COMPENSATION CLAIM FORM

(to be completed in duplicate)

INTRODUCTION

The Policyholders Compensation Fund (herein referred to as the Fund or PCF) is a State Corporation under The National Treasury and Planning that was established through the Legal Notice No.105 of 2004 and commenced its operations in January 2005. The Fund was established for the primary purpose of providing compensation to the claimants of an insurer placed under a Manager appointed under Section 67C(2) of the Insurance Act or whose license has been cancelled under the Act.

Pursuant to the provisions of Section 179(1) of the Insurance Act and the Insurance (Policyholders Compensation Fund) Regulations, 2010, PCF has developed this claim form for ascertaining eligible claimants for compensation.

NOTES

1. Only claims arising from policies issued from 1st January 2005 (when the fund was established) will be admissible for consideration.
2. Cases currently active before Courts of Law will not be considered.
3. All relevant information and documents to support the claim must be provided.
4. Kindly fill all the information (where applicable) honestly and truthfully. Filling of the form fraudulently will be construed as a criminal offense.

To enable us to complete the process of claims verification and compensation, kindly complete the questionnaire provided below: -

PART A

CLAIMANT'S DETAILS

NAME OF INSURANCE COMPANY AGAINST WHICH YOU ARE LODGING YOUR CLAIM: ______________________

YOUR FULL NAME:

ID NO *(KINDLY ATTACH A CERTIFIED COPY):* ______________________

PHYSICAL ADDRESS: ______________________

POSTAL ADDRESS: ______________ POSTAL CODE: ______________

CITY: ______________________

EMAIL ADDRESS: TELEPHONE NO:

PART B

DETAILS FOR MOTOR RELATED CLAIMS

NAME OF THE INSURED PERSON (POLICYHOLDER): ____________________

POLICY NUMBER: ____________________

VEHICLE REGISTRATION NO: ____________________

VEHICLE BODY TYPE
(e.g. Saloon, Mini Bus, Van e.t.c.) ____________________

DATE OF ACCIDENT: CLAIM NUMBER:

TYPE OF CLAIM

OWN DAMAGE (INCLUDING FIRE OR THEFT ☐

THIRD PARTY PROPERTY DAMAGE ☐

THIRD PARTY INJURIES/ DEATH ☐

FOR INJURY

NAME OF INJURED PERSON: ____________________

FOR DEATH:

NAME OF THE DECEASED PERSON: ____________________
(KINDLY ATTACH CERTIFIED COPY OF DEATH CERTIFICATE)

STATE YOUR RELATIONSHIP TO THE DECEASED: ____________________

NAME OF ADMINISTRATOR OF ESTATE OF
THE DECEASED: ____________________
*(KINDLY ATTACH A CERTIFIED COPY OF THE
LETTER OF ADMINISTRATION)*

CONTACT TELEPHONE NO: ____________________

ID NO:

FORM C.1

Kindly tick(√)in the appropriate box and fill in where applicable(*)

1. Own damage claims only

Were you issued with a discharge voucher? (If Yes please attach copy)		State amount (Kshs)	Had you received partial payment? (If Yes please attach payment advice)		State amount Received (Kshs)	Balance of amount outstanding being claimed (Kshs)
Yes	No		Yes	No		

2. Third Party Property Damage

(i) Was a discharge voucher issued? (If Yes please attach copy		State amount (Kshs)	Was partial payment made? (If Yes please attach payment advice)		State amount Received (Kshs)	Balance of amount outstanding being claimed (Kshs)
Yes	No		Yes	No		

ii)Court Award (where applicable)

State Date of Judgment___________________

Case Number	State judgment amount (Kshs)	Had you received partial payment? (If Yes please attach payment advice)		State amount Received (Kshs)	Balance of amount outstanding being claimed (Kshs)
		Yes	No		

3. Third Party Injuries/deaths

Court Award (where applicable)

State Date of Judgment_______________________

Case Number	State judgment amount (Kshs)	Had you received partial payment? (If Yes please attach payment advice)		State amount Received (Kshs)	Balance of amount outstanding being claimed (Kshs)
		Yes	No		

4. Third Party Injuries/deaths

Out of Court Settlement

Claim No.	State settlement amount (Kshs)	Had you received partial payment? (If Yes please attach payment advice)		State amount Received (Kshs)	Balance of amount outstanding being claimed (Kshs)
		Yes	No		

PART C

DETAILS FOR NON-MOTOR RELATED CLAIMS

NAME OF INSURED (POLICYHOLDER): ______________________________

CLASS OF INSURANCE:

POLICY NUMBER: ______________________________

CLAIM NUMBER: ______________________________

DATE OF LOSS:

Kindly tick(√)in the appropriate box and fill where applicable(*)

Were you issued with a discharge voucher? (If Yes please attach copy)		*If Yes state amount (Kshs)*	*Had you received partial payment? (If Yes please attach payment advice)*		*State amount Received (Kshs)*	*Balance of amount outstanding being claimed (Kshs)*
Yes	*No*		*Yes*	*No*		

ii)Court Award (where applicable)

State Date of Judgment:

Case Number	*State judgment amount (Kshs)*	*Had you received partial payment? (If Yes please attach payment advice)*		*State amount Received (Kshs)*	*Balance of amount outstanding being claimed (Kshs)*
		Yes	*No*		

PART D

DETAILS FOR LIFE INSURANCE CLAIMS

Particulars	**Details *(Kindly fill in where applicable)***	*Further additional Comments by Claimant*
Type of Policy		
Policy Holder's Name		
Name of Beneficiaries		
*Policy Number/Claim Number *(where applicable)*		
Policy Term (From………..to………………………		
*Sum Assured (Kshs)		
Maturity Date		
In case of Partial Maturity Claim (where applicable):		
Date of Partial Maturity:		
Amount of Partial Maturity:		
In case of Final Maturity:		
Date of Maturity:		
Amount of Final Maturity:		
In case of Disability Claim (where applicable) (temporary or permanent):		
Date of diagnosis:		
Amount of disability claim:		
In case of illness Benefit (where applicable):		
Date of diagnosis:		
Amount of Benefit:		
In case of Surrender Claim:		
Date of Surrender:		
Amount of Surrender:		
In case of Death Claim:		
*Name of the Deceased ***(Copies of death certificate if applicable and copy of letter of administration)***		
*Name of Next of Kin (*if policyholder deceased)*		
*Relationship to the deceased (*Kindly indicate if you are a beneficiary/Administrator under the policy and attach either ID or letter of Administration)*		
Court Awards if any (attach date of judgment/advocate/case number)		

Policy Loan advanced/ assignment of policy (where applicable):		
Date of Loan/ assignment:		
Amount of Loan:		

DECLARATION

I /We____ of I.D No………………….. Solemnly declare that all the information indicated above is correct and true to the best of my/our knowledge.

Signature(s) ____

Date ____

Before me;

Commissioner for Oaths

Date: ____

NOTES

Attachment of the following documents is required for the stated entities:

a) Individual Claimants (Policyholders and Third-Party Claimants)

- i) Copy of ID or Passport
- ii) Copy of the PIN cert.
- iii) Original Discharge Voucher (where applicable)
- iv) Court Judgment/ Award (where applicable)
- v) Letter of Administration (where applicable)
- vi) Copy of police abstract (where applicable)
- vii) Copy of life insurance policy document (where applicable)
- viii) Any other proof of claim (where applicable)

b) Companies, Registered Business Firms and other corporations

- i) Copy of certificate of incorporation.
- ii) Copy of the PIN certificate
- iii) Original Discharge Voucher (*where applicable)*
- iv) Any other proof of claim (*where applicable)*

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CLAIM PAYMENTS DISBURSEMENT OPTIONS

KINDLY INDICATE YOUR PREFFERED MODE OF PAYMENT

a) **MOBILE MONEY TRANSFER** - *If to be paid by mobile money transfer please provide mobile number (only registered mobile money users will be allowed to use this option)*
FULL NAME OF RECEPIENT:
MOBILE NUMBER:

b) **DIRECT CREDIT TO MY /OUR BANK**
Full name of recipient:
Bank Name:
Bank Swift code:
Branch:
Account Title:
Account Number:

c) **CHEQUE PAYMENT METHOD**
Full name of recipient:

FOR COMPANIES ONLY		
Company Name:		
Officer authorized to collect on behalf of company:		
Signature:	Date:	

FORM C.1

ACKNOWLEDGEMENT OF PAYMENT

For All Claims Paid By Policyholders Compensation Fund

1. I/We____

   acknowledge receipt of KSh ______________ against Claim Number _______________________ on behalf of ______________________ Insurance Company.

2. I/we further confirm that we shall have no further claim against the said (Insurer) with respect to the said claim now or in the future and hereby subrogate all my / our rights therein to Policyholders Compensation Fund entirely to the extent of Monies paid to me/us by the Fund.

   Signature (s)____

   ID Number (s)____

   Date____

***Part 2 – CLAIMS VERRIFICATION FORM (For official use only)**

A) Approved/Admitted Payable Claim Form

Particulars	Amount (Kshs)	Comments/Remarks
Total Claim		
Adjustments (If any)		
Deductions *(If any)*		
Net Adjusted Claim		
Amount Payable by PHCF		
Balance of Outstanding amount yet to be settled		

Verified by:

Signature: ____________________ Date: ____________________

Approved by:

Signature: ____________________ Date: ____________________

B) Declined/Inadmissible Claim Form

Particulars	Amount (Kshs)	Reasons for Decline and Proposed Action
Total Claim		
Adjustments (If any)		
Deductions *(If any)*		
Net Adjusted Claim		

Verified by: Name ______________________________

Signature: ____________________ Date: ____________________

Approved by: Name ______________________________

Signature: ____________________ Date: ____________________

C) ***To be filled out by: Compensation Manager/Senior Authorized Officer of the Fund***

Verified by: Name ______________________________

Signature: ____________________ Date: ____________________

Approved by: Name ______________________________

Signature: ____________________ Date: ____________________

Claim Paid By: Name ______________________________

Signature: ____________________ Date: ____________________