MetLife

**American Life Insurance Company**
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# Self Health Statement (Dependant)
# Group Insurance

**To be Completed by Dependant or Employee on behalf of the Dependant** | **Policy No. .....**

1. Name of Dependant _____ 3. Address _____

2. Name of Employee _____ 4. Relationship _____

5. Sex Male ☐ Female ☐ | 6. Date of Birth ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y) | 7. Place of Birth _____

8. Height ☐ ft. ☐ inch OR ☐ cm. | 9. Weight ☐ lbs OR ☐ kgs | 10. Occupation _____

11. 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 (12-20) "Yes" or "No" in the space [ ] provided** | **Yes** | **No** |
|---|---|---|
| 12. Have you been a patient in a hospital or similar institution during the past three years? | | |
| 13. Have you been examined by, or consulted a doctor during the past three years? | | |
| 14. Have you been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so? | | |
| 15. Have you been advised to have a surgical operation or procedure but did not do so? | | |
| 16. Have you any known physical impairments, deformities, or ill health not covered in 11-15? | | |
| 17. If female, are you pregnant ? | | |
| 18. Have you ever had an application for or reinstatement of Life, Accident or Health insurance declined, postponed, rated or in any way modified ? | | |
| 19. Do you intend to seek medical advice, treatment, or have any medical tests performed? | | |
| 20. Acquired Immune Deficiency Syndrome (AIDS) Related Questions. Describe in detail any affirmative answers.<br>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)<br>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 11-20 (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 _____ Signature of Employee _____ Signature or Thumb Print of Dependant _____

Seal & Signature of Employer _____ Name of Policyholder _____