

# Proof of Death Claimant's Statement

**ADVISE INSURE INVEST**  
Regulated by the Insurance Regulatory Authority

**Liberty Life Assurance Kenya Limited**  
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## PART 1

Name of insured (if married woman, give maiden name also)

Policy (or certificate) number  Amount

City

State

Country

Place of death  Date of death     
Date Month Year

Place of birth  Date of birth     
Date Month Year

Occupation at time of death

Name and address of last employer

Date last time worked full time at full day     
Date Month Year

Cause of death

When did insured first complain or give other indications at of last illness?     
Date Month Year

When did insured first consult a physician for last illness?     
Date Month Year

List all physicians who attended to insured during last illness and during three years prior thereto:

| NAME                 | ADDRESS              | DATE                 | DISEASE OR IMPAIRMENT |
|----------------------|----------------------|----------------------|-----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>  |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>  |

Has insured other life insurance? If so, in what companies and for what amounts?

| COMPANIES            | POLICY NUMBER        | POLICY DATE          | AMOUNT               |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

In what capacity title/relation do you claim this insurance

Who has the policy document (certificate)?

What mode of settlement do you select? Tick one EFT  Cheques

What is your date of birth?     
Date Month Year

The undersigned hereby makes claim to said insurance, and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, shall constitute and they are hereby made a part of these Proofs of Death, and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said Company, shall not constitute nor be considered by it that there was any insurance in force on the life in question, nor a waiver of any of its rights or defences.

|                         |                      |                      |                      |                      |                      |                      |
|-------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Date                    | <input type="text"/> | <input type="text"/> | <input type="text"/> |                      |                      |                      |
| Claimants Name          | <input type="text"/> |                      |                      | Claimant's Signature | <input type="text"/> |                      |
| Claimant's Telephone No | <input type="text"/> |                      | Email Address        | <input type="text"/> |                      |                      |
| Claimant Address        | PO Box               | <input type="text"/> | Code                 | <input type="text"/> | Town                 | <input type="text"/> |
| Witness Name            | <input type="text"/> |                      |                      | Witness's Signature  | <input type="text"/> |                      |
| Witness Address         | PO Box               | <input type="text"/> | Code                 | <input type="text"/> | Town                 | <input type="text"/> |

This must be witnessed by Employer, if Group Insurance, otherwise Agency Manager, otherwise before an officer authorized by law to administer oaths.

## DECLARATION

I/We consent to Liberty Life Assurance Kenya Limited:

- (i) Collecting, using, disclosing and/or processing and/or storing my/our personal data for purposes that are relevant to my policy and as permitted by law;
- (ii) Collecting and sharing my personal data in accordance with the privacy statement on its website (<https://www.liberty.co.ke/>);
- (iii) Transferring my/our personal data to their reinsurers and affiliated companies for the purposes of insurance and as permitted by law;
- (iv) And /Or its contracted Third parties contacting me via email/phone-call/SMS/post in regard to insurance products and/or services.

I/We hereby declare the truth and correctness of the above statements and agree that this Declaration shall be held to be promissory and the basis of the contract between me/ us and Liberty Life Assurance Kenya Limited.

I/We hereby declare that I have read and understood the provisions this Form.

Proposer's Signature

Date