yes If 'Yes' please provide details

Admission date	Admission time	Discharge date	Discharge time	Hospital name and town	Ward name

Has the patient been referred to any other Doctor or specialist for treatment or advice in relation to the condition they are claiming for?

Yes No

If 'Yes' please provide details below:

Name

Address

City	Country	Postcode
Work telephone number Name		
Address City Work telephone number	Country	Postcode
Policyholder Name:	Policy Number:	BPA number:

Please provide details of any prior medical history for your patient that might relate to the current claim

Please advise the type of break sustained (if more than one bone is broken please confirm details of each break)

Is the break (or each break if applicable) a complete break involving the entire width of the bone?

If the bone is bruised, please advise whether this is intraosseous or periosteal bruising

Please use this space to provide any further information you feel is relevant or would assist us with your patient's claim

Please return this form with copies of your patient's medical records and hospital letters related to this illness or injury.

Policy Number:

BPA number:

Section 5 - Declaration - to be completed by the Doctor

I declare that I am the patient's GP / treating medical practitioner / specialist* and the information given in section 4 is true, accurate and complete. (*delete as appropriate)

Print Name		Date D D M M	Y 4 4 Y	
Please sign here				
Address				
City	Country		Postcode	
Practice or Hospital Stamp		lephone number		
Email Address	Fa	x number		

Policyholder Name:

Policy Number:

BPA number:

Section 6 - Payment of fees for providing medical information - to be completed by the Doctor

Your patient holds a policy with us under which they wish to make a claim. The claim assessment requires us to request medical information including but not limited to medical notes, copy correspondence, copies of discharge letters, X-rays, MRI scans, test results, as well as responses to specific reports and questions.

Full and accurate responses to all of our requests are required to enable us to complete our claim assessment. We appreciate that it may be appropriate for a reasonable professional fee to be charged associated with the provision of medical information in accordance with those agreed with the British Medical Association (BMA). MetLife confirms that it will be responsible for the payment of this fee.

In order for us to arrange to pay you the fee to provide the medical information requested, please either issue an invoice for this fee to MetLife (sending the information requested at the same time) or complete the details below and send us under separate cover the information requested.

If there are any questions around the provision of the information or payment of the medical fee please contact us on 0800 917 1333.

Payment instructions

Mr	Mrs	Miss	Ms	Other - please specify
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account	holder			
		D	ostando	
		FV	JSICOUE	
number				Sort code -
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MetLife Europe d.a.c. is a private company limited by shares and is registered in Ireland under company number 415123. Registered office at 20 on Hatch, Lower Hatch Street, Dublin 2, Ireland. UK branch office at One Canada Square, Canary Wharf, London E14 5AA. Branch registration number: BR008866. MetLife Europe d.a.c. (trading as MetLife) is authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Conduct Authority and Prudential Regulation Authority. Details about the extent of our regulation by the Financial Conduct Authority are available from us on request. www.metlife.co.uk

