CRITICAL ILLNESS CLAIM FORM

Statement by Employee

A. SCHEME AND EMPLOYEE DETAILS

Scheme Name: _____

Employee Details

Name: _____

Identity Number: _____ Date of Birth: _____ (DD/MM/YYYY)

B. CRITICAL ILLNESS DETAILS

Date of Diagnosis: _____ (DD/MM/YYYY)

Critical Illness:

- ☐ Cancer
- ☐ Heart Attack
- ☐ Coronary Artery Surgery
- ☐ Stroke
- ☐ Renal Failure
- ☐ Major Organ Transplant
- ☐ Paraplegia
- ☐ Blindness

Date of First Symptoms: _____ (DD/MM/YYYY)

Date of First Consultation with a Doctor: _____ (DD/MM/YYYY)

Name of Attending Doctor: _____

Have you ever had the same or similar condition? _____ (If yes state when and describe)

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

NAME	SPECIALITY	CONTACT DETAILS	DATE

Cannon Life Assurance (K) Limited

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a Gateway Park, Block D, Mombasa Road, P.O. Box 46783-00100 Nairobi, Kenya
www.cannon.co.ke

Regulated by the Insurance Regulatory Authority

C. EMPLOYEE'S DECLARATION

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Employee's Full Names: _____

Signature: _____ Date: _____ (DD/MM/YYYY)

D. CONSENT

I permit/authorize the Company to collect, store, communicate and process information relating to the policy and all transactions therein, by the Company and any of its affiliates wherever situated including sharing, transfer, and disclosure between them and to the authorities in and/or outside Kenya of any confidential information for compliance with any law or regulation whether domestic or foreign.

I further authorize any medical attendant or any other person who has attended to the life assured, or any hospital or other institution that has medical information about the life assured, to disclose this information to Cannon Life Assurance (K) Limited.

Signature: _____

Click to Submit

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