

12 Habits

- a) Do you take beer, wine or spirit? Yes No
 b) What is the quantity and type of alcohol do you consume per day? _____
 c) Do you smoke? Yes No
 d) How many cigarettes do you smoke per day? _____
 e) Has your consumption of liquor changes in the last 5 years? Yes No
 f) Have you ever received medical advice to stop or reduce your tobacco or liquor consumption? Yes No

Should you have answered " Yes" to any of the above please provide details below:

Question _____ Details _____

13. Health Hazards

Have you intention or prospect of:

- a) Engaging in any hazardous occupations, sports or pastime? Yes No
 If so, please give details by completing the relevant Questionnaire.
 b) Flying other than as fare paying passenger by recognized airline, or scheduled air routes? Yes No
 If yes, please give details by completing Aviation Questionnaire
 c) Engaging in naval, Military or air services? Yes No
 If yes please give details by completing the relevant questionnaire
 d) Is there anything , not mentioned earlier in the proposal relating to your health, habit or other circumstance which might result in this assurance on your life being more than normally hazardous? Yes No
 Please give details. _____

14. Declarations and signatures

i) Declaration by Life Assured

I, the Life to be Assured, do hereby declare that all the forgoing information is true, that I have not concealed or withheld anything with 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 other 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 this and 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.

Signed _____ Date _____

ii) Declaration by Prosper (if Different From the Life Assured)

I the person whom the policy is to be granted, declare that I know of a reason involving the health, occupation, or habits of Life Assured that might cause the life to be ineligible for assurance, and on the basis that all the statements made by of the life to be assured are true, I request the company to issue the proposed policy in my name.

Signed _____ Date _____

iii) Declaration by the agent

I _____ have discussed the proposed life policy with the client and have explained all the features of the policy and the client has agreed to take the policy.

Signed _____ Date _____

Code _____ Agency _____

Agency Manager's signature _____ Date _____

Branch Stamp _____

PROPOSAL FOR HEKIMA POLICY

PROPOSAL No. _____

Serial No.: 500001

Agent's Name _____

Agent's Tel. No. _____

All questions must be answered in full. Please use block letters or tick as appropriate.

IMPORTANT

- 1) Please complete this proposal form in Block/Capital Letters.
- 2) Attach **ID** copy or **passport** or **birth certificate**, **PIN** certificate copy and **ATM Card**
- 3) All questions on 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 appropriately.
- 4) Incase of cancellation, applicant should countersign. Erasing or use of white out will not be accepted.
- 5) All measurement e.g. weight, height etc should be expressed in their standard unit measurements e.g. Fts, Kgs Lbs, Kms, Metres etc.
- 6) No abbreviations should be used unless the common ones e.g. Mr., Mrs., Ms., Prof. e.t.c

1.i) Name of the proposer (as in National ID Card/Passport)

Title _____ Surname _____ Other Names _____

National ID Card /Passport No. _____ Personal identification (PIN) No. _____

Date of Birth DD/MM/YYYY. _____ Describe Occupation _____

Address _____ Code _____ Town _____

Telephone No: _____ Mobile No: _____ Email Address _____

Relationship to the life assured _____

1.ii) Name of the life assured (as in National ID Card/Passport) (if different from above)

Title _____ Surname _____ Other Names in full _____

National ID Card/Passport No. _____ PIN No. _____ Date of Birth (DD/MM/YYYY) _____

Describe Occupation _____

Marital status: Married Widow/er Divorced Single

Physical/Residential Address (Estate and Town) _____

Current Address _____ P.O. Box _____ Code _____

Permanent Address _____ P.O. Box _____ Code _____

Mobile No. _____ Office/House Tel No _____ Email Address _____

Names of the Employer/Business _____

Location (bld/flr) _____

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

Name	Relationship	Date of Birth	Tel. No.	%Split
1.				
2.				

I Understand that if:-

One of the above nominated persons is a minor at the time of death, any intestate benefits payable under the policy shall be payable to the other beneficiary who is of majority age to hold in trust for such beneficiary minor and distribution as he thinks fit. Such a nominee should be of majority age of sound mind and a resident of Kenya.

All interest accrued shall be used for the education and maintenance of said minors and the principal amount shall be paid to the minors upon the minor attainment of the majority age.

In the event of my death prior to submission of satisfactory medical evidence or any other document required by the Company, the sum payable shall be restricted to a return of all premiums paid.

2. Detail of Policy Requirements

i) The basic cover policy

Policy option	option 1 <input type="checkbox"/>	option 2 <input type="checkbox"/>	Policy Term(yrs)	Basic sum Assured	Basic Premium
Please tick the policy option applicable			Years	Kshs.	Kshs.

ii) Optional Rider Benefits

Rider Benefits	Sum Assured	Premium
A) Accidental death benefits _____	Kshs. _____	Kshs. _____
B) Permanent Total Disability _____	Kshs. _____	Kshs. _____
C) Waiver of premium _____	Kshs. _____	Kshs. _____
D) Accidental Indemnity Rider _____	Kshs. _____	Kshs. _____
E) Funeral Cash _____	Kshs. _____	Kshs. _____
F) Family Funeral Cash _____	Kshs. _____	Kshs. _____
(Indicate name & date of birth) _____	Kshs. _____	Kshs. _____
spouse: _____	Kshs. _____	Kshs. _____
Child 1: _____	Kshs. _____	Kshs. _____
Child 2: _____	Kshs. _____	Kshs. _____
Child 3: _____	Kshs. _____	Kshs. _____
Child 4: _____	Kshs. _____	Kshs. _____
Total Premium _____	Kshs. _____	Kshs. _____
policy Holder Compensation levy		
GRAND TOTAL PREMIUM PAYABLE		

Where Family funeral Cash benefit is required forward the following:

- Declaration of Continued Good Health (DCGH) & proof of marriage for the spouse
- Declaration of Continued Good Health (DCGH) & birth certificate or clinical card for the children aged 5 and above years.

Note children below 5 (five) years are not covered

3. Details of premium payment (please tick the appropriate)

Frequency of payment	Monthly <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Half yearly <input type="checkbox"/>	Yearly <input type="checkbox"/>
Mode of payment	SDO <input type="checkbox"/>	BO/DDI <input type="checkbox"/>	Mobile Money <input type="checkbox"/>	Cheque <input type="checkbox"/>

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 your change you account you should notify the company immediately.

A/C holder's name _____	Bank Account No. _____
Bank name _____	Branch Name _____
Town _____	Address _____
For Salary Reduction Order (SDO)	
Name of employee _____	Address of Head office _____
Station _____	Department _____
Payroll number _____	

4. Previous insurer and acceptance Terms

Has a previous proposal of the life to be insured ever been made to this company? Yes No

If yes - give date & policy/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, Insurance date and special terms imposed eg Extra premium, Declined, Postponed or any other. _____

5. i) Family History - The following questions must be answered by the assured

Surviving Relative			Deceased Relatives			
Relative	Age	State of health	Age at the time of death	Cause of Death	Duration of Illness	Year of Death
Father						
Mother						
Brothers						
No. Born						
Sister						
No. Born						
Spouse						

ii) Has any close relative had diabetes, heart disease, stroke, high blood pressure, mental illness, prophyria or any other hereditary disease?

Yes No

If yes please explain _____

6) Current health:

Are you in good health? Yes No

If not please give details _____

7. Past Illness and Disease

Nervous disorder e.g fits, fainting, giddiness etc Yes No

Urinary trouble e.g kidney or bladder disease, gonorrhoea, syphilis etc Yes No

Heart trouble or any other disease of chest or respiratory organs? Yes No

Malaria Black water fever or other tropical disease? Yes No

Tuberculosis Yes No

Hepatitis B Yes No

If any of the above have been answered yes please give date of attack, name of doctor(s) consulted and hospital visited plus the result.

8. Private Medical Attendant

Please give name(s) and address of your usual doctor(s)/hospitals(s); or your last hospital / doctor visited.

How long has the doctor/hospital known you? _____

Have you consulted any other doctor during the last 5 years? Yes No

If yes when and for what complains? _____

9. Acquired Immune Deficiency Syndrome (AIDS)

a) Have you ever had sexually transmitted diseases? Yes No

b) Have you ever experienced genital sores or discharge? Yes No

c) Have you been refused as a blood donor? Yes No

d) Have you ever had or been advised to have a blood test for AIDS or AIDS related conditions? Yes No

e) Have you ever had blood transfusion within the last 5 years? Yes No

f) Do you experience weight loss, tiredness, skin lashes and/or hair loss? Yes No

10. Notice and consent for Blood testing for HIV Antibodies

I _____ do hereby give consent to undergo HIV test to facilitate issuance of this policy document. I am aware underwriting decision will be based on the test results.

All test result and the fact of the test occurred will be treated confidentially. The result in a sealed cover will be reported to the underwriting Department.

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.

11. Life Assured Statistics

What is your height (without shoes)? _____ What is your Weight (in under clothes)? _____

Is your weight increasing, decreasing or stationary?

(For female only) are you pregnant? Yes No

If yes please give the expected date of delivery _____