HEALTHCARE RETAIL APPLICATION FORM

MADISON BetterLife

Intermediary

Name _____ **Code** _____ **Branch** _____

Please complete this form in BLOCK Letters. Ensure you provide all the information requsted in this form. Any Blank spaces will be taken to mean you have nothing to disclose.

Part 1: Personal Details to be completed by the Principal Applicant.

Full Name: _____ Mobile _____

KRA Pin No._____ ID No. _____

(Compulsory)

Date of Birth: _____ Occupation _____

Physical Address: _____ Email Address: _____

Postal Address: _____ Code: _____

Part 2: Details of Dependent (s) to be Covered

	Name	Date of Birth	Weight	Height	Relationship
1.					
2.					
3.					
4.					
5.					

Part 3: Cover Benefits Selected

	Member	Inpatient Limit	Outpatient Limit	Maternity	Optical & Dental	Total Premium
1.	Limit					
2.	Premium					

* The Total Premuim is exclusive of levies (0.45%) and stamp duty change of Kshs. 40

Part 4: Particulars of Next of Kin: (Must be over 18 years of age)

Name	Date of Birth	Relationship	Telephone No.

Part 5: Medical History

Note: All infomation provided in this part will be treated with confidence and only be disclosed to the applicant's doctor or third party with the written approval of the applicant. Failure to disclose any material information may lead to claims relating to such information being declined or nulification of the policy.

1. Have you any of your declared dependants ever suffered or do suffer from any of the following conditions?

Please indicate Yes or No in the Applicant's box below. The Principal applicant is No. 1						
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
Cardiovascular Conditions						
Hypertension						
High Cholestral Level						
Heart Disease						
Palpitations						
Varcose Veins						
Deep Vein Thrombosis						
Respiratory						
Asthma						
Chronic obstructive airway disease						
Sinus disease						
Tuberculosis						
Persistent Cough						
Shortness of breath						
Cigarette smoking related disorders						
Endocrine						
Diabetes						
High cholestrol						
Thyroid abnormalities						
Blood disorders						
Leukemia						
Anaemia						
Musculoskeletal Disorders						
Arthritis						
Gout						
Chronic Back pains / slipped disk						
Osteoporosis						
	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6

Genito urinary / reproductive disorders						
Pelvic Inflamatory disease						
Fibroids						
Enlargement of the prostate						
Kidney failure						
Blood in urine						
Any form of cancer						
Gastro Intenstinal Disorders						
Heart burn						
Liver disease						
Hernia						
Reccurent indigestion						
Piles						
Fissures						
Stomach Ulcers						
Pregnancy						
History of caesarian section						
Any pregnant member						
Neurogical						
Paralysis						
Celebral palsy						
Menengitis						
Migraines						
Stroke						

1. Have you or any of your declared dependants been admitted in a hospital in the last two years? If yes, please provide full details and attach discharge summary / medical report of the admission.

2. (a) Please state any other condition in you or any of your declared dependants that may require suegery or regular medication

3. Do you, or any of your dependants. currently have onother Health Insurace Cover in force? If yes, please provide full details and attach renewal invitation and / or claims experience.

Part 6: Declaration

I declare that to the best of my knowledge and belief the above statement are true and that no material information has been withheld. I accept to the company, seeking medical information from any doctor whom may dependants or i have consulted in the past and consult in the future.

I confirm that i read, understood and agree with the cover option, exclusion, terms and conditions as stipulated in the product brochure and benefit schedule.

Name of Principal member (Policy holder): _____

Signature: _____ Date: _____

Is Underwriting criteria fulfilled? Yes/No

If NO, indicate comments _____

_____

_____

Signed by: _____ Date: _____

NB: Acceptance of cover is subject to medical underwriting.

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