# CLAIM FORM

**FUNERAL | DEATH | DISABILITY | HOSPITAL CLAIM FORM | ANNUITY DEATH**

Complete where applicable using block letters or tick

## POLICY DETAILS

Policy Number

Policy Owners Name

On the lives of

## TYPE OF CLAIM

Funeral　Death　Disability　Hospital　Annuity death　Claim Amount

## CLAIMANT DETAILS

Name of Claimant

Omang/ID/Passport Number　Contact Number

Relationship to Policy Owner

**Are you KYC compliant**　**YES**　**NO (If no, please provide the below)**　**Year of KYC Completion**

KYC Form　Proof of Residence　Source of funds (Pay Slip/3 Months Bank Statement)　PIP Form

## BANKING DETAILS

Bank Name　Bank Acc.　Branch Name

## CUSTOMER DECLARATION

I hereby confirm that the above information is true and correct to the best of my knowledge

Claimant Name　Date　Claimant Signature

## FOR OFFICIAL USE

Processed by　Approved by

Date　Date

Signature　Signature

## REQUIRED CHECKLIST

### HOSPITAL CLAIM

Certificate by Medical Attendant　Certificate by Employer　Sick Notes/Sick Leave　Hospital Bill

### DEATH

List of Dependents　Declaration by Next of Kin　ITW6　Police Report　Certified Death Certificate

### DISABILITY CLAIM

Certificate by Specialist　Boarding Letter　Declaration by Claimant