MADISON
Life Assurance

MADISON LALA SALAMA UMBRELLA MEMBERSHIP APPLICATION FORM

Proposal No.	Branch / Agency	Agent Name	Agent Code:
2138			

PART I: PRINCIPAL MEMBER DETAILS

Full Name of Applicant (Exactly as appearing in the National Identity Card or Passport)

Title: First Name:	Other Names:	Surname:	
Date of Birth:	Gender:	ID Card No.	PIN No.
P. O. Box	Postal Code:	City/Town:	Country:
Mobile Phone No:	E-mail:		
Occupation:			

Proposed Benefit (s) / Sum Assured (Kshs):

Funeral Cash	Permanent And Total Disability	Critical Illness

PART II: PREMIUM DETAILS

OPTION 1

Funeral Cash	Annual Premium	Tick Applicable Option	Monthly Premium (For Check-off Payments Only)	Tick Applicable Option
200,000	2,750		277	
150,000	2,063		208	
100,000	1,375		139	
80,000	1,100		111	
60,000	825		83	
45,000	619		62	
30,000	412		42	

OPTION 2

Funeral Cash	Permanent & Total Disability (100% of FE)	Critical Illness (50% of FE)	Annual Premium	Tick Applicable Option	Monthly Premium (For Check-off Payments Only)	Tick Applicable Option
200,000	200,000	100,000	4,560		459	
150,000	150,000	75,000	3,420		345	
100,000	100,000	50,000	2,280		230	
80,000	80,000	40,000	1,824		184	
60,000	60,000	30,000	1,368		138	
45,000	45,000	22,500	1,026		103	
30,000	30,000	15,000	684		69	

N:B: *The premiums above are per person*

PART III: OTHER (OPTIONAL) MEMBER(S) DETAILS

(Copies of national Identity Cards (and birth certificates for children) MUST be attached)

	NAME	DATE OF BIRTH	RELATIONSHIP	FUNERAL CASH	PERMANENT & TOTAL DISABILITY	CRITICAL ILLNESS	TOTAL PREMIUM
1							
2							
3							
4						8813	
5							
6							
7							
8							
9							

N.B:

1. The benefit of the optional member cannot exceed that of the principle member
2. The optional members can take option two if the principal has taken that option
3. The maximum period of cover for the other members is one (1) Year upon the death of the principal member

PART IV: EMPLOYER DETAILS (IF CHECK OFF EMPLOYER OR SPONSOR)

Name of Employer: _____ Pay Roll Number: _____ Industry: _____

Postal Address: _____ Postal Code: _____ Town: _____

Physical Location: _____ Telephone Number: _____

Email Address: _____ Branch / Region / Country: _____

PART V: NOMINATION OF BENEFICIARIES

No.	Full Names Of Beneficiary	Relationship	Percentage (%) Of Entitlement	National Identity Card Number (Where Applicable)	Phone No.
1					
2					
3					
4					
5					

N.B:*In case of more beneficiaries, please provide details in seperate sheet duly signed and dated by you.*

DECLARATION

I hereby declare to the best of my knowledge and belief that the information given above is true and complete and together with any written statement made by me in this regard shall be deemed to form part of my resultant contract(s) between me and the Company and that any material information with held or not truly or fairly stated shall render any assurance null and void. I also understand that I have the final discretion and decision to decide who should receive the benefits in the unfortunate event of my demise and as such the nomination of beneficiaries herein overides any other in existence in respect to the benefits above. Further, as at the time of completing and signing this declaration, all the above named persons were in good health.

Signed By (Name): _____ **Signature:** _____

Dated this _____ **Day of** _____ **Year** _____