American Life Insurance Company
MetLife Building, 18-20 Motijheel C.A. Dhaka-1000, Bangladesh
Phone: (880-2) 9561791 Fax: (880-2) 9558682
Email: American.Life@metlife.com.bd

SELF HEALTH STATEMENT
GROUP INSURANCE

Part A - To be Completed by EMPLOYEE	Employee ID No.	Policy No. ....

1. Name ____________________ 2. Address ____________________

3. Marital Status Single [ ] Married [ ]

4. Sex Male [ ] Female [ ] 5. Date of Birth [D][D][M][M][Y][Y][Y][Y] 6. Place of Birth ____________

7. Height [ ] ft. [ ] inch OR [ ] cm. 8. Weight [ ] lbs OR [ ] kgs 9. Occupation ____________

10. Have you, at any time, been treated for or been told that you had any trouble with any of the following?
(Answer each item "yes" or "no" in space [ ] provided)

	Yes	No		Yes	No		Yes	No
Heart			Lungs			Urinary System		
Tumors			Diabetes			Nervous Disorders		
High Blood Pressure			Kidneys			Stomach or Intestines		
Cancer			Back or Joints			Hernia		

Answer each of the following questions (11-19) "Yes" or "No" in the space [ ] provided	Yes	No
11. Have you been a patient in a hospital or similar institution during the past three (3) years?		
12. Have you been examined by, or consulted a doctor during the past three (3) years ?		
13. Have you been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?		
14. Have you been advised to have a surgical operation or procedure but did not do so ?		
15. Have you any known physical impairments, deformities, or ill health not covered in 10-14 ?		
16. If female, are you pregnant ?		
17. Have you ever had an application for or reinstatement of Life, Accident or Health insurance declined, postponed, rated or in any way modified ?		
18. Do you intend to seek medical advice, treatment, or have any medical tests performed ?		
19. Acquired Immune Deficiency Syndrome (AIDS) Related Questions. Describe in detail any affirmative answers. a. Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease ? Have you been told you had AIDS or AIDS related complex ? Have you had or been told you had a positive blood test for antibodies to the AIDS virus ? (Human Immune Deficiency Virus)		
b. Do you have any of the following which are unexplained: Fatigue, Weight Loss, Diarrhoea, Enlarged Lymph Nodes, or Unusual Skin Lesions ?		

If you have answered "Yes" to any of the above questions 10-19 (a & b) explain in full below:

Indicate the Question No. when answering.

I hereby declare that all statements and all answers to the above questions are complete and true and they are the basis on which insurance is requested under the Group Policy. I hereby authorize any doctor or other practitioner and any hospital or sanitarium to give the American Life Insurance Company (MetLife) any information it requests about me with reference to any treatments, examinations, advice or hospitalization.

Date ____________ Witness ____________ Signature of Employee ____________

Part B - To be Completed by EMPLOYER

	Yes	No	**If " Yes" give details and dates below along with Question No.**
20. From a health standpoint, do you know of any reason why the employee should not be covered under Group Plan ?			
21. Has the employee been absent form work because of injury during the past six (6) months ?			

Name of Policyholder ____________ Seal & Signature of Employer ____________

American Life Insurance Company is incorporated in the USA as a Limited Company