INDIVIDUAL LIFE DISABILITY CLAIM FORM

Kindly answer all questions in full and attach the supporting documentation listed below.

A. DOCUMENTS REQUIRED

Documents Required	Tick
Certified copy of policyholder's identity document	
Certified copy of claimant's identity document	
Original medical reports	
Medical reports from medical specialists	

Cannon Life Assurance (K) Ltd reserves the right to call for additional documents where necessary to validate the claim.

B. LIFE ASSURED DETAILS

Policy Number: _____

Name of Policyholder: _____

Identification Number: _____ Date of Birth: _____

Mobile Number: _____ Alternate Phone Number: _____

Email Address: _____

C. CLAIMANT'S DETAILS

Claimant's Name: _____

Identification Number: _____ Date of Birth: _____

Mobile Number: _____ Alternate Phone Number: _____

Email Address: _____

Relationship to Policyholder: _____

D. PAYMENT METHOD

☐ EFT ☐ Mobile Money ☐ Cheque

Cannon Life Assurance (K) Limited

t +254 (20) 3966000, +254 (0) 724259847 | **e** info@cannon.co.ke
a Gateway Park, Block D, Mombasa Road, P.O. Box 46783-00100 Nairobi, Kenya
www.cannon.co.ke

Regulated by the Insurance Regulatory Authority

E. ACCOUNT DETAILS

Name of Account Holder: _____

Name of Bank: _____

Branch Name: _____ Account Number: _____

F. DISABILITY DETAILS

Please indicate if the disability is a result of: ☐ Disease/ Illness ☐ Accident/ Injury/ Trauma

If the Medical Condition is Due to an Accident

Date of Accident: _____ Time: _____ Place: _____

Provide details of how the accident occurred:

_____

_____

_____

What injuries did you sustain?

_____

_____

_____

Was the accident reported to the police? ☐ Yes ☐ No

Name of Police Station: _____ Case Number: _____

If the Medical Condition is Due to a Disease/ Illness

Nature and earliest symptoms of the condition:

_____

_____

_____

When did you first consult a medical doctor regarding the condition?

_____

_____

Date of Earliest Symptoms of the Condition: _____ Date Diagnosis Confirmed: _____

Prescribed treatment you are currently taking/ using:

_____

_____

_____

Cannon Life Assurance (K) Limited

t +254 (20) 3966000, +254 (0) 724259847 | **e** info@cannon.co.ke
a Gateway Park, Block D, Mombasa Road, P.O. Box 46783-00100 Nairobi, Kenya
www.cannon.co.ke

Regulated by the Insurance Regulatory Authority

G. TREATING MEDICAL PRACTITIONER'S DETAILS

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

Family Doctor's Details

Doctor's Full Name: _____

Mobile Number: _____ Email Address: _____

H. CLAIMANT'S DECLARATION

I, in my capacity as claimant, hereby certify that the above information submitted by me is, to the best of my belief and knowledge, both true and correct. I further confirm that I have not withheld, concealed, or misstated any information. I further understand that any misstatement or non-disclosure of information, which materially affects the assessment of this claim, will entitle Cannon Life Assurance (K) Limited to declare this claim null and void.

Claimant's Name: _____

Claimant's Signature: _____ Date: _____

I. MEDICAL CERTIFICATE (TO BE COMPLETED BY THE DOCTOR)

Name of Patient: _____

Policy Number: _____

Date on which the patient first became aware of the injury/ condition: _____

Date of last consultation for the current injury/ condition: _____

Date of next consultation scheduled with the patient: _____

Was the patient referred to you? __ Yes __ No

If Yes, Please Provide the Referring Medical Practitioner's Information Below

Name of doctor who referred the patient: _____

Specialty: _____

Contact Number: _____ Email Address: _____

Cannon Life Assurance (K) Limited

t +254 (20) 3966000, +254 (0) 724259847 | **e** info@cannon.co.ke
a Gateway Park, Block D, Mombasa Road, P.O. Box 46783-00100 Nairobi, Kenya
www.cannon.co.ke

Regulated by the Insurance Regulatory Authority

History of Critical Illness Event

What is the patient's diagnosis? _____

Date that diagnosis was confirmed: _____

Please give details of the nature and extent of the disability:

_____

_____

_____

Is there a previous history of the same or similar medical conditions?

_____

_____

_____

To what is the current injury/ condition directly attributable?

_____

_____

Effect of the symptoms on normal activities of daily living:

_____

_____

_____

Current treatment and compliance:

_____

_____

Future treatment options:

_____

_____

_____

Is the injury/ condition permanent? Kindly provide a detailed explanation:

_____

_____

_____

Is there any reason to believe that the claimant's illness, disability, or injury is in any way due to, or arises entirely or partially from:

(a) Unlawful alcohol consumption or misuse of drugs and narcotics? Yes No

(b) Non-compliance to medical treatment? Yes No

NB: Please attach copies of results for all special investigations performed.

Cannon Life Assurance (K) Limited

t +254 (20) 3966000, +254 (0) 724259847 | **e** info@cannon.co.ke
a Gateway Park, Block D, Mombasa Road, P.O. Box 46783-00100 Nairobi, Kenya
www.cannon.co.ke

Regulated by the Insurance Regulatory Authority

J. ACKNOWLEDGEMENT BY ATTENDING DOCTOR

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.

Doctor's Full Name: _____

Registration Number: _____

Doctor's Signature: _____ Date: _____

Stamp

K. DECLARATION BY CLAIMANT

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.

Policyholder's Signature: _____

Stamp

Click to Submit

Cannon Life Assurance (K) Limited

t +254 (20) 3966000, +254 (0) 724259847 | **e** info@cannon.co.ke
a Gateway Park, Block D, Mombasa Road, P.O. Box 46783-00100 Nairobi, Kenya
www.cannon.co.ke

Regulated by the Insurance Regulatory Authority