

LAPF/13 CLAIM FOR GROUP LIFE ASSURANCE COVER ~ DEATH BENEFIT

IMPORTANT NOTES/REQUIREMENTS

You must carefully read the following notes before filling this application form.

1. The claimants must give correct names and in the order they appear on their NATIONAL IDENTITY CARDS.
2. Copies of LEGIBLE National Identification Cards for ALL listed claimants if of majority age.
3. The contacts given on the application form must be the one the claimant is sure he/she will get a letter delivered to him/her without difficulties or in the case of mobile number, he/she can be reached easily.
4. Where there is no named beneficiaries, or the nominated beneficiaries are unable to complete the form due to various reasons like grave injuries/insanity; the benefit must be applied for (attach proof of relationship to deceased where applicable) by those who qualify in the following order:
 - (a) Husband/Wife
 - (b) Children (if of majority age)
 - (c) Both Parents
 - (d) Brother/Sister
 - (e) Guardian
 - (f) Other dependents/beneficiaries
5. An Original death certificate must be provided for the claim to be processed.
6. Provide payslip for the last month in service duly certified by the employer.
7. Police abstract or postmortem report if the cause of death is accidental or sudden.
8. Do not leave any blank spaces. Write NOT APPLICABLE (N/A) instead.
9. If the space provided is not enough, fill on a separate sheet and attach to this form. Ensure you append your signature (s) on each separate attachment to this claim.
10. Banking details for ALL claimants (i.e. copy of bank cards, account numbers, branch and name of banks).
11. Once ALL spaces have been filled, this application form MUST be witnessed by the employer before forwarding it to LAPFUND offices for processing.
12. The Next of Kin shall notify us of the death of a LAPFUND member and furnish us with all information necessary within 90 days.
13. The claim shall be paid subject to the terms and conditions of this policy.

FOR LAPFUND OFFICIAL USE ONLY (Checked and received by)

NAMES

POSITION/DESIGNATION

SIGNATURE DATE.....



LAPFUND
OFFICIAL
RUBBER STAMP

THE CLAIM FORMS CAN BE OBTAINED FROM THE WEBSITE AND OR THE FOLLOWING LAPFUND OFFICES:

NAIROBI (Head Office) P.O. Box 79592 – 00200 Nairobi, Kenya 2nd Ngong Avenue, 316 Upper Hill Chambers, 10th Floor. Tel: +254 709805000/100 Email: info@lapfund.or.ke www.lapfund.or.ke	KISUMU (Western Zone Office) Al-Imran Plaza, 2nd Floor Oginga Odinga Street Kisumu City, Kenya Email: kisumuoffice@lapfund.or.ke Mobile: 0709805600	NAKURU (Rift Valley Zone Office) Polo Centre, 1st Floor, Kenyatta Ave Nakuru, Kenya Email: nakuruoffice@lapfund.or.ke Mobile: 0709805500
ISIOLO OFFICE Desert Trail Building Behind Shell Petrol Station Email: isioloffice@lapfund.or.ke	MOMBASA (Coast Zone Office) Imaara Building, 2nd Floor Opp. Pandya Hospital Dedan Kimathi Road, Mombasa City, Kenya Email: mombasaooffice@lapfund.or.ke Mobile: 0709805300	NYERI (Central Zone Office) The Fortress Building, 1st Floor (Next to Gakwaja School Uniforms) Kimathi Way, Nyeri Town Email: nyerioffice@lapfund.or.ke Mobile: 0709805400
GARISSA OFFICE, LILAC CENTRE, 1ST FLOOR-OFF KISMAYU L ROAD DESK OFFICE: ELDORET, KAKAMEGA, MANDERA, WAJIR		

LAPF/13 CLAIM FOR GROUP LIFE ASSURANCE COVER ~ DEATH BENEFIT

PART I – PARTICULARS OF DECEASED MEMBER		
1.	Employer	
2.	Name of deceased (in capital letters)	
3.	LAPFUND membership number / ID	
4.	Date of Death	
5.	Date of termination of employment (if different from above)	
6.	Date of cessation of contributions (if different from above)	
7.	Full names of claimant (in capital letters)	
8.	Mobile number	
9.	Address	
10.	Basic pay in KES (attach most recent payslip)	
11.	Claimants bank details (Please attach a copy of your bank card) Bank..... Branch.....A/C Number.....	

PART II ~ PARTICULARS OF SPOUSE AND CHILDREN	
Full names of 1 st Spouse	
ID Number	
Mobile Number	
Address	

Names of children of 1 st spouse	ID number/Age	Mobile number	signature
1.			
2.			
3.			
4.			

I of ID No..... hereby declare that the foregoing statements are true to the best of my knowledge and understanding Signature: Date:

Full names of 2 nd spouse	
ID Number	
Mobile Number	
Address	

LAPF/13 CLAIM FOR GROUP LIFE ASSURANCE COVER ~ DEATH BENEFIT

Names of children of 2 nd spouse	ID number/Age	Mobile number	Signature
1			
2			
3			
4			

I of ID No hereby declare that the foregoing statements are true to the best of my knowledge and understanding Signature: Date:

PART III ~ PARTICULARS OF CLAIMANTS (to be filled by NOMINATED claimants who are not the deceased spouse or child)				
Full names of claimants	ID number	Mobile number	Relationship to deceased	Signature
1.				
2.				
3.				
4.				
5.				
6.				

PART IV – WHERE DECEASED WAS UNMARRIED			
Father's Full Names	ID Number	Mobile Number.	Signature
Mother's Full Names	ID Number	Mobile Number.	Signature

Where both parents are alive but only one has applied for this benefit, the other parent should give consent below for the applicant to be paid the Benefit.

I (Name of father/mother) do hereby give authority for my husband/wife Mr/Mrs of ID No to be paid this Benefit.

Signed: Date: ID No

LAPF/13 CLAIM FOR GROUP LIFE ASSURANCE COVER ~ DEATH BENEFIT

PART V – TO BE FILLED BY THE EMPLOYER

1	Employer	
2	Date of member's death	
3	OFFICIAL RUBBER STAMP	

I (Name) the (Official Title)
do confirm
 on behalf of the Sponsor that the information given above is correct to the best of my knowledge and understanding.
 Sign: Date:

PART VI – TO BE COMPLETED BY A LOCAL ADMINISTRATOR OR A COURT OF LAW ONCE THE EMPLOYER HAS WITNESSED

1	Name and title	
2	Comments	
3	OFFICIAL RUBBER STAMP	

Sign Date