



THE KENYAN ALLIANCE INSURANCE COMPANY LIMITED

Head Office: Chester House 1st Floor, Koinange Street P.O Box 30170-00100 GPO, Nairobi, Kenya. Tel: 2227723, 2241626, Fax: 2217340, 2211158, Cell phone: 0722-205286, Email: kai@kenyanalliance.com

Branch Offices: Mombasa – Mombasa Trade Centre; Karatina – Uchumi Building; Thika – Thika Arcade; Machakos – Susu Centre; Meru – Angaine Plaza; Kisumu – Reinsurance Plaza; Kitui – Muli Mall

APPLICATION BY EMPLOYEE FOR GROUP LIFE ASSURANCE SCHEME MEMBERSHIP

SECTION A: TO BE COMPLETED BY EMPLOYER

SURNAME:	OTHER NAMES:
I.D./PASSPORT NO.	P.I.N. NO.
DATE OF BIRTH:	
DATE OF EMPLOYMENT: <i>D D / M M / Y Y Y Y</i>	DATE OF JOINING THE SCHEME: <i>D D / M M / Y Y Y Y</i>
EXACT NATURE OF OCCUPATION:	
SEX: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
SALARY (SHILLINGS PER ANNUM):	
SCHEME NAME:	
NAME OF EMPLOYER:	
ADDRESS OF EMPLOYER:	

Signed and stamped for and on behalf of Employer

Date

SECTION B: DECLARATION OF GOOD HEALTH

1. Are you now, in all respects in good health?

Yes No

If NO, please give details _____

2. Have you ever suffered from any illness or accident which required more than three (3) visits by or / to a doctor, and or caused your absence from work for more than 14 days.

Yes No

If YES, give details _____

3. Are there any unusual hazardous circumstances which might affect the Assurance (for example, change in exact nature of occupation, dangerous sports, service in the Armed Forces, aviation other than as a fare paying passenger on a scheduled Airline?) If so, please give details _____

4. Has a proposal on your life ever been declined, postponed, withdrawn or accepted on special terms?

Yes No

If YES, please give details of the office(s) and date (s) _____

5. Have you ever had: (please tick only one)

- a. Unexplained recurrent or persistent fever or skin disorder? Yes _____ No _____
- b. Unexplained or persistent night sweats? Yes _____ No _____
- c. Unexplained weight loss? Yes _____ No _____
- d. Unexplained infections or swollen glands? Yes _____ No _____
- e. Chronic or recurrent diarrhea? Yes _____ No _____
- f. Persistent cough? Yes _____ No _____
- g. Hepatitis B or sexually transmitted diseases? Yes _____ No _____

6. Have you ever had or been advised to have a blood test for AIDS or an AIDS related condition? Yes _____ No _____

7. Have you ever been refused as a blood donor? Yes _____ No _____

8. Have you received a blood transfusion in the last five (5) years? Yes _____ No _____

Please give details of all positive answers _____

9. What is the name and address of your usual medical attendant (s)? _____

SECTION C: NOMINATION OF BENEFICIARY (IES)

Full Name(s) of Children/Beneficiary

Full Name	Date of Birth	Passport/ I.D. No	Relationship	% of Benefits
	D D/MM/YYYY			
	D D/MM/YYYY			
	D D/MM/YYYY			

Attach extra sheet if more beneficiaries are being nominated

I declare that the above statements are true and complete. I agree that they shall form part of my proposal for assurance to THE KENYAN ALLIANCE INSURANCE COMPANY LIMITED.

Signature _____

Date _____