Britam Life Assurance Company (K) Ltd
Head Office, Britam Centre
P.O. Box 30375-00100, Nairobi
+254 709 100 100
customerservice@britam.com
www.britam.com

CRITICAL ILLNESS BENEFIT CLAIM FORM

1. DETAILS OF THE INSURED

Name of Insured: _____
As appears on National ID/Passport/Alien ID

National ID No: _____
Mandatory for all Kenyan Citizens.

Passport No/Alien ID No: _____ Alien ID/Passport Expiry Date: _____
Alien ID details is mandatory for all non-Kenyan Citizens.

Policy Number: _____

Bank Name: _____ Branch _____

Account Number: _____ Account Name _____

2. PARTICULARS WITH REGARD TO ILLNESS *(To be completed by Insured)*

2.1 Provide the name and address of your current regular doctor and the duration over which he/she has attended to you.

2.2 Provide the name and address of your previous regular doctor, if any. If you had no regular doctor, state hospital(s) where you usually receive treatment.

2.3 State the abnormality, injury or illness which is responsible for the claim.

2.4 Date of First Occurrence: _____ Date of Diagnosis: _____

2.5 Provide the names and addresses of the doctors/hospitals that treated you for this condition and the relevant dates.

2.6 If the claim is the result of an accident, please provide the following information:
a) Give a full description of the circumstances surrounding the accident.

b) If there was a formal investigation into the accident, please state who was responsible for the investigation and what the results were.

c) Have you submitted a similar claim to another insurance company? If so, which company and what is the sum assured? Have you previously received or currently receiving payment from any insurance company for the same condition or a similar condition?

3. ATTENDING PHYSICIAN'S STATEMENT

3.1 Provide the previous history and treatment, if any, including previous doctor/hospital (with dates): How long has the patient suffered from the condition? When was the condition first diagnosed?

3.2 Please state the diagnosis and specific evidence thereof. Is the condition permanent?

3.3 Provide the condition summary, management and prescriptions:

3.4 If case of heart attack/myocardial infarction/thrombosis, is there unequivocal elevation of cardiac enzymes?

3.5 In case of stroke/cerebrovascular accident, is there permanent neurological defect? What is the evidence of this?

3.6 In case of case of paralysis or paraplegia, is there total loss of muscle function with permanent paralysis? What neurological evidence is adduced and what limbs are involved?

3.7 What specific treatments or operative procedures are anticipated?

- I attest to the fact that the information furnished above is to the best of my knowledge, complete and accurate.
- I am aware that presenting a false or fraudulent claim for payment of a loss or benefit is a criminal offence and I may be subject to fines, imprisonment, or both.
- I have provided a copy(ies) of my medical license/qualification(s)

Doctor's Name: KMPDC No:

Signature & Stamp: Date:

4. 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.

5. DECLARATION BY THE INSURED

a) I attest to the fact that the information furnished above is to the best of my knowledge, complete and accurate.
b) I am aware that presenting a false or fraudulent claim for payment of a loss or benefit is a criminal offence and I may be subject to fines, imprisonment, or both.
c) I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medical related facility, insurance company, reinsurance company, government agency (both County and National) that has information, records, or knowledge of the deceased's health both past and present, to furnish such information to Britam Life Assurance Co. (Kenya) Ltd.
d) I understand that the Britam Holdings Plc. (or any of its subsidiaries) may disclose the information to other insurance carriers, reinsurers, medical providers, claim management/investigation firms, government agencies, agents, employees, and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing.
e) A photocopy of this Authorization shall be as valid as the original.

I HEREBY CERTIFY that I have understood the meaning and effect of the above declaration and agree to be bound by it.

Full Name:

Signature & Stamp: Date:

6. OFFICIAL USE ONLY *(Supporting Documentation)*

- ☐ Certified Copy of National ID / Surrender of I.D / Birth Certificate / Passport / Alien ID of the Insured Person
- ☐ Copy of Police Report *(where cause of is Accidental)*
- ☐ Copy of Medical Reports *(Discharge summary, scans, pathology reports etc)*
- ☐ Copy of Proof of Banking Details for the Insured
- ☐ Copy of Attending Physician's License / Medical Certificates *(If they are not registered in Kenya)*
- ☐ Copy of Policy Document

I HEREBY CERTIFY that I have validated the original National Identification Card or Passport and confirm the claimant's identity as per the attached copies of the verified original National Identification Card or Passport.

Name of Britam Staff: _____ Designation: _____

Signature & Stamp: _____ Date: _____