



Kenindia Assurance Company Limited

(Incorporated in Kenya)

EMPLOYEE'S APPLICATION FORM

PLEASE COMPLETE BOTH SECTIONS OF THIS APPLICATION USING CAPITAL LETTERS

To be retained by the Employer

AUTHORITY FOR DEDUCTION OF CONTRIBUTION FROM SALARY OR WAGES

Percentage of Basic Salary
for contribution

To (name of Employer)

5%	7.5%	10%	15%
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I hereby apply for admission as a member of the Group Scheme and authorise deduction from my salary or wages of the amount of my contribution to the scheme. I agree to be bound by the rules of the Scheme.

Surname of Employee Title

First Names of Employee

Date of Birth

DAY	MONTH	YEAR

 Date of entry into service

DAY	MONTH	YEAR

Salary Kshs per annum

Employee's usual signature _____ Date _____

10th Floor, Kenindia House, Loita Street
P Box 30377,
Nairobi

Life Department
Tel: 316099/337733/214439
Fax: 214662

Email: life@kenindia.com
Website: www.kenindia.co.ke

A member of the Association of Kenya Insurers

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To be retained by KENINDIA ASSURANCE COMPANY LIMITED

Percentage of Basic Salary
for contribution

5%	7.5%	10%	15%
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Employer's name

Surname of Employee Title

First Names of Employee

Date of Birth

DAY	MONTH	YEAR

 Date of entry into service

DAY	MONTH	YEAR

Salary Kshs per annum

The employee should ensure that his date of birth is correct and evidence of that should be produced at the earliest possible date.

Employee's usual signature _____ Date _____

As employer I confirm that the information given above is correct. I have seen a birth certificate/passport/identity card as proof of the employee's date of birth. A Marriage certificate (for a married woman only) has also been seen. (Please delete the documents that have not been seen)

This employee is to be included in the Group Scheme from

DAY	MONTH	YEAR

Signature for Employer _____ Date _____

Position at Company _____



Kenindia Assurance Company Limited

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EMPLOYEE'S NOMINATION FORM

Scheme

Member's Name	SURNAME	TITLE	FIRST NAMES IN FULL

Member's Address

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

	1 st Beneficiary	2 nd Beneficiary	3 rd Beneficiary	4 th Beneficiary
Full name				
Address				
Relationship to me				

I understand that the Trustees of benefits under the Scheme have final discretion to decide who should receive benefits under the Scheme, but I request the Trustees to act according to my nomination.

This nomination cancels and supersedes any previous nominations.

I understand that if the person nominated is under the age of 18 at the time of my death, any benefits becoming payable may have to be paid to the Public Trustees to be held in Trust for such dependant and distributed as he shall think fit.

Date of signing _____

Member's signature _____

Note: - Unless indicated otherwise above, if more than one person is nominated any benefits accruing will be divided amongst the persons nominated in equal shares.

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