MetLife

HEALTH CERTIFICATE PARTICULARS — PERSONAL ACCIDENT POLICIES

☐ **APPLICATION FOR REINSTATEMENT BY REDATING**
☐ **APPLICATION FOR REINSTATEMENT**
☐ **APPLICATION FOR ADDITION OF DEPENDENTS**
☐ **APPLICATION FOR ADDITION OR INCREASE OF BENEFITS**

1. Policy No.

2. Name of Proposed Insured in Full — Identity Card No.

3. Date of Birth | Height | Weight

4. First Occupation — Secondary Occupation

a. Full description of Occupation ……
b. Employer's Name and Address ……
……
c. Last Year's Gross Income ……
d. How long have you been practicing your present occupation? ……

5. PROPOSED FAMILY MEMBERS	IDENTITY CARD NO	DATE OF BIRTH	HEIGHT	WEIGHT	OCCUPATION	CLASS
Spouse Name						
Child's Name						
Child's Name						

6. To the best of your knowledge and belief are you and all the minor proposed persons now in good health and free from physical impairment or deformity?
☐ YES ☐ NO

7. Have you, or any of the minor proposed persons, ever made application for accident, sickness, disability, hospital or life insurance, which has been declined, postponed, cancelled, modified, rated up or renewal refused? ☐ YES ☐ NO

8. Have you, or any of the minor proposed persons, had medical advice or treatment or been hospitalized during the past 5 years?
☐ YES ☐ NO

9. Have you or any of the minor proposed persons, to the best of your knowledge and belief, ever been treated or told you/they had diabetes, abnormal blood pressure, any disorder or disease of the heart, lungs, back or spine, mental or nervous condition, cancer or any other sickness or disease, defect or injury?
☐ YES ☐ NO

10. Have you or any of the minor proposed persons, now or do you/ they expect to have any connection with hazardous activities or trips? (Skydiving, scuba diving, pilot aircraft, parachuting, rally races or others?)
☐ YES ☐ NO

11. Do you play football? ☐ YES ☐ NO If yes, in which football team?

12. Is the disability indemnity under all policies the proposed persons or proposed spouse insured now own or are applying for, less than, or equal to 75% of their average earnings?
☐ YES ☐ NO

13. AIDS (Acquired Immune Deficiency Syndrome) 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 sexually transmitted disease?
☐ YES ☐ NO

B. Have you been told you had 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).
☐ YES ☐ NO

C. Do you have any of the following, which are unexplained? Fatigue, weight loss, diarrhea, enlarged lymph nodes, or unusual skin lesion?
☐ YES ☐ NO

14. Females Only: Are you now pregnant?
☐ YES ☐ NO If "Yes", please submit a medical report from your gynecologist.

If in question No. 6 the answer is no and in question Nos. 7-14 the answer is yes, please give details by giving the number of the question, the name of the proposed insured, summary of medical history, name of doctor, etc.

I agree that there shall be no insurance coverage until this application has been accepted by the Company, and I hereby declare that to the best of my knowledge and belief all statements made in this application are true and shall be the basis for reinstatement or modification of the contract.
I have paid €…… on account of charge for reinstatement or change under the above mentioned Policy.

Date ……

……..	……	……
Signature of Witness	Signature of Proposed Insured	Signature of adult Proposed Family members

UNDERWRITER'S DECISION

Consent for data processing

Insured / Proposed Insured

We, MetLife Europe d.a.c. (Cyprus Branch) of 38 Kennedy Avenue, 1087 Nicosia, use your personal data as further explained below and will be the controller of the personal data you provide to us or that we collect about you.

We request your consent to process your personal data for the purposes detailed below:

1. In order to enable us to consider your application and administer your policy accordingly if this is approved, we will need to process the health data that you have provided or may be asked to provide in the future, including health data that you have provided or may provide in respect of other policies where these are relevant. This may include the need for us to share your health data with doctors or other specialist consultants to assist us in or for the purpose of determining whether to accept your application and administering your policy.

   If you don't provide your consent, we will be unable to consider your application.

   If you agree to this, please tick the box below.

   ☐ Yes, I agree to MetLife Europe d.a.c. (Cyprus Branch) processing my health data for the reasons referred to above.

   You have the right to withdraw this consent at any time by sending us a letter at 38 Kennedy Avenue, 1087 Nicosia or emailing us at ccd@metlife.com . However, if you do so we will not be able to consider your application or, if we have already approved it, we will no longer be able to administer your policy and it will be deemed to have been cancelled. This won't affect any previous processing of your data up to that point.

More information

Our privacy policy, which sets out in greater detail how we use your personal data, and your rights in relation to such usage is enclosed and is also available at www.metlife.com.cy .

Please confirm that you have read the privacy policy by ticking the box below.

☐ Yes, I confirm that I have read the privacy policy

……
Name of Insured / Proposed Insured

……
Signature

Consent for data processing

Spouse

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☐ Yes, I confirm that I have read the privacy policy

……
Name of Spouse

……
Signature

Consent for data processing

Child 1

Note: If this consent relates to a minor, this form must be completed by the parent or other person with parental responsibility over the child. References to "your health data", "my health data" or similar references must be read as references to the minor's health data.

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☐ Yes, I confirm that I have read the privacy policy

……

Name of child

……

Signature of child or
parent or other person with parental responsibility
where child is a minor

Consent for data processing

Child 2

Note: If this consent relates to a minor, this form must be completed by the parent or other person with parental responsibility over the child. References to "your health data", "my health data" or similar references must be read as references to the minor's health data.

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……

Name of child

……

Signature of child or
parent or other person with parental responsibility
where child is a minor

Consent for data processing

Child 3

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……
Name of child

……
Signature of child or
parent or other person with parental responsibility
where child is a minor

Consent for data processing

Policyowner / Applicant (if different to proposed insured)

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Please confirm that you have read the privacy policy by ticking the box below.

☐ Yes, I confirm that I have read the privacy policy

……
Name of Policyowner / Applicant (if different to proposed insured)

……
Signature