PRUDENTIAL LIFE ASSURANCE KENYA LTD
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PRUDENTIAL

US$750BN assets under management, OVER 24 MILLION life insurance customers worldwide,Protecting the interests of customers and shareholders since 1848

Critical Illness Claim Form

1. Claimant/Insured details

Title																									
First Name																				Other Name					
Gender		Male		Female		Date of Birth	D	D	M	M	Y	Y	Y	Y											
Mobile Number																				ID Number					

2. Cover Details

Type of Cover *(Please tick appropriately)*		Individual Life Cover		Policy No.																					
		Group Life Cover		Name of Employer																					
Is the claimant?		Policyholder		Spouse		Child		Other *(Specify)*																	

I hereby submit my critical illness claim and I further authorize Prudential Life to request for my medical history and records to facilitate assesment of my claim

Signature	D	D	M	M	Y	Y	Y	Y

3. Medical Practitioner's Details. The following section should be completed by the attending physician

Name of Doctor																									
Qualifications/Speciality																									
Hospital/Clinic																									
Physical Address																									
Telephone (Work)																									
Email																									

4. Consultation History

Date of your first consultation with the member	D	D	M	M	Y	Y	Y	Y
Date of your first consultation with regard to current condition	D	D	M	M	Y	Y	Y	Y
Date of your last consultation with regard to current condition	D	D	M	M	Y	Y	Y	Y

5. Medical References

Please give details of any other practitioners, specialists or hospitals that the member has been refered to over the last 5 years

Name of Practitioner/ Hospital			
Speciality			
Physical Address			
Telephone No.			
Email Address			
Complaints refered for			
Date refered	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y

6. Critical Illness Details

What illness/impairment has led to this claim?

Cancer		End stage liver failure	
Heart Attack		Coma	
Stroke		Multiple Scelerosis	
Kidney Failure		Major organ transplant	
Paralysis		Aplastic Anaemia	
Coronary Artery Disease			

Date of onset of illness/event claimed for	D	D	M	M	Y	Y	Y	Y
Date of diagnosis	D	D	M	M	Y	Y	Y	Y

Please mention any other illness or injury for which the member consulted you

Complaint	Date	Degree of severity

Describe fully the cause of illness/event/injury being claimed for
Please give details of the member's treatment (including dose and date/duration). Refer to medication, surgery, hospitalisation, rehabilitation etc...)

7. Member's Condition

Do any of the definitions listed in section (6) above accurately describe the member's condition? If Yes which definition is the accurate description of the member's condition? ☐ Yes ☐ No

Please provide all the relevant medical information substantiating the members condition.
Documentation substantiating claim is also required.

8. Supporting documents required

I have included copies of relevant medical information and specialist reports ☐ Yes ☐ No

I have included copies of all relevant clinical/diagnostic test results ☐ Yes ☐ No

9. Declaration

I hereby declare that I have personally examined and attended to the member and that the contents of this report are true and correct

Name & Signature of Doctor

D	D	M	M	Y	Y	Y	Y

Clinic/Hospital stamp