SERIAL NO: 000001

Better. Simple. Life.

AfyaImara Executive

Individual Health Insurance Cover

Application Form

Please complete this form using BLOCK letters. It is important that you provide **ALL** the information requested to facilitate prompt processing of your application. Any blank spaces will be taken to mean that you have nothing to disclose.

Principal members Surname (00)		First Name	Others
National ID / Passport No		Date of Birth (DD MM YY)	Specific Occupation
NHIF No.		Postal Address	Code
Physical Address		Email	Employer
Telephone No. Office		Residence	Mobile

Dependant's Details

	Surname	First Name	Middle Name	Date of Birth			Relationship
				Date	Month	Year	
01.							Spouse
02.							
03.							
04.							
05.							
06.							
07.							
08.							
09.							

Name of current/previous health insurer and the expiry date: _____

_____

Last Expense

Name of beneficiary	ID Number	Relationship

Medical history of applicant and dependants

Have you ever had any of the following medical conditions? (Ask your doctor for any assistance if needed.) If the answer is yes to any of the questions asked, kindly obtain a medical report from your attending doctor or discharge summary from hospital and forward together with your application form under confidential cover. This information is essential in processing your application. Please note that no liability will be accepted for any medical conditions which originated before the date of enrolment or which was foreseeable at the time of application unless such medical condition has been declared to and accepted by UAP Insurance in writing. If in doubt you should still disclose the medical condition.

Questions		**Members**									
		00	01	02	03	04	05	06	07	08	09
A)	**Cardiovascular Conditions**										
	High Blood Pressure										
	Heart Disease										
	High Cholesterol levels										
B)	**Respiratory**										
	Asthma										
	Chronic obstructive airway disease										
	Sinus Disease										
C)	**Endocrine**										
	Thyroid Disease										
	Diabetes Mellitus										
D)	**Neurological**										
	Paralysis										
	Epilepsy										
E)	**Blood Disorders**										
	Sickle Cell										
	Disease Leukemia										
F)	**Musculoskeletal**										
	Arthritis										
	Gout										
	Chronic back pain/slipped disc										
G)	**Genito-Urinary**										
	Pelvic inflammatory disease (female)										
	Fibroids (Female)										
	Enlargement of the prostate (male)										
H)	**Gastrointestinal**										
	Liver Disease										
	Stomach and Duodenal Ulcers										
I)	Surgical Operations										
J)	Hospitalised (within the last seven years)										
K)	On Regular Medication										
L)	**Pregnancy (Female)**										
	Historyof Caeserian										
	Section Pregnant Member										
M)	Other medical conditions or disabilities not mentioned Above										

Details of positive (yes) answers to questions (i), (j), (k), (l) and (m) or any other. If this space is insufficient append an additional sheet.

Family doctor's information

Doctor's name	Tel No.	Mobile
Postal address		
Code	Clinic physical address	

COVER PLAN and Premium (in Kshs) (See Brochure for details)

Inpatient per family	**10,000,000**	**20,000,000**
Outpatient per person	**200,000**	**250,000**
Premium for all members Proposed		

MATERNITY per family	**400,000**	**600,000**
Premium per family		

LEVIES

Training levy & policy holders levy	@ **0.45%**
Stamp duty Kshs	**Kshs. 40.00**
TOTAL PREMIUM PAYABLE (Premium is payable upfront)	

Declaration

This membership application form is part of the contract with UAP Insurance

A. I declare that all the persons named in the application form are members of my immediate family for whose membership I am responsible

B. I hereby apply to join the above mentioned health insurance plan

C. I understand that any mis-statement or the non-disclosure of any material information in this form will jeopardize my membership.

D. I warrant that the answers in this form are true, correct, and complete and I acknowledge that such answers are all material

E. I hereby authorize the hospital, medical or dental practioners who have treated me or any of my dependants to disclose to the company the records relating to such current or previous hospitalisations/medical treatment and to allow the company to receive extracts from such records and undertake to assist in obtaining such information.

F. I have read, understood and agree with the cover options, exclusions, terms and conditions as stipulated in the product brochure and benefit schedule

G. I have appointed _____ as my Agent/Broker for this policy.

SIGNATURE OF THE PRINCIPAL MEMBER (POLICY HOLDER)

SIGNATURE _____DATE_____

AGENT/BROKER DECLARATION

I CONFIRM THAT I HAVE EXPLAINED TO THE CLIENT THE BENEFIT STRUCTURE, GENERAL CONDITIONS AND EXCLUSIONS OF THIS COVER

AGENT'S / BROKER'S NAME_____

AUTHORISED SIGNATURE & STAMP _____ DATE _____