Britam Life Assurance Company (K) Ltd
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ACCIDENT INDEMNITY 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 _____

Have you made an accident indemnity claim before? Yes ☐ No ☐

If Yes, provide: Date of claim _____ Amount _____

2. INJURY INFORMATION BY PHYSICIAN/SURGEON

2.1. Home Confinement

Date of Injury: _____

Nature of the injury

_____

_____

_____

_____

Cause of the injury

_____

_____

_____

_____

Date you first attended to the Insured _____ Date you last attended to the Insured: _____

Was the insured at the time of this accident or during this disability affected with any previous injury? Yes ☐ No ☐

If Yes, provide details below:

_____

_____

_____

_____

_____

To your knowledge, did the insured have any infirmity or physical impairment prior to this accident/disability? Yes ☐ No ☐

If Yes, did it contribute to the cause of the accident or prolonged disability? Yes ☐ No ☐

Was the insured able to work? Yes ☐ No ☐

For what period (months/weeks/days) was the insured unable to secure gainful employment? _____

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2.2. Hospital Confinement

Was the insured confined to a hospital? Yes ☐ No ☐

If Yes, provide: Name of hospital ☐ Admission Date _____ Discharge Date _____

- 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: _____

3. DETAILS OF EMPLOYER *(Or Witness If Insured Is Self-Employed)*

Name of Employer/Witness: _____

Postal Adress and Code: _____ Tel No: _____

Date Insured Left Work _____ Date Insured Resumed Work _____

Staff Name: _____ Designation: _____

Date: _____ Signature: _____

Official Stamp: _____

4. COMPLIANCE WITH THE DATA PROTECTION ACT *(To be completed by insured)*

☐ 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

- 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 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.
- 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.
- 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: _____

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6. OFFICIAL USE ONLY *(Supporting Documentation)*

Section 6.1 – 6.3 to be completed by Front Office/Branch Staff

6.1. 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 Doctor's Exemption from Work certificate

6.2. Claim Verification *(For Injury Claim Only)*

Date Insured is viewed: _____ Age of Insured at Claim Event Date: _____

Description of the injury:

_____

_____

_____

_____

Details of investigations made, if any:

_____

_____

_____

_____

6.3. Amounts Payable

No Of Weeks Confined at home: _____ Sum Assured: _____

No Of Days Confined at hospital: _____ 50% of Sum Assured: _____

Total Amount Payable: _____

I HEREBY CERTIFY that I have validated the original National Identification Card/Passport/Alien ID 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: _____

6.4. To Be Completed by Life Claims Staff

Checked By

Name of Britam Staff: _____ Designation: _____

Signature: _____ Date: _____

Approved By

Name of Britam Staff: _____ Designation: _____

Signature: _____ Date: _____