**WELFARE CLAIM FORM**

***Please complete this form and return it to the management promptly. All fields MUST be filled fully.***

**Principal member’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deceased name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: Self Spouse Child Father Mother Other: Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nature of claim, Death Long sickness**

**Cause of Death/ Sickness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Death\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Claim amount: Ksh.**

**CLAIMS PROCESSING REQUIREMENTS**

1. **Duly completed claim form.**
2. **Copy of ID Card for the principal member/Deceased.**
3. **Original burial permit/press obituary.**
4. **Doctor’s report on long sickness cases.**

**DECLARATION**

**We hereby jointly both the beneficiary and the management declare and certify that all particulars furnished herein are the true records of the deceased at the date of coverage and at the date of the claim.**

**Signed on behalf of the Deceased,**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID/NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGN\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_**

**CONFIRMED ON BEHALF OF ALARMS SACCO LTD;**

**CHAIRMAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TREASURER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMEBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**