Medical Claim Reimbursement Form

Complete the form in CAPITAL LETTERS.

MetLife
GULF OPERATIONS
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www.metlife-gulf.com

FASTER
SECURE
RECOMMENDED
HASSLE-FREE

SAVE TIME and GET your money FASTER, in just a few clicks by submitting your claims on e-Services and selecting wire transfer.

Visit www.eservicesgulf.metlife.com to login or register.

Instructions: Use this form to make claim for in-patient or out-patient treatments.

To avoid any delays in the processing of your claim, please ensure that:

1. All original claim documents should be submitted either in English or Arabic. Documents in other languages must be translated by an official public translator prior to submission.
2. All necessary original claims documents are to be submitted within 30 days of the incurred date. Subject to your policy terms and conditions, MetLife reserves the right to deny claims that you submit after 90 days of the incurred date.

Requirements: 1- Medical Claim Reimbursement Form (if not submitting the claim on e-services)
2- Attending Physician Section (mandatory)
3- Supporting documents - Please refer to the checklist on page 2

EMPLOYEE'S SECTION (*All Fields are Mandatory) – Not required if submitting the claim directly on e-Services

Employees's Full Name* _____ Date of Birth D D M M Y Y Y Y

Patient's Full Name* _____ Date of Birth D D M M Y Y Y Y

Employee's Nationality* _____ Patient's Nationality* _____

Employee Contact No.* Country Code – Area Code – _____

Policy Number* *(Mentioned on your Medical Card)* _____ Certificate Number* *(Mentioned on your Medical Card)* _____

Employee E-mail Address.* _____

Address* _____

REIMBURSEMENT METHOD

☐ ***Wire Transfer[1]*** ☐ ***Cheque***

[1]Bank detail must be updated on e-services

Total Amount Claimed _____ Currency _____

AUTHORIZATION STATEMENT

- I hereby certify that all answers and all original documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and / or any of my family members to provide MetLife (American Life Insurance Company) with the complete information's, including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

DISCLAIMER

- I hereby authorize MetLife to wire transfer claim reimbursements to the account indicated above. This agreement will remain in effect until I give written notice to withdraw from wire transfer or MetLife notifies me that this service has been terminated. If ever MetLife credits more money than the correct benefit amount to the account due to duplicate or erroneous electronic funds transfers, I authorize MetLife to revise the Transaction and withdraw the overpayment.
- MetLife will bear charges on account of claims reimbursement levied by the remitting bank. All charges that may be levied by the beneficiary's bank / other third-party provider will be borne by the beneficiary. We suggest confirming these charges, if any, with your banking provider".
- I verify that the documentation submitted electronically is true and unaltered and I have all the original documents that can be presented upon request of the Insurance Company. I also accept and recognize that at the sole discretion of the MetLife, these documents may be requested at any time during a period of one year counted from the submission of the claim, which I will provide within a period not exceeding of 30 days from the request. Failing to comply could imply the claim to be declined. If the case is confirmed to be declined, I will reimburse any amount paid by MetLife to me or to any party as related to this claim.
- **MetLife will not provide coverage in, reimburse for treatment obtained in, reimburse for services received in, or make wire transfers or any payments to the countries identified on OFAC's sanctions list, including but not limited to payments to any financial institutions or medical providers located in a sanctioned country. Also, MetLife will not pay a claim to individuals who: i) are residing in a sanctioned country; ii) are listed on the OFAC Specially Designated Nationals (SDN) list or any other international or local sanctions list; or iii) have traveled to a sanctioned country for purposes of receiving medical, or other treatment or services, subject to the Policy and / or Supplementary contract terms and conditions.**
- 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 and Reinsurer) 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.

Employee's Signature _____ Date D D M M Y Y Y Y

Need Help?	UAE	KUWAIT	OMAN	BAHRAIN	QATAR	ANY OTHER COUNTRY
	800 6385433	+965 2 247 4277	800 70708	800 08033	800 9711	+971 4 415 4555

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ATTENDING PHYSICIAN SECTION (*Mandatory Fields)

To be filled by attending physician

Patient's Full Name

Date of Birth D D M M Y Y Y Y

Chief Complains*

Diagnosis*

How long has the patient been suffering from this sickness?*

Please specify the date symptoms first appeared.

If treated by other medical provider please specify the name and treatment details

If the claim is resulting from pregnancy / childbirth, please provide the LMP*

Details of the treatment (other than Prescription)

If further treatment or operative procedure anticipated, please provide the details

Physician's Name, Address and Tel. No.

Physician's Signature and Stamp

CHECKLIST FOR INSURED MEMBER

REQUIRED	CHECK BOX	DOCUMENTS	NOTES
YES	☐	Claim Form (including Attending Physician Section)	Fully completed and signed by you and your physician / surgeon
YES	☐	Detailed medical report	Detailing ailment / diagnosis or accident with dates it started / happened, signed by your treating physician
YES	☐	Original hospital / clinic bill	Original
If applicable	☐	Copy of all relevant X-Rays / Echography / MRIs and reports	Should reflect your name and date they were taken
If applicable	☐	Copy of all lab tests and reports	Only related to this incident
If applicable	☐	Copy of police report	Required if claim relates to an accident

Please remember:

To help us process your insurance claim as quickly as possible, we ask you to provide the above documents. Otherwise your claim could be delayed or potentially rejected.

HOW TO SUBMIT THE CLAIM

Login to e-Services **OR** Please contact your H.R. for the Claim Submission Process