EMPLOYER'S STATEMENT

SECTION A : PERSONAL DETAILS

Insured/Client Name: _____

Name of Employee: _____

Cell Phone No: _____

Date of Birth: _____ Occupation: _____

Genger F/M: _____ Marital Status (S/M): _____

Postal Address: _____ Postal Code: _____

Telephone No: _____ Mobile Phone No: _____

E-mail Address: _____

Policy Number: _____

SECTION B : TECHNICAL DETAILS

This statement must be completed by the employer, or his duly authorized agent, such as a Superintendent Paymaster, etc. It must not be completed by a Clerk, Bookkeeper or Foreman, unless specially authorized, nor by any Agent or employee of AIG KENYA INSURANCE CO. LTD.

1 (a) Full name of Insured _____

(b) Full name of Claimant _____

2. Name and business address of insured's employer _____

3. (a) Description of injury or illn insured's absence from employment _____

_____

(b) Was injury caused by reason of occupation? _____

4. When was Insured compelled to give up his duties? (Give exact date) _____

5. When did Insured return to work? (Give exact date) _____

6. (a) Describe Insured's duties _____

(b) Was there a period of time during which Insured could only perform part of his occupational duties? (Give exact dates) _____

7. Was Insured's injury or illness the sole cause of his absence from duty for all the above period? If not, give particulars _____

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SECTION C: DECLARATION

i. Privacy Statement

By completing this form, you have provided AIG with your personal information. AIG is committed to protecting the integrity, confidentiality, access and use of personal information that we collect from you in the course of our business. "Personal Information" is information that identifies and relates to you or other individuals (such as your dependants). You have the right to access and correct personal data that may be incorrect or incomplete. I hereby authorize AIG to use my personal information for lawful business purposes. For more information on how we handle personal information kindly obtain a copy of our privacy policy from our office.

ii. Declaration

I/We declare that the above information is true and correct and that the signing of this claim form also constitutes written authority for AIG to inspect or investigate any medical records or details relevant to this claim. I/we further declare that i/we are aware that any misrepresentation and / or non-disclosure in respect of information provided herein shall render my/our claim null and void.

I/We hereby acknowledge the contents of the statements i-ii above)

Name:_____

Signature:_____ Designation _____

Company Stamp: