

## CLAIM NOTIFICATION FORM (To Be Completed By The Person Giving Notice Of The Claim)

Please fill in BLOCK letters and tick (✓) where appropriate. Fields marked with a '\*' are **MANDATORY**.

### 1. Policyholder and Claimant Details

#### 1.1. Insured Information

Surname\*: \_\_\_\_\_ First Name\*: \_\_\_\_\_

Middle Name(s): \_\_\_\_\_

ID Number\*: \_\_\_\_\_ Policy Number\*: \_\_\_\_\_

#### 1.2. Claimant Information (To be completed if different from the Insured e.g policy owner, legal representative, beneficiary)

Surname\*: \_\_\_\_\_ First Name\*: \_\_\_\_\_

Middle Name(s): \_\_\_\_\_

ID Number\*: \_\_\_\_\_ KRA PIN No\*: \_\_\_\_\_

PO Box\*: \_\_\_\_\_ Code: \_\_\_\_\_ Town: \_\_\_\_\_

Mobile Tel\*: \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to the Insured\*: \_\_\_\_\_

### 2. Claim Details

Death  Redundancy  Disability  Critical Illness  Other

Date Claim Event Occurred \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Cause of Claim Event (Accident/Illness,etc): \_\_\_\_\_

If Accident, state nature of accident: \_\_\_\_\_

Is Insured Alive: \_\_\_\_\_ Present Location/Estate/Hospital: \_\_\_\_\_ Town: \_\_\_\_\_

Is/Was Insured in Hospital?: \_\_\_\_\_ Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Has Insured Resumed Work?: \_\_\_\_\_ Resumption Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

If Insured is Deceased, has he/she been buried? \_\_\_\_\_ Burial Date: \_\_\_\_\_ Burial Place: \_\_\_\_\_

State the location of the mortal remains of the Insured if not yet buried: \_\_\_\_\_

### 3. COMPLIANCE WITH THE DATA PROTECTION ACT (To be completed by claimant)

By checking this box, I consent to Britam's Privacy Policy, and hereby authorize Britam to collect, use, disclose, and/or process our personal data or information without further notification to me/us, confidentially with its affiliated companies, third party service providers, business partners and/or other parties which may be sited outside of Kenya, for setting up and administering our investment account with Britam, customer services and to allow Britam and/or its business partners to perform marketing and related activities, until Britam receives our written instruction to the contrary. Britam's Privacy Policy is available at <https://customerconnect.britam.com/privacy-policy>

I confirm that I have read and understood, and hereby consent to the general terms and conditions, and hereby consent to the general terms and conditions, and hereby make the above declaration.

I confirm that the details given above are accurate to the best of my knowledge.

Notification given at (location)? \_\_\_\_\_ Date: \_\_\_\_\_

Name of notifier: \_\_\_\_\_ Signature: \_\_\_\_\_

#### 4. FOR OFFICIAL USE ONLY

Name \_\_\_\_\_ Designation: \_\_\_\_\_ Office: \_\_\_\_\_

Give date, place viewed and brief description of the state of the insured's injuries/illness if viewed: \_\_\_\_\_

If not viewed, indicate evidence received of proof of occurrence of claim event: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_