

**CLAIM NOTIFICATION FORM**

**IMPORTANT NOTICE:** Written notice of the occurrence of an insured event must be given to British-American within the time limit stipulated in your policy document. Failure to give such notice may invalidate your claim. **Please use this form to notify us of any claim.**

**TO BE COMPLETED BY THE PERSON GIVING NOTICE OF THE CLAIM**

**A) Details of Insured**

Full name of insured who is the subject of the claim \_\_\_\_\_ ID/PP No \_\_\_\_\_  
Postal address P. O. Box \_\_\_\_\_ Post Code \_\_\_\_\_ Town/City \_\_\_\_\_ Country \_\_\_\_\_  
Physical address: Estate \_\_\_\_\_ House/Plot No \_\_\_\_\_ Town \_\_\_\_\_  
Road/Street \_\_\_\_\_ Nearest landmark \_\_\_\_\_  
Landline Telephone No. \_\_\_\_\_ Mobile No \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_ Name & location of employer/business/school (if student) \_\_\_\_\_  
\_\_\_\_\_ Tel No \_\_\_\_\_

**B) Details of the person giving notice of the claim (complete only if different from insured e.g policy owner, beneficiary, or legal rep.)**

Full Name \_\_\_\_\_ ID/Passport No \_\_\_\_\_  
Postal address P. O. Box \_\_\_\_\_ Post Code \_\_\_\_\_ Town/City \_\_\_\_\_ Country \_\_\_\_\_  
Physical address \_\_\_\_\_  
Town \_\_\_\_\_ Road/Street \_\_\_\_\_ Nearest landmark \_\_\_\_\_  
Landline Telephone No. \_\_\_\_\_ Mobile No \_\_\_\_\_ Email \_\_\_\_\_  
Relationship to insured \_\_\_\_\_ Capacity in which notice is given (e.g beneficiary) \_\_\_\_\_

**C) Claim details**

Policy Number(s) that is/are the subject of this claim \_\_\_\_\_  
Claim Type (tick boxes as appropriate) Funeral Expense  Death  Mediflex  Personal Accident  Accident Indemnity   
Disability  Debility  Critical Illness  Other (Please specify) \_\_\_\_\_  
Claim event date \_\_\_\_\_ Time event occurred \_\_\_\_\_  
Where did the event happen (Institution/Residence/Road & Town)? \_\_\_\_\_  
\_\_\_\_\_ Cause of claim event (Accident or Illness – state actual cause if known) \_\_\_\_\_  
If accident, briefly state nature of accident (e.g. Road Traffic Accident etc) \_\_\_\_\_  
Is insured alive? \_\_\_\_\_ If YES, state their present physical location: Place \_\_\_\_\_  
Town \_\_\_\_\_ Road/Street \_\_\_\_\_ Is/was insured confined to a hospital? \_\_\_\_\_  
If YES, give name & location of hospital \_\_\_\_\_  
Admission Date (DD/MM/YYYY) \_\_\_\_\_ Discharge Date \_\_\_\_\_  
If confined at home, state actual location if different from details given in (A) above: Estate \_\_\_\_\_  
House/Plot No \_\_\_\_\_ Town \_\_\_\_\_ Road/Street \_\_\_\_\_ Nearest landmark \_\_\_\_\_  
If insured has returned to their usual occupation, state date of resumption \_\_\_\_\_  
If insured is deceased: Has he/she been buried? \_\_\_\_\_ If YES, place & date of burial \_\_\_\_\_  
\_\_\_\_\_ If NO, state location of mortal remains \_\_\_\_\_  
List documents provided (burial permit/hospital invoice etc) \_\_\_\_\_

I confirm that the details given above are accurate to the best of my knowledge. Notification given at (town) \_\_\_\_\_  
this \_\_\_\_\_ Day of \_\_\_\_\_ Year \_\_\_\_\_  
Name \_\_\_\_\_ Signature \_\_\_\_\_

**TO BE COMPLETED BY COMPANY OFFICIAL (FINANCIAL ADVISOR/ BRANCH STAFF/ HOME OFFICE STAFF)**

Full Name \_\_\_\_\_ Office Location \_\_\_\_\_ Designation/Position \_\_\_\_\_  
Did you view the insured? \_\_\_\_\_ If YES, give date & place viewed & brief description of the state of the insured's injuries/illness \_\_\_\_\_

If not viewed, what evidence do you have of the occurrence of the claim event? \_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_