CIC INSURANCE GROUP LIMITED

THE COOPERATIVE INSURANCE COMPANY OF KENYA LIMITED
P.O. BOX 59485-00200 NAIROBI-KENYA

EMPLOYEE GROUP LIFE INSURANCE CLAIM FORM

EMPLOYER

Name ______________________________

Address ______________________________

DECEASED

Name ______________________________

Address ______________________________

Date of birth ______________________________

Payroll Number ______________ ID Number ______________

Date last in full time active employment ______________________________

Was the deceased on the payroll at the time of death? Yes ☐ No ☐

If **NO** give reason ______________________________

Monthly salary at the time of death ______________________________

If there is no designation of beneficiary apply the Provision of the policy Number ______________

BENEFIT PAYABLE TO

Name ______________________________

Address ______________________________

____

Date of birth ______________________________

Relationship ______________________________

Date of decision ______________ Signature ______________

TO BE FILLED IN BY CIC Claim No. ______________________________

Group Life Insurance Policy No. EGL ______________________________

Effective date of the policy ______________________________

Premium paid date

Amount of Insurance ______________________________

Is there a designation of beneficiary? Yes ☐ No ☐

BENEFICIARY Name ______________________________

Address ______________________________

Date ______________ Signature ______________