



# Critical Illness Claim Form By Life Assured

Please complete in block letters or tick appropriate box, unless otherwise indicated

Original copy – Insurer

## Member's personal details

First name(s)											
Surname						Date of birth (ddmmyyyy)					
Title											
Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed							
ID/Passport number						Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Email address											
Postal address				Town				Postcode			
Telephone No. (W)					Mobile No.						
Residential address											
Residential town					County						
KRA PIN No.											

## Employment details

Employer											
Occupation						Employment date (ddmmyyyy)					
Annual salary					Employee number						
Employer Tel. Number					Postal address						
Email address											

## Claim details

Please indicate the impairment benefit that you are claiming for

Cancer    CAGB    End stage renal failure    Heart Attack    Stroke    Major organ Transplant

## Claim event details

State the date of earliest symptoms of the illness

State the nature and earliest symptoms of the illness

When did you first consult a medical doctor regarding the illness?

What prescribed treatment are you currently taking?

Please provide copies of all results of investigations performed (e.g. ECG, Histology/Laboratory reports, MRI scan reports etc) in connection with the impairment that you are claiming for

## Treating medical practitioner's details

Kindly provide names, addresses and telephone numbers of all medical practitioners (including specialists etc) consulted with this illness

Name	Speciality	Contact Details	Date

## Family doctor's details

Doctor's full name	<input type="text"/>		
Doctor's specialization	<input type="text"/>		
Doctor's office	<input type="text"/>		
Telephone Number	<input type="text"/>	Practice number	<input type="text"/>
Email address	<input type="text"/>		

## Claimant declaration

I, in my capacity as the claimant, hereby certify that the above information submitted by me is to the best of my belief and knowledge both true and correct. I further confirm that I have not withheld, concealed or misstated any information. I further understand that any misstatement or non-disclosure of information which materially affects the assessment of this claim will entitle Absa Life Assurance Kenya to declare this claim null and void.

Signature  Date (ddmmyyyy)