MEDICAL INSURANCE APPLICATION FORM

Please fill up this form in CAPITAL LETTERS and attach passport sized colour photographs for yourself and your dependants and write the names of the person (s) above the photograph (s).

1. PROPOSER DETAILS:

Proposer: Mr. /Ms. /Mrs. ....
First Name Middle Name Last Name

Postal Address:.....Code.....City/Town.....

Physical Residence.....

Mobile No:.....Office Telephone No:.....

Nationality: .....Marital Status: ..... .

Date of Birth: (date /month/year).....

ID No.....Sex:.....

Allergies:.....

OTHER DETAILS:

Employer:.....

Postal Address:.....Code.....City/Town.....

Occupation:.....

Selected Plan:.....Family Size.....Annual Premium(Kshs).....

3. PROPOSED DEPENDANT (S) DETAILS:

Details of Dependants:

Dependant 1. Name: Mrs/Mr.....

Relationship: ..... Gender*..... Date of Birth (date /month/year).....

Dependant 2. Name: .....

Relationship: ..... Gender*..... Date of Birth (date /month/year).....

Dependant 3. Name: .....

.Relationship: ..... Gender*..... Date of Birth (date /month/year).....

Dependant 4. Name:. .....

Relationship: ..... Gender*..... Date of Birth (date /month/year).....

Dependant 5. Name: .....

Relationship: ..... Gender*..... Date of Birth (date /month/year).....

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Please paste the photographs in sequence (Proposer, Dependant 1, Dependant 2, Dependant 3, Dependant 4, Dependant 5, Dependant 6, Dependant 7…….) as specified in section of details of proposed dependant(s)

Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4	
……	……	……	……	……	
Dependant 5	**Dependant 6**	**Dependant 7**	**Dependant 8**	**Dependant 9**	

…….. …… …… …… ……

4. NOMINEE DETAILS: (NEXT OF KIN)

In the event of the death of the Proposer, any payment due under the policy shall become payable to the nominee and his/her receipt of the proceeds would be sufficient discharge to the company. The nominee must be an immediate relative of the Proposer. Nominee for all other persons proposed to be insured shall be the Proposer himself/herself. Following section to be filled by the proposer

Nominee Name (Next of Kin)	Relationship	Address and Mobile No: of the Nominee(s)

5. MEDICAL & LIFESTYLE INFORMATION:

Medical History: Please answer the below mentioned questions in Yes(Y)/No (N): If required kindly attach extra sheet duly signed.

Section A: Have any of the insured ever suffered from/currently suffering from any of the following:	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**	**Insured 6**	**Insured 7**	**Insured 8**
(i) Are you or any of your dependants physically healthy?								
(ii) Have you or any of your dependants been involved in any kind of accident, in the last twelve (12) months.								
(iii) Do you or any of your dependants have a medical condition (s) that requires surgery or regular medication?								
(iv) Do you or any of your dependants suffered from Renal Failure or any form of cancer.								
(v) Do you or any of your dependants suffered from Stroke, Epilepsy, Paralysis or other brain/nervous system disorder								
(vi) Have you or any of your dependants had any surgery in the last three years.								
(vii) Have you or any of your dependants suffered from HIV / AIDS or sexually transmitted disease or any immune system disorder.								
(viii) HIV/AIDS or sexually transmitted diseases or any immune system disorder								
(ix) Are you or any of your dependants pregnant?								
(x) Have you or any of your dependants suffered from Psychiatric/Mental illnesses or sleep disorder.								

7. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

I hereby declare and warrant on my behalf and on behalf of all persons proposed to be insured that the above statements are true and complete in all respects and that there is no other information which is relevant to this application for insurance that has not been disclosed to Xplico Insurance Company Limited. I agree that this proposal and the declarations shall be the basis of the contract between me and all persons to be insured and Xplico Insurance Company Limited. I further consent and authorize Xplico Insurance Company Limited and/or any of its authorized representatives to seek medical information from any Medical facility/consultant that I or any person proposed to be insured had attended or may attend in future concerning any disease or illness or injury.

Signature of Proposer:.....

Signature of Employer: .....

Date: .....

Stamp:.....