



P. R. Date: .....  
 Tk. ....

**LONG FORM APPLICATION AND HEALTH CERTIFICATE FOR**  Reinstatement  Removal of Reduction in Rating  
 Change in  Plan  Amount  
 Addition of Benefits

AGENCY ..... POLICY NO ..... DUE DATE .....

**PART 1-QUESTIONS TO BE ANSWERED BY POLICYOWNER**

1.	NAME	DATE OF BIRTH	HEIGHT	WEIGHT
INSURED				
OWNER				
SPOUSE				
DEPENDENT (S)				

2. A. Present Occupation of Owner ..... B. Occupation of Spouse .....  
 C. Exact Daily Duties .....  
 D. Employer's Name & Address .....
3. A. Smoking (day/week by the insureds) .....  
 B. Alcohol consumption (day/week by the insureds) .....
4. Has any of the insureds now or do they expect to have any connection with  
 A. Military or Naval Service  Yes  No  
 B. Aerial Navigation or Piloting  Yes  No
5. A. Are the Insureds negotiating or contemplating to negotiate for other Life Insurance?  Yes  No  
 B. Since date of your application for the above mentioned policy, have the insureds applied, either formally/informally, for new insurance, change of plan or reinstatement which was declined, postponed, withdrawn/modified in kind, amount or rate?  Yes  No  
 If so, state to what companies, date and cause .....
6. A. Since that date, have any deaths occurred in the family of the insureds?  Yes  No  
 B. If so, state relationship, age and cause of death .....
7. Since date of your application for the above numbered policy, has any of the insureds  
 A. Been ill or injured? (Give all dates and details)  Yes  No  
 B. Consulted or been treated by anyone on account of the insureds health or their physical or mental condition? (Give all dates and details)  Yes  No  
 C. Been a patient in any hospital and sanitarium?  Yes  No
8. Females only : are you now pregnant? (If yes, how many months)  Yes  No
9. Are all the insureds now in good health? (If no, explain in details)  Yes  No
10. Does any of the insureds intend to seek medical advice, treatment or have any medical treatment tests performed?  Yes  No
11. Other Insurance Policies including Policies with MetLife

POLICY NO.	COMPANY	AMOUNT	SUPPLEMENTARY CONTRACTS

12. AIDS (Acquired Immune Deficiency Syndrome). Describe in detail any affirmative answers.  
 A. Have you or any of the insureds received medical advice, or treatment in connection with AIDS or an AIDS related condition or a sexually transmitted Disease?  Yes  No  
 B. Have you or any of the insureds been told that you had AIDS or AIDS related complex?  Yes  No  
 C. Have you or any of the insureds been told that you had a positive blood test for antibodies to the Acquired Immune Deficiency Syndrome (AIDS) virus  Yes  No  
 D. Do you or any of the insureds have any of the following which are unexplained: Fatigue, Weight Loss, Diarrhea, Enlarged Lymph Nodes, or Unusual Skin Lesion?  Yes  No

If the answers to any of the above question is yes, identify question number and include diagnoses, dates, duration, degree of recovery or results and names and addresses of all the attending physicians and medical facilities and any other details as required.....

I declare that each of the above answers is full, complete and true, and agree that they shall be taken as basis of the reinstatement, change or issue of the above insurance and that such reinstatement, change or issue shall not be considered as effected by reason of any cash paid or settlement made in payment of or on account of the amount now due until this application shall be duly approved by the company and that receipt, retention, deposit or cashing of any such payment or settlement by the Company or its agent shall not constitute a waiver of forfeiture or otherwise affect this condition. Also, I understand that, notwithstanding any provisions to the contrary in said policy, the period of two years mentioned in the incontestability and self-destruction provisions thereof shall, in the event of reinstatement of said policy, be deemed to run from date of such reinstatement.

Amount paid with this Application: .....

Signed at ..... This ..... day of ..... 201.....  
 (City)

**Name & Signature of the Financial Associate/Medical Examiner with SEAL and ID No.**

**Full Name & Signature of the Applicant**

Phone (if any) .....

**PART II : MEDICAL EXAMINATION**  
**IMPORTANT : PLEASE CHECK IDENTITY OF INSURED**

Type of Identification: ..... Number ..... Signature of Insured .....

1. A. How long have you known the Insured? ..... B. Are you related? ..... C. Race .....

2. A. Height ..... Ft. .... Ins C. Did you { Weigh him/her?  Yes  No D. Girth { Chest Forced Expiration ..... Ins  
 B. Weight ..... Lbs { Measure him/her?  Yes  No (males only) { Chest Full Inspiration ..... Ins  
 Abdomen at Umbilicus ..... Ins

3. Does inquiry or examination reveal any past or present disease of **brain, chest, digestive, genito-urinary, cardiovascular, renal, glandular or nervous system**? (Give Details)

	Yes	No

4. A. Is his appearance unhealthy?  
 B. Does he appear older than age given? (Why)  
 C. Is there any impairment of sight or hearing?  
 D. Are pupillary and patellar reflexes abnormal?  
 E. Is there any deformity or other physical defect?  
 F. Has serological test for syphilis ever been made? (Give reason, date and result)  
 G. Are there any abdominal varicostes or hernias? (Locate, describe in details)  
 H. Do you know anything about his character, habits or morals which would affect the risk adversely?

10. Name and Address of this Medical Examiner  
 .....  
 .....

DETAILS (Mention Ref. Question Number)

5. Pulse per-minute

Rate at rest	* After exercise	5 minutes later

\* (25 beats above resting)

Irregularities per-minute

6. Blood Pressure

Systolic	Diastolic (5th phase)

7. Is there any evidence of arteriosclerosis or aneurysm?  Yes  No

8. Is there { a heart murmur? ..... } Describe in detail  
 { any hypertrophy? ..... }

9. A. Urinalysis

Specific Gravity	Sugar	Albumin

B. Are you satisfied that the specimen is authentic? .....

Dated at .....  
 (City)

this ..... day of ..... 201..... M.D.  
 Signature of Medical Examiner with SEAL and ID No.

**FOR HEAD OFFICE USE ONLY**

Referred to Underwriting Dept.

**UNDERWRITING COMMENTS:**

- |  |                                   |                                    |                                   |
|--|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Signature Differs   | <input type="checkbox"/> Approved | <input type="checkbox"/> Postponed | <input type="checkbox"/> Declined |
| <input type="checkbox"/> Medical & Urinalysis of Policy Owner/Insured required (due to NMP-0/Coverage/Age/Claim) | Additional Comments:              |                                    |                                   |
| <input type="checkbox"/> Reinstate policy of Husband/Father/Mother first   |                                   |                                    |                                   |
| <input type="checkbox"/> Fresh CSC 19-J/CSC-20 required  |                                   |                                    |                                   |
| <input type="checkbox"/> Others :  |                                   |                                    |                                   |

\_\_\_\_\_  
 UNDERWRITER

\_\_\_\_\_  
 UNDERWRITER