Critical Illness Claim Form

LIBERTY
In it with you

LIFE INSURE INVEST

Liberty Life Kenya Reg.No. C7118
Liberty House, Processional Way, Nairobi, Kenya
P. O. Box 30364 - 00100 Nairobi, Kenya
Contact Centre +254 711 076 222
t +254 20 286 6000 **f** +254 20 271 8365
e csc@libertylife.co.ke **w** www.liberty.co.ke

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

Liberty Life reserves the right to call for additional documents where necessary in order to validate the claim

- [ ] Certified copy of policyholder's identity document
- [ ] Certified copy of claimant's identity document
- [ ] Proof of banking of policyholder / claimant
- [ ] Medical certificate
- [ ] Medical reports (please see below for the relevant report)

- Cancer - histology report
- Major organ transplant - surgery report
- STROKE - CT/MRI SCAN
- CABG – surgery report
- Heart attack - ECG tracing and blood test results
- End stage renal failure – blood test results

POLICY NUMBER

1. POLICYHOLDER DETAILS *(Always complete this section. This individual is the Owner and the Principal Life Assured under the Policy terms and conditions. This individual is entitled to receive all Benefits ascribed to this Policy.)*

Surname

Title

First names

Gender M F

ID /Passport number

Date of Birth D D - M M - Y Y Y Y

Income Tax Number

Not Applicable

PIN Number

Telephone number

Email address

Postal address

Post code

Residential address

Post code

Occupation

Occupation Industry

2. CLAIMANT'S DETAILS *(Must always be policyholder, except where the policyholder is incapacitated or deceased or the policyholder is an employer.)*

Surname | Title

First names | Gender M F

ID /Passport number | Date of Birth D D - M M - Y Y Y Y

Income Tax Number | Not Applicable

PIN Number

Telephone number

Email address

Postal address

Post code

Residential address

Post code

3. CLAIM PAYMENT DETAILS

CLAIM PAYMENT METHOD

EFT Mpesa

BANK DETAILS FOR EFT PAYMENTS

(Please attach a copy of the latest bank statement – must not be older than 3 months, or confirmation of account details on the Bank's letterhead, copy of ATM debit card & cheque leaf.)

Name of account holder

Name of bank

Account number

Branch name | Branch code

Account type

4. CLAIM DETAILS

PLEASE INDICATE THE IMPAIRMENT BENEFIT YOU ARE CLAIMING FOR

Cancer | CABG | End stage renal failure | Paraplegia

Heart attack | Stroke | Major organ transplant

5. CLAIM EVENT DETAILS

State the date of earliest symptoms of the illness D D - M M - Y Y Y Y | Time H H M M

State the date of earliest symptoms of the illness

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

What prescribed treatment are you currently taking?

Please provide copies of all results of investigations performed (e.g. ECG, histology/laboratory reports, MRI scan reports, etc.) in connection with the event that you are claiming for.

6. TREATING MEDICAL PRACTITIONERS 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

7. FAMILY DOCTOR'S DETAILS

Doctor's full name

Telephone number

Fax number

Email address

8. 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 liberty life to declare this claim null and void.

Claimant's name and surname

Claimant's signature

Date D D - M M - Y Y Y Y

9. MEDICAL CERTIFICATE *(This certificate is to be completed by the attending (treating) medical practitioner at the insured's expense)*

Name of patient

Policy number

When were you first consulted for the current critical illness? D D - M M - Y Y Y Y

When were you last consulted for the current critical illness? D D - M M - Y Y Y Y

When is the next appointment scheduled for with the patient? D D - M M - Y Y Y Y

Was the patient referred to you? Yes No

Name of doctor who referred the patient

Specialty

Contact number

10. HISTORY OF CRITICAL ILLNESS EVENT

What is the patient's diagnosis

Date that the diagnosis was confirmed D D - M M - Y Y Y Y

What were your findings on initial consultation (signs, symptoms, investigations)?

Please detail all treatment / interventions to date

11. CURRENT STATUS OF CRITICAL ILLNESS EVENT

At the time of your most recent consultation, how did the life assured present (signs, symptoms, etc)

What further treatment/intervention is envisaged?

PLEASE ATTACH COPIES OF RESULTS FOR ALL SPECIAL INVESTIGATIONS PERFORMED

12. 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

Telephone number

Fax number

Email address

Doctor's signature

Date D D - M M - Y Y Y Y

Doctor's stamp