



American Life Insurance Company
 MetLife Building, 18-20 Motijheel C.A.
 P.O. Box 9, Dhaka 1000, Bangladesh
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 E-mail: American.Life@metlife.com.bd

**Request for
 Group Insurance
 Proposal and/or Rates**

1. (a) Name of Organization _____
 (b) Address _____

 _____ Tel _____
 _____ Fax/E-mail _____

2. Nature of Business _____

3. Effective Date of Coverage Proposed _____ 4. Maximum Age LimitYears

5. Employees to be Covered (Tick "✓" Only One)
 () All full - time and permanent salaried employees (Job Confirmation)
 () _____

Note (1) Complete List of Employees Showing Dates of Birth, Amounts of Insurance, Salary/Status and Dates of Employment Must be Provided Herewith.
 (2) Temporary or Part-Time Employees or Those on Retainer Basis Should not be Included.

6. Premium Payable (Tick "✓" Only One) Annual Semi-Annual

7. Employer's Contribution Towards Premium (Tick "✓" Only One)
 100% 50% %
 (In Contributory Plans, A Minimum Participation of 75% is Required Depending Upon Size of Group.)

8. Additional Coverage(s) Desired
 Accidental Death (AD) Permanent Total Disability (PTD) Permanent Partial Disability (PPD)
 AD, APTD, APPD Accidental Medical Reimbursement (AMR)
 Critical illness (CI)
 Comprehensive Major Medical (CMM)
 In-Patient (IP) Maternity Out- Patient (OP) General Dental Optical

9. Beneficiary Through Employer Individual (each employee to fill enrollment card)

10. Health Declaration _____

11. Name & Code of Metlife Financial Associate _____

12. Form Completed by Mr./Ms. _____ Designation _____

Signing Date _____

Seal & Signature of Employer