



EMPLOYEE'S GROUP LIFE APPLICATION FORM

SECTION A – Employee Details

Scheme Name _____
Full Names of Employee _____
Date of Birth _____
Identity Card/Passport Number _____
Occupation _____
Salary per Annum _____
Employee No. _____

SECTION B (i) – Nomination of Beneficiary

I hereby nominate the following person(s) to be considered for receipt of all benefits Payable on my death under this Scheme.

Full Name	Age	Relationship	Address	%

If any of the above mentioned person(s) has not attained the age of majority (18 years), Section B (i) must be completed naming a Guardian(s) who must be over 18 years of age.

SECTION B (ii) – Nomination of Guardian(s) where applicable

Full Name	Age	Relationship	Address

I understand that unless otherwise indicated any benefits from this policy will be divided equally among all persons who are nominated as beneficiaries and who survive me and have attained the age of majority OTHERWISE to the Guardian(s) (on appointment by the High Court of Kenya where necessary).

This nomination cancels and supersedes any previous nominations in respect of this Scheme.

Date _____
Member's Signature _____

SECTION C - To be completed by Employer.

As Employer I confirm that the information given in section 'A' above is correct.
This Employee is to be included in the Group Life Scheme with effect from _____ (date)

Signature & Stamp of Employer _____
Date of signing _____
Position of Company _____

**SECTION D:
HEALTH DECLARATION BY MEMBER**

PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE OR BELIEF

1. a) Name and Address of your present doctor..... (If none, so state)
 b) Date and reason last consulted (If within last 10 years)
 c) What treatment was given or medication prescribed?

(TICK APPLICABLE ITEMS)

Yes No

If the answer to any question is "Yes", identify question number and include diagnosis, dates, duration, degree of recovery or results and names and addresses of all attending physicians and medical facilities.

2. Are you under medical treatment by diet, medicine or other means? Yes No

3. Have you ever had or sought advice for:-
- (a) chest pain, high blood pressure, heart murmur, heart or circulation disorder? Yes No
 - (b) asthma, chronic cough, shortness of breath or lung disorder? Yes No
 - (c) diabetes or sugar in the urine? Yes No
 - (d) ulcer, colitis, liver or digestive disorder? Yes No
 - (e) cancer, tumour or enlarged glands? Yes No
 - (f) anaemia, bleeding or blood disorder? Yes No
 - (g) dizzy or fainting spells, epilepsy, nervous system or mental disorder? Yes No
 - (h) urine, kidney or bladder disorder? Yes No
 - (i) arthritis or other joint disorder? Yes No
 - (j) any other illness, surgery or injury? Yes No

4. Have you had any change in weight in the past year?
 Current weight ----- Height ----- Yes No

5. Have you ever been advised to stop drinking alcohol or to drink less? Yes No

6. (a) Have you received medical advice or treatment in connection with - AIDS or an HIV/AIDS related condition or a sexually transmitted disease? Yes No
- (b) Have you been told you had HIV/AIDS or an HIV/AIDS related complex? Yes No
- (c) Have you had or been told you had a positive blood test for antibodies to the HIV virus (Human Immune Deficiency Virus)? Yes No
- (d) Do you have any of the following, which are unexplained: Fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions? Yes No

7. Have you within the past 5 years:
- a) Had any mental or physical disease or disorder not listed above? Yes No
 - b) Had a check-up, consultation, illness, injury or surgery? Yes No
 - c) Been a patient in a hospital, clinic, sanatorium, or other medical facility? Yes No
 - d) Had electrocardiogram, X-ray, other diagnostic test? Yes No
 - e) Been advised to have any diagnostic test, hospitalization, or surgery, which was not completed? Yes No
 - f) Had a blood transfusion? Yes No

8. Have you ever had military service deferment, rejection, or discharge because of a physical or mental condition? Yes No

I declare that the answers to the above questions are true and complete and that I have not withheld any material information and agree that such answers shall be the basis of the contract for assurance.

I consent to the Company seeking information from any doctor, hospital or clinic I have consulted or from any Company I made a proposal for insurance and I hereby authorise the giving of such information.

Member Name _____

Date _____

Member's Usual Signature _____