Signature of proposed insured _____ Date _____

Agent or other witness _____ Date _____

_____, the life to be assured, having been requested to undergo the HIV test declared that I am not willing to undergo the same and hereby give Madison Life Assurance Company Kenya Limited authority to issue the policy subsequent to Aids Exclusion Clause.

Signature of proposed insured _____ Date _____

Signature of the agent or other Witness _____ Date_____

Non - health hazards

Do you have any intention or prospect of:-

a) Engaging in any hazardous occupations, sports or pastime? If so, please give details by completing the relevant Questionnaire	YES	NO
b) Flying other than fare paying passenger by recognized airline, on scheduled air routes? If so, please give details by completing aviation Questionnaire	YES	NO
c) Engaging in Naval, Military or Air Services? If so, please give details by completing the relevant Questionnaire	YES	NO

Is there anything, not mentioned earlier in the proposal relating to your health, habits or other circumstances which might result in this assurance on your life being more than normally hazardous? Please give details.

Declaration and Signature

For all proposals to be read and signed by the life to be assured.

I, the life to be assured, do hereby declare that all the previous information is true, that i have not concealed or withheld anything which the Company ought to be made acquainted in order to assess my eligibility for assurance and that I am willing to be medically examined if required.

I consent to the company seeking medical information from any doctor who has at any time attended me or seeking information from any office to which I have at any time made a proposal for life or sickness or Accident Insurance and I authorize the giving of such information. I agree that these and all other statements I have made or shall make to the Company or to its medical examiners in connection with this or any previous proposal shall be the basis of the contract of Assurance to be written in the currency of and within the laws of Kenya.

Date _____ Signed _____

Witness Name_____ Signed _____

Name of Agent _____ Agency_____

Code _____ Signed _____

Agency Manager _____ Date _____

Signature _____

CLIENTS SLIP. TEAR ALONG THIS LINE

Proposal for Bima Ya Karo Policy

Proposal No.

NOTE- Our esteemed client kindly note that this is not a receipt of payment or policy document but an acknowledgement. If you have paid cheque / mobile money an official receipt will be issued within reasonable time and given to you within two weeks. If you do not get it get in touch with us.

This proposal is for Bima ya karo which is an Educational policy and main sum assured is Kshs.....
First premium paid with this proposal is Kshs.....(CASH/CHEQUE). The same amount should reflect in the proposal form.

Subsequent premium will be though: Check off ☐ Bank ☐ CHEQUE ☐ Mpesa ☐

Branch Office.....

Physical Address .....

Agents Name.....Mobile Number.....

Code..... Sign.....Date.....

Name of Applicant.....

Signature.....Date.....

Madison House, Upper Hill Close | P.O. Box 47382 - 00100, Nairobi | Tel: 020 - 2864000 | Cell: 0709 922 000
Email: madison@madison.co.ke | Website: www.madison.co.ke

MADISON Life Assurance

PROPOSAL FOR BIMA YA KARO POLICY

PROPOSAL No.

Serial No.: 500001

IMPORTANT

1. Please complete this proposal in block letters
2. Attach a copy of your ID or PASSPORT or BIRTH CERTIFICATE, a copy of your PIN CERTIFICATE and ATM CARD copy.
3. All questions in the proposal form MUST be answered by the applicant or to the dictation of the agent. Dashes, blanks or empty spaces will not be accepted. Not applicable should be used where appropriate.
4. Incase of cancellations, applicant should countersign. Erasing or use of white out will not be accepted.
5. All measurements e.g weights, heights e.t.c should be expressed in their standard unit of measurement e.g Fts, Kgs, Lbs, Kms, Metres e.t.c
6. No abbreviations should be used unless the common ones e.g. Mr. Dr. TSC e.t.c

1. i) Nominated Child Details

Names	Date of Birth
P.O. Box	Resident
Code	Relationship to the insured

ii) Name of Proposer/Life to be Assured; (as in ID/PP)

Title Surname		Other names in full
National Identification or passport Number		Personal Identification Number (PIN)
Date of Birth DD/MM/YY		Describe Occupation:
Physical/Residential Address (Estate and Town)		
Current Address P.O. Box Code		Permanent Address: P.O. Box Code
Email		
Mobile Phone		
Names of Employer/Business	Location (bld/flr)	Street/Road

I hereby nominate the following person(s) to be the Beneficiary(ies) of the policy benefits in the event of my death

Name	Relationship to the insured	Date of birth	Phone Number	Percentage Split
1				
2				
3				
4				

I hereby nominate the following as the guardian(s) of the above minor(s) named as beneficiary(ies) so as to receive benefits incase of my death prior to the minor(s) attaining majority age

Name	Relationship to the insured	Date of birth	Phone Number	Percentage Split
1				
2				

NB: If no guardian is named incase of a minor beneficiary (ies) the benefits shall be payable to a Trust or estate as instructed by High court and held until the minor(s) attain age of majority

Details of Policy Requirements

The Basic Policy Details

Tick option With bonuses ☐ Without bonuses ☐

Policy term (yrs)	Basic Sum Assured	Basic Premium
	Kshs.	Kshs.

Optional Benefits (Riders)

a) Death Benefit -50% of Basic Sum Assured	Kshs.	Kshs.
b) Critical Illness -25% of Basic Sum Assured	Kshs.	Kshs.

c) Family Funeral Cover	Date of Birth		
Main life		Kshs.	Kshs.
Spouse		Kshs.	Kshs.
Child 1:		Kshs.	Kshs.
Child 2:		Kshs.	Kshs.
Child 3:		Kshs.	Kshs.
Child 4:		Kshs.	Kshs.
Child 5:		Kshs.	Kshs.
Total Premiums (Basic + Riders Premium)			Kshs.
Policy Holders Compensations Fund (PHCF)			Kshs.
Where funeral cash is required forward the following:-		**GRAND TOTAL**	**Kshs.**

(i) DCGH (Declaration of Continued Good Health) & proof of marriage for spouse
(ii) DCGH (Declaration of Continued Good Health) and birth certificate or clinical card for child aged 5 years and above
Note: Children below 5(five) years are not covered.

Details of Premium Payments

Frequency of Payments

Monthly ☐ Quarterly ☐ Half Yearly ☐ Annually ☐

Mode of payment: SDO ☐ Airtel Money (Business Name: MADISONL) ☐ Mpesa (Pay Bill NO: 600800) ☐

Cheque/Mobile Money ☐ BO/DDI ☐

Please ensure you are given Company's official receipt for each payment made

Bank Account details for future payment. The company shall pay you all policy benefits through your bank account provided. If you change your account you should notify the company immediately.

A/C Holders Name	Bank Account No.	
Bank Name	Branch Name	
Town	Address	

For Salary Deduction Order (SDO)

Name of Employer	Address of Head Office	
Station	Department	Payroll Number

Previous Insurance Acceptance Terms

Has a previous proposal of the life to be assured ever been made to this company?	YES		NO	
If yes - Date and Policy No/Proposal No:				
Has any proposal for Life Assurance or Accident Insurance by the life now to be assured ever been accepted at an extra premium or other special terms, or declined by another insurer?	YES		NO	
If Yes, please give name of insurer, insured date and special terms imposed e.g Extra premium, Declined, Postponed or any other				

Family History: The following questions must be answered by the life to be assured

	Surviving Relatives		Deceased Relatives			
	Age	State of health	Age at the time of death	Cause of Death	Duration of illness	Year of Death
Father						
Mother						
Brother						
No.born)						
Sister						
No.born)						
spouse						

Has any close blood relative had diabetes, heart diseases, stroke, high blood pressure, mental illness, prophyria or any other heriditary disease?	YES	NO
If yes please explain		
Do you take beer, wine or spirits?	YES	NO
If yes what quantity and type of alcohol liquor/beer do you consume? (per day?)		
Do you smoke?	YES	NO
Have you ever received medical advice to stop or reduce your tobacco or liquor consumption?	YES	NO

Past illness and disease

Have you ever suffered from, had symptoms or been told you had:-				
Nervous disorder e.g. fits, fainting, dizziness etc?	YES / NO		Heart trouble or any other disease of chest or respiratory organs?	YES / NO
Urinary trouble e.g. Kidney or Bladder disease, Gonorrhoea, syphillis etc	YES / NO		Malaria, backwater fever or other tropical disease?	YES / NO
Tuberculosis	YES / NO		Hepatitis B	YES / NO
Any other disease?				
If any of the above have been answered YES please give dates of attack, name of doctor(s) consulted and hospital visited plus the results.				

Acquired Immune Deficiency Syndrome (AIDS)

a) Have you ever had Sexually Transmitted Diseases?	YES / NO		b) Have you ever had or been advised to have a blood test for AIDS or AIDS related conditions?	YES / NO	
c) Have you ever experienced genital sores or discharges?	YES / NO		d) Have you received a blood transfusion within the last year?	YES / NO	
e) Have you ever been refused as a blood donor?	YES / NO		f) Do you experience weight loss, tiredness, skin rashes and/or hair loss?	YES / NO	

Private Medical Attendant

Please give names and address of your usual doctor / hospital;or doctor/hospital you visited last	How long has the doctor/hospital known you?
Have you consulted any doctor during the last 5 years? If so, when and for what complains?	

Life Assured's Statistics

What is your height? (without shoes)		What is your weight? (in under clothes)	
(For female only) Are you pregnant? If yes, please give expected date of delivery		YES	NO

Current Health

Are you in good health? If not please give details	YES	NO

Notice and consent for blood testing for HIV Antibodies

I_____hereby give consent to undergo HIV test to facilitate issuance of this policy. I am aware underwriting decision will be based on the test results.
All test results and the fact the test occurred will be treated confidentially. The results in a sealed cover will be reported to Underwriting Department, Madison Life Assurance Kenya Limited, Madison House, Upper Hill Road, Nairobi. However at your written request to Underwriting Department the test results may be disclosed to your personal doctor or any other doctor of your choice
Name of Doctor_____ Address _____

MADISON
Life Assurance

Dear Sir/Madam,
On my behalf and that of the entire Company, I would like to thank you for choosing Madison Life Assurance Kenya Ltd as your insurer. We have been translating policy owners' dreams into realities through carefully designed products such as the one you have applied for.

If you do not receive the legal Policy Document or hear from us within a month after the receipt of the first premium check with your nearest /any branch or head office. Carry this portion with you when making inquiries.

Kindly note that No Coverage will be effected until:-
a. The application is approved by the Company at the premium applied for
b. A policy document is issued with the effective Date of coverage stated here in, and
c. The policy is delivered during the good health of the named Insured(s)

I wish you a happy relationship with Madison Life Assurance Kenya Limited.
Yours truly,

Managing Director
Madison House, Upper Hill Close
P.O. Box 47382 -00100 Nairobi, Kenya
Tel: +254020 2864000, Mobile: 0709 922 000
Sms: 20286
Email: madison@madison.co.ke Website: www.madison.co.ke

Branches: Buruburu Branch | City Square Branch | Industrial Area Branch | Moi Avenue Branch | Ngong Road Branch | Westlands Branch | Kitengela Branch Machakos Branch | Ongata Rongai Branch | Eldoret Branch | Kakamega Branch | Kericho Branch | Kisii Branch | Kisumu Branch | Kitale Branch | Homabay Branch Malindi Branch | Mombasa Branch | Voi Branch | Embu Branch | Nakuru Branch | Meru Branch | Nyeri Branch | Thika Branch

Madison Life Assurance Kenya Limited is regulated by the Insurance Regulatory Authority