MetLife

INFORMATION OF THE STATE OF HEALTH REQUIRED FOR ENTERING LIFE INSURANCE WITHIN A GROUP INSURANCE POLICY

MetLife Europe d.a.c.
Irská společnost s reg. č. 415123
20 on Hatch, Lower Hatch Street, Dublin 2, Irsko
MetLife Europe d.a.c., pobočka pro Českou republiku
Purkyňova 2121/3, 110 00 Praha 1, IČ: 03926206
Zapsaná v OR vedeném MS v Praze | sp. zn. A77032
tel. 227 111 000 | info@metlife.cz | www.metlife.cz

Policy number

1. Identification information

Surname, First Name

Maiden Name

Marital Status

Personal Identification Number

Date of Birth

Place of Birth

If you answer yes to any of the following questions please state details in the reserved space.

1) First name, surname and address of the current physician (G.P.) or previous physicians if you switched to another physician during the last year.

2) Height ___ cm Weight ___ kg Age ___

Have you had any change in weight in the last 12 months? ☐ yes ☐ no

If yes, please give reason (if known) and the amount of weight increased/ lost.

3) How many cigarettes do you smoke daily? ___ How many alcoholic beverages do you drink daily?

4) What children diseases have you undergone (measles, chickenpox, German measles, mumps, etc.)?

5) Have you ever been ill and did you or do you currently suffer from:

a) high blood pressure, heart diseases, rheumatic fever or diabetes? ☐ yes ☐ no

b) cancer, lung diseases, neural disorders or digestive system disease? ☐ yes ☐ no

6) Where you checked by X-ray, ECG or otherwise diagnosed in the last two years? ☐ yes ☐ no

7) Regardless of the said examinations did you go to the doctor in the last two years? ☐ yes ☐ no

8) Do you currently have some health problems? ☐ yes ☐ no

9) Are you currently being treated for something? ☐ yes ☐ no

10) Do you intend to consult a G.P. in the nearest future, undergo a treatment or diagnostic examination? ☐ yes ☐ no

11) Have you ever had a surgery? ☐ yes ☐ no

12) Are you on a sick leave now? ☐ yes ☐ no

13) Do you have any physical handicap or do you draw disability pension? ☐ yes ☐ no

14) Has any of your closest relatives had diabetes, high blood pressure, heart disease or mental disorder? ☐ yes ☐ no

15) Have you ever sought medical assistance or have you been treated with AIDS or syndromes related to AIDS or diseases transmitted by sexual connection? (AIDS = Acquired Immune Deficiency Syndrome) ☐ yes ☐ no

16) Have you ever been told that you have AIDS or syndromes related to AIDS? ☐ yes ☐ no

17) Have you ever been told that your blood test for HIV antibodies is positive? ☐ yes ☐ no

18) Do you have any of the following symptoms without knowing the cause: asthenia, loss of weight, diarrhea, increased lymph glands or unusual skin changes? ☐ yes ☐ no

2. Additional information

a) Has your application for life insurance even been suspended, rejected or accepted with special conditions? ☐ yes ☐ no

If yes please state the date and the insurance company

b) Do you have an insurance policy concluded with MetLife or another company? ☐ yes ☐ no

If yes please state the name of the insurance company, type of insurance and the sum insured

Please state detailed information relating to all positive answers: duration of illness, conclusions of your physician (year), addresses of the health care facility where you were treated and names and addresses of your current physicians (enclose hereto).

Important: Failure to state all known and essential facts may influence the entitlement for the payment of insurance benefit in the future. If you are not sure about whether a fact is essential or not, you are advised to state it.

3. Declaration of the Insured

I hereby declare that I have provided true and complete information to the best of my knowledge in this form. I agree that any statement made in this form forms the part of the insurance contract concluded between policyholder and insurance company.

I agree that my personal data and data on my state of health may be provided abroad to the reinsurer of the insurance company and inside the financial group of which insurer is a member.

In case of medical consultations – TM I understand and agree that the insurance company does not provide or arrange for the translation of medical records which the insured or his/her physician submits to WorldCare International Ltd. Company, into English, nor for the translation of written materials constituting the part of the medical consultation into Czech. The insurance company also does not provide nor takes the responsibility for translation of personal consultations or consultations over the telephone. I also understand that the insurance company nor WorldCare International Ltd. Company does not take the responsibility for damage caused by eventual mistaken diagnoses, insufficient medical care or by other mistake or omissions, which could be result of wrong translation of medical records or written materials, which constitute the part of the medical records, inaccurate translations of telephone or personal consultations.

I hereby authorize any physician, healthcare facility or other person having my personal data and medical records, to make available to the insurance company and/or its representative my personal data regarding suffered illnesses, accidents, injuries, stays in medical facilities, consultations, sick leaves, medical or diagnostic procedures or treatment. I agree that a copy of this statement has the same effect as the original. The authorisation remains valid even after my death.

4. Declaration regarding personal data protection

☐ I hereby give explicit consent to the processing of my personal health data provided in this form, other documentation requested by the insurance company and possibly obtained from doctors and other insurers. Insurance company is processing my personal health data for the purpose of the insurance risk appraisal, assessment of insured events and claims for indemnification and, if necessary, also for the purpose of exercising other rights and performing other obligations arising from the contract.

I hereby acknowledge that after conclusion of the insurance contract, the insurance company will process my personal data, including health data, as it is necessary for the establishment, exercise or defence of legal claims.

I hereby acknowledge that information regarding processing of personal data is provided in the Data Privacy Notice at www.metlife.cz under personal data protection ("zpraco-vání osobních informací").

Please sign the form and send it in scanned form from your e-mail address, which was assigned to you by the policyholder (with the suffix @intl.att.com) to the e-mail address of the insurer: bela.bursova@metlife.cz. In the subject of the e-mail, please state: AT&T form for insurance contract no. 100.387.

Signed in

Date ☐☐.☐☐.20☐☐

Signature