MetLife

American Life Insurance Company
(Incorporated in USA, Nepal Regn. No. 6/062/063)
Narayani Complex, Pulchowk
G.P.O Box: 11590, Kathmandu, Nepal
Tel: +977-1-5555166, Fax: +977-1-5555173
E-Mail: service-nepal@metlifealico.com.np
Web: www.metlife.com.np

GROUP MEDICAL CLAIM FORM

(A) CLAIM SUBMISSION PROCEDURE

To avoid any delays in the processing of your claim please ensure that:
1. The claim is submitted through your Employer. Please obtain the Group Policy No. and your Certificate No. from your employer
2. All questions on the form are answered. Do not leave any blanks. Please use BLOCK LETTERS
3. All Submitted claim documents should be submitted either in English or Nepali.
4. All Necessary claims documents are submitted within 30(thirty) DAYS from the incurred date.
5. The following original documents are attached:

(a) **Out-Patient Treatment**
i) Original money receipt showing the attending physician's detailed charges along with his stamp and signature.
ii) Original itemized pharmacy bill showing the date of purchase, name of patient, quantity and name of drugs along with photocopy of physician's prescription.
iii) Original receipt showing charges for each of the Lab. Test, X-ray Films, and other examination done and supported by the respective physician's request to undergo examination and copies of the results of examination undertaken.
iv) Photocopy of MetLife Medical Insurance Card.

(b) **In-Patient Treatment**
i) Itemized original hospital bill supported by the official hospital receipt for the total amount paid.
ii) Original receipt showing attending physician's / Surgeon's charges along with his stamp and signature.
iii) Photocopy of detailed hospital discharge report.
iv) Photocopy of MetLife Medical Insurance Card.
v) Photocopy of MetLife pre-approval for nonemergency hospitalization.

(B) EMPLOYEE'S SECTION

1. Employee's Name/ Date of Birth / CS or Code No: ____________________
   (As shown on G-42 Health Statement Form)
2. Patient's Name/ Date of Birth / Relation with Employee: ____________________
   (As shown on G-42 Health Statement Form)
3. Group Policy No: ____________________
4. Employer's Name: ____________________
5. Individual Certificate No: ____________________
6. Patient's Effective Date of Coverage: ____________________
7. Nature of Sickness/ Accident: ____________________
8. Dependent Code: ____________________
9. Physician's / Surgeon's Tel. No. & Complete Mailing Address: ____________________

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic 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 American Life Insurance Company with the complete information, including copies of their record with reference to any sickness or accident, any treatment examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy. I also authorize the Company to deposit the payable claim amount in my below mentioned bank account.

Bank: ____________________ Account No.: ____________________

Employee's Signature: ____________________ Date: ____________________

(C) EMPLOYER'S SECTION

1. Is this Claim arising out of the Patient's Occupation? ☐ Yes ☐ No
2. Are all the documents checked are attached? ☐ Yes ☐ No
3. Cheque payment made in the name of: ☐ Employee ☐ Employer ☐ Assigned Provider
4. Total Amount Claimed: ____________________
5. Employer's Claim Number: ____________________
6. Employer email ID: ____________________
7. Employer's Representative Signature: ____________________
8. Employer's Stamp: ____________________ Date: ____________________