APA INSURANCE
A New Dimension in Insurance

MEDICAL PROPOSAL FORM

abc INSURANCE

Policy Holder Details

(Fill in all the details in capital letters and enclose 2 passport photos for each individual beneficiary)

Title: Mr. Mrs. Ms Miss Other

First Names

Surname

Postal Address Code

Telephone Home Office

Mobile Fax

Email Address

How would you prefer us to communicate with you? Tick Appropriate box

Fax Phone Email SMS

The following section is only to be filled in if you already have an existing cover.

Company Name

Insurer

Member/Policy No.

Expiry Date

Policy Commencement Date

Please indicate the month and year you wish your cover to commence Month Year

Please note that the APA Individual Health Cover will commence on the 1st of every month, Cover is conditional upon acceptance of your Proposal which is confirmed when you receive your Policy Document

Plan Details

Please tick to indicate the plan you require.

Inpatient	Core Plan	Benefit
	OPTION A	500,000
	OPTION B	300,000
	OPTION C	100,000

Outpatient	Core Plan	Benefit
	OPTION A	100,000
	OPTION B	75,000
	OPTION C	50,000

Year of being on the APA Individual Cover

1st Yr 2nd Yr 3rd Yr 4th Yr

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Payment Details

All payments must be made to APA Insurance Ltd with the Policy Holder's name and Policy Number marked clearly on the back of the cheque. All bank transfers must be clearly marked with the Policy Holder's name and Policy Number. APA Insurance does not accept liability for any payment which does not clearly identify the Policy Holder. Please note that Insurance Premium Tax and other government levies will apply. Any Tax Relief that applies accordingly will also apply Where such taxes, levies or reliefs apply, they will be detailed on your invoice / payment details.

Details of Person(s) to be Covered

	Policy Holder	Dependant 1	Dependant 2	Dependant 3
Title (Mr, Mrs, Ms, Miss, Other)	AS ABOVE			
First Name	AS ABOVE			
Middle Name	AS ABOVE			
Surname	AS ABOVE			
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Relationship	SELF	Spouse ☐ Child ☐	Spouse ☐ Child ☐	Spouse ☐ Child ☐
Date of Birth		Date Month Year	Date Month Year	Date Month Year
Occupation				
Town of Residence				
ID / PP No.				
Name of any other current cover				
Name of Insurer				
Policy Number				
Start Date				

If space is not sufficient for dependants, please use an additional Proposal Form

Details of Person(s) to be Covered

Pre-existing conditions are not covered unless they have been declared by you in the Health Declaration section and accepted by APA Insurance. Conditions arising between signing the Proposal Form and confirmation of acceptance by the underwriting department of APA Insurance, will equally be deemed to be pre-existing. Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this Proposal and acceptance by us. You are hereby obliged on request to provide any further information that we might require. Pre-existing conditions are medical conditions or any related conditions, for which symptoms have been shown at some point during the lifetime of the member prior to commencement of cover, irrespective of whether any medical treatment or advice was sought.

Any such condition or related condition about which you or your dependants know, knew, or could reasonably have been assumed to have known, will be deemed to be pre-existing and excluded from the cover.

Health Declaration

All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is any information that would be likely to influence the Insurer's assessment and acceptance of this Proposal Form. If you are in any doubt whether a fact is material then it should be disclosed.

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Health Declaration

	Policy Holder	Dependant 1	Dependant 2	Dependant 3
HEIGHT/WEIGHT	cm _____ kg _____	cm _____ kg _____	cm _____ kg _____	cm _____ kg ____
Are you currently suffering from any complaints, illnesses, after effects of an accident, mental or physical disabilities, psychiatric disorders and chronic / long term medical or dental conditions?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for: Rheumatism, gout, arthritis or disease of the muscles or joints including the back?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Epilepsy / paralysis or other neurological disorder?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Any digestive disorder including stomach and / or bowel problems?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Anxiety, depression or psychiatric or mental illness?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Any disorders of the genetourinary system including gynacological and prostate conditions	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Any disorder of the kidneys, bladder or liver / pancreas including diabetes?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Any lump, cyst, mole or cancer	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Any skin disorder?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Have you ever been advised to consult a doctor for a recurrent complaint, or been advised to have any diagnostic test or treatment which has not been completed or that you still await the results of?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

Health Declaration

Are you currently pregnant? If so state expected date of birth	YES ☐ NO ☐ _____/_____/_____			
Have you been tested for HIV - antibodies? If yes, please state when	YES ☐ NO ☐ _____/_____/_____	YES ☐ NO ☐ _____/_____/_____	YES ☐ NO ☐ _____/_____/_____	YES ☐ NO ☐ _____/_____/_____
Was the result HIV - positive?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Have either of your parents or any of your brothers or sisters,living or deceased, suffered before the age of 65, from diabetes, heart disease, high blood pressure, cancer, kidney disease, raised cholestrol, nervous or brain disorders such as Alzheimer's, Parkinson's, or M.S., eye, hearing or speech disorder or any family disorder?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

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Telephone number of your family doctor.

Name:

Email Address:

Telephone:

Additional Information

If you answered yes to any questions from 2 to 9, please give all necessary details in the box below (in BLOCK CAPITALS) Failure to provide complete information may result in APA Insurance seeking the information from your family doctor.This may in turn result in a delay in proceeding with your Proposal. If in doubt whether a fact or information is material, then it must be disclosed.

Name	Number of question with "yes" answer	Where applicable, please provide date of 1st diagnosis/consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current and known future treatment.

Data Protection Legislation

APA Insurance would like to assure you that all personal information and medical data will be dealt with in strict confidence. Personal data may be given to hospitals and / or medical providers with relation to medical insurance claim services provided by us to you. You have a right to access the personal data that is held about you. You also have the right to amend or delete any information we hold about you if you believe that it is inaccurate or out of date.APA Insurance, or an organisation appointed by us, might contact you in the future in relation to other products / services that you might be interested in.

Do you wish to receive information on other products or services from us? YES NO

Declaration

I declare that all information supplied above is true and complete, including those answers that are not in my own hand-writing. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this Proposal shall be the basis of the contract between APA Insurance and I, and that any false, incorrect or misleading statement may render this insurance null and void. I undertake to inform APA Insurance immediately in writing of any change in my or my dependants' state of health occurring after the Proposal Form has been signed and before the commencement or renewal date. I understand that I can withdraw my Proposal in writing by letter or email within 14 days from the Policy's date of commencement and provided that I have not submitted a claim, I am entitled to a full refund of the premium. I accept that it is my responsibility to check the accuracy of the information contained within the Policy Document once issued.If the content is not in accordance with the Proposal Form, the policy will be considered accepted if I enter no protest within14 days following the issue date of the Policy Document. I consent to the fact that APA Insurance, if it considers it appropriate, will check statements concerning the condition of my health and will check with other health insurers all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, members of medical professions, employees of hospitals and health authorities as well as medical facilities to release my medical records to APA Insurance. I also make this statement for my co-insured children as well as for the co-insured persons for whom I am responsible, or those who cannot assess the meaning of this statement. I accept that the Policy will be subject to the standard Policy Terms and Conditions effective at the time of Policy commencement. I understand that the Policy will only be valid where full premium has been settled and a receipt issued acknowledging the same.

I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this Policy including the exclusions relating to pre-existing conditions.

Policy Holder's Signature Date:

Signature of all adult dependants

ABC INSURANCE BROKERS LTD.
ABC Bank House, Westlands
P.O.Box 46452 - 00100, Nairobi.
Tel: +254 (20) 4450873, 4441162
Fax: +254 (20) 2222437
Email: insurance@abcthebank.com

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