Disability/Accident Claim
Declaration by claimant

METROPOLITAN LIFE KENYA

☐ Individual Life ☐ Credit Life ☐ Employee Benefits Policy No.

Full name of insured Member No.

Form of identification ☐ ID document ☐ Passport ☐ Tax Ref. No.

Scheme name Scheme code

Address

Postcode

Telephone: Home Work Cell

Name of Administrator

1. Occupational details

(a) Name and address of employer

Postcode

(b) What was your normal full-time occupation immediately prior to the happening of the event giving rise to this claim?

(c) When was your last day at work? (yyyy/mm/dd)

(d) Give a complete and accurate description of the exact duties and nature of your full-time occupation. Please attach a copy of your Job Description if available.

(e) Breakdown of duties: Admin % Manual % Supervisory % Travel %

(f) For what alternative occupation are you suited by education, training or experience?

(g) Have you been boarded or discharged from your present occupation? Yes ☐ No ☐

Please attach a copy of your boarding/discharge letter.

(h) Details of all school, academic, professional or trade qualifications you possess

(i) Are you self-employed? Yes ☐ No ☐

If "yes", who is conducting the business while you are unable to do so?

Which functions do you still perform in the business, if any?

Admin % Manual % Supervisory % Travel %

1. Occupational details (continued)

(j) Work history

Dates		Company	Position held	Type of work done
From	To			

2. Details of accident/illness giving rise to the claim

(a) Give full particulars of the nature of your injuries or illness.

(b) On what date did the symptoms first begin? (yyyy/mm/dd)

(c) If your condition is due to an accident, give details of circumstances, police station, case number, etc.

(d) Give full details of the condition you are claiming for, mentioning causes and extent.

(e) Details of doctors consulted

Date	Doctor	Telephone	Examinations done or advised

(f) Details of hospitals/clinics consulted

Date	Hospital/Clinic	Telephone	Reference No.	Diagnosis	Treatment

(g) Please give full details of current treatment.

2. Details of accident/illness giving rise to the claim (continued)

(h) When last did you receive treatment?

(i) When last did you have symptoms?

(j) How successful has the treatment been?

(k) Is there any likelihood of surgical or other treatment in the future? Yes ☐ No ☐

If "yes", please comment

(l) Are you confined to: Bed ☐ Home ☐ Hospital ☐ None ☐

(m) Have you instituted a similar claim against any other insurance company? Yes ☐ No ☐

If "yes", please give name and policy numbers.

Name of Insurer	Policy number	Date of inception	Amount of benefit

3. Details of income

(a) Gross monthly income prior to ceasing work

(b) Gross monthly income since ceasing work

Source of income	Amount	Date of commencement of payment

4. General comments

5. Declaration by claimant

I hereby declare that all statements made in this form have been correctly answered and are true in every respect.

I authorise any hospital, physician or other person who has examined me, to furnish Metropolitan Life Insurance Kenya or its representative, any information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original and I agree that this authority shall remain in force after my death.

I also understand that while a claim is being considered, that I am to continue paying premiums to avoid the policy/benefits ceasing.

Signed at _____ on this _____ day of _____ 20 _____

Signature _____

Witness _____