INDIVIDUAL LIFE DISABILITY CLAIM FORM

KINDLY ANSWER ALL QUESTIONS IN FULL AND ATTACH SUPPORTING DOCUMENTATION AS LISTED BELOW

A. Certified copy of policyholder's identity document
B. Certified copy of claimant identity document
C. Original medical reports
D. Medical reports from medical specialists

Metropolitan Cannon Life reserves the right to call for additional documents where necessary to validate the claim

LIFE ASSURED DETAILS

Policy Number: ____________________

Name of Policyholder: ____________________

Identification Number: ____________________ Date of birth: ______ / ______ / ______

Mobile Number: ____________________

Alternate Phone number: ____________________

E-mail Address: ____________________

CLAIMANT'S DETAILS

Claimants name: ____________________

Identification Number: ____________________ Date of birth: ______ / ______ / ______

Mobile Number: ____________________

Alternate Phone number: ____________________

E-mail Address: ____________________

Relationship to policyholder: ____________________

PAYMENT METHOD

EFT ☐ Mobile Money ☐ Cheque ☐

ACCOUNT DETAILS

Name of Account Holder: ____________________

Name of Bank: ____________________

Branch Name: ____________________

Account Number: ____________________

M-pesa Number: ____________________

DISABILITY DETAILS

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Please indicate if the disability as a result of

Disease/illness ☐

Accident/injury/trauma ☐

IF 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 police?

Yes ☐

No ☐

Name of police station: ____

Case number: ____

IF MEDICAL CONDITIONS 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: _______/___________/__________

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Date diagnosis confirmed: ______/_________/_______

Prescribed treatment you are currently taking/using

TREATING MEDICAL PRACTITIONER'S DETAILS

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

NAME	SPECIALITY	CONTACT DETAILS	DATE

FAMILY DOCTOR'S DETAILS

Doctor's fullname:

____

Mobile number: ____

E-mail address: ____

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 Metropolitan Cannon life to declare this claim null and void.

Claimant's name: ____

Claimant's signature: ____

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Date: ________/___________/_________

MEDICAL CERTIFICATE (to be completed by 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: ____

E-mail address: ____

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?

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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 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?

Unlawful alcohol consumption or misuse of drugs and narcotics: yes ☐ No ☐

Cannon Life Assurance (K) Limited

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Non-compliance to medical treatment: yes ☐ No ☐

PLEASE ATTACH COPIES OF RESULTS FOR ALL SPECIAL INVESTIGATIONS PERFOMED

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: __________/__________/__________

Hospital's stamp

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 Limited.

Policyholder's signature: Policyholder's signature

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