

DEATH CLAIM APPLICATION FORM

	.RELATIONSHIP WITH DECEASED
	GROUP: (where applicable)
Caution Upon submission of fraudulent documentation errejection of your claim. If after settlement of claim	ven in genuine cases may result in delay of payment or outright m, our investigations prove that there was any falsified as the right to prosecute the claimant and publish the act in any
1. IDENTIFICATION OF DECEASED	
	OCCUPATION
MOBILE NO OF DECEASED	
Deceased Religious Background:	
RELIGION: PLACE OF WORSHIP	LOCATION
CONTACT FROM RELIGIOUS BODY: NAME OF PERSON.	MOBILE NO
Deceased Employer Details:	
	LOCATION
CONTACT PERSON'S NAME	MOBILE NUMBER
Deceased Relative Detail (Sibling/Family head/other	relative)
NAME OF RELATION	RELATIONSHIP TO DECEASED
MOBILE NO	
2. DEATH DESCRIPTION:	
DATE OF DEATH	PLACE OF DEATH (HOME, HOSPITAL, OTHERS)
HOSPITAL NAME	. NAME OF DOCTOR
CAUSE OF DEATH	
3. DETAILS OF MORTUARY/ BURIAL INFORMATION	
WAS BODY DEPOSITED AT MORTUARY YES NO	
NAME OF MORTUARY:	TEL
HAS DECEACED BEEN BURIED YES NO	7
NAME OF CEMETERY OR INTENDED CEMETERY:	
	ODY THAT HANDLED THE BURIAL

4. PARTICULARS OF CLAIMANT/ BENEFICIARIES		
FULL NAME:	DATE OF BIRTH:	TEL
RESIDENTIAL ADDRESS		
NOTABLE LANDMARK:		
GPS ADDRESS		
EMPLOYER NAME	OCCUPATION	
DEPARTMENT	COMPANY TEL	
NAME OF SUPERVISOR OR MANAGER		
DETAILS OF CLAIMANTS SIBLING/RELATION		
FULL NAME	AGE	TEL
RESIDENTIAL ADDRESS		
NOTABLE LANDMARK:		
NAME OF EMPLOYER	OCCUPATION	
Pay me through: Bank	Mobile Money Ch	neque
Name of Bank:	Branch:	
Account No. /Mobile No:		
5. REQUIRED DOCUMENTATION FOR DEATH CLAID DEATH CERTIFICATE MEDICAL CERTIFICATE OF DOCTOR'S REPORT OF CAIR POLICE REPORT IN CASE OF ACCIDENT AFFIDAVITS OF IDENTITY OF BENEFICIARIES AND TRUST ACCEPTABLE NATIONAL ID PROOF OF AGE OF DECEASED MORTUARY/ BURIAL DOCUMENTATION	USE OF DEATH	
NB: PLEASE NOTE THAT ADDITIONAL INFORMATION M.	AY BE REQUESTED WHERE APPLICAB	LE
DECLARATION I do hereby declare that all the answers to the above concealed or withheld any material information; an miLife Insurance Company. I expressly waive all proany institution who attended, treated or examined such persons or agencies to furnish any information in	d that I undertake to furnish any do visions of law, custom or profession the deceased to disclose any info	ocumentation which may be required by nal etiquette forbidding any physician or ormation acquired. I hereby authorize all
SIGNATURE OF CLAIMANT:	SIGNED DATE:	TIME: