INDIVIDUAL LIFE SAVINGS/ TERM PROPOSAL FORM

All questions must be answered in full and in block letters. In case of alterations, please put a line through the incorrect part of the answer and counter sign next to the alteration. Proof of identity of ALL the proposed lives assured is required. Provide a copy of your National Identity Card or Passport and PIN certificate.

PRODUCT (*Please tick one*)

APA Elimu ☐ Imarika ☐ Akiba Halisi ☐ Term Assurance ☐

Serial No.: SP

SECTION 1: CLIENT'S DETAILS

Policy Owner/Applicant

Surname: | Other Name: | Title:

Postal Address: | Postal Code: | City/Town:

Email Address: | Occupation: | Tel:

Residential Address: | Relationship to Insured: | Nationality:

PIN No.: | ID No.:

Proposed Insured/Life Assured

Surname: | Other Name: | Title:

Postal Address: | Postal Code: | City/Town:

Date of Birth: D D M M Y Y Y Y | Gender: Male ☐ Female ☐ | Nationality:

ID No.: | Telephone No.:

Email Address: | Occupation:

Name and Address of Employer
OR details of Business if self employed:

Marital Status: | PIN No.:

Residential Address:

Benefits Options Selected (please tick where applicable)

Sum Assured:	KShs.
Basic Premium:	KShs.
Total Premium (includes riders):	KShs.
Term in Years (Elimu, Term and Imarika):	
Term in Years (Akiba Halisi):	6 ☐ 9 ☐ 12 ☐ 15 ☐ 18 ☐
Option (Elimu and Term):	Option 1 ☐ Option 2 ☐
Lien Option (Elimu and Imarika Only):	Yes ☐ No ☐
Frequency of Payment:	Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Single ☐
Method of Payment:	Banker's Order ☐ Direct Debit ☐ Check Off ☐ Cash ☐ (*Cash only applicable to non-monthly payment frequencies*)

Optional Cover Desired	Premium
Total and Permanent Disability:	KShs.
Waiver of Premium (on disability):	KShs.
Accidental Death Benefit (Imarika, Term and Akiba Halisi only):	KShs.
Critical Illness:	KShs.
Adult Medical Reimbursement (Accident):	KShs.
Child Medical Reimbursement (Accident) (Elimu only):	KShs.
Retrenchment:	KShs.

SECTION 3: DETAILS OF BENEFICIARY FOR PROCEEDS

Please note that **ALL** benefits are payable to the policy owner on the maturity date. Kindly nominate your beneficiary(ies). For more than one beneficiary, the percentage shared must add up to 100%.

PRIMARY BENEFICIARIES						Guardian *(if beneficiary is a minor)*			
Full Name	D.O.B	ID No.	%	Tel No.	Relationship	Full Name	ID No.	Tel No.	Relationship

SECTION 4: HEALTH QUESTIONNAIRE

When completing the application form, all material facts must be disclosed. Failure to disclose all relevant facts including full disclosure of your medical details and history may delay or prevent the issue of our policy and/or invalidate future claims. If you are in doubt as to whether a fact is a material fact, you should disclose it.

Have you ever applied for a life insurance before? Yes ☐ No ☐

If yes, please give details below:

Insurance Company	Date of Application	Policy Number	Sum Assured	Premium

Please provide complete details of all YES answers below (including details of treatment, medical institution, where treated and name of treating doctor. Additional sheets of information or reports can be attached to this form where required.

	Medical History	Yes	No
a)	Are you in good health?		
b)	Have you consulted any doctor or medical facility as an inpatient or outpatient in the last 3 years? If so, when and for what complaints?		
c)	Are you pregnant? If yes, how far advanced?		
d)	Have you within the past 6 months undergone any medical tests?		
e)	Have you ever had any serious injuries?		
f)	Are you at the moment taking any medication regularly or as needed?		
g)	Have you ever been tested for, received treatment or counseling from a medical professional or been told you have (tick appropriate item and give details where applicable on the space provided below):		
	i. Dizziness, fainting, convulsion, epilepsy, paralysis, stroke or severe headaches?		
	ii. Depression, anxiety, Alzheimer's disease, a mental or nervous disorder?		
	iii. Shortness of breath, bronchitis, emphysema, asthma, pleurisy, pneumonia, tuberculosis or persistent cough?		
	iv. Chest pain, angina, palpitations, irregular heartbeat, high blood pressure, heart attack, congestive heart failure or coronary artery disease?		
	v. Heart murmur, heart valve disorder, edema or disorder of the heart or blood vessel?		

	vi. Ulcers, intestinal bleeding, bleeding colitis, ulcerative colitis, crutins disease, jaundice, hernia, diarrhoea, hepatitis or any other disorder of the stomach intestines, spleen, liver or rectum?		
	vii. Diabetes, high blood sugar or sugar in your urine?		
	viii. Venereal disease or any disorder of the reproductive system?		
	ix. Blood or protein in your urine, any disorder of the kidneys, bladder, prostate or urinary system?		
	x. Thyroid, thymus, pituitary or lymph gland disorder?		
	xi. Cancer, Sarcoidosis, tumor or any abnormal growth?		
	xii. Back pain arthritis, muscular dystrophy or any disorder of the muscles, bones or joints?		
	xiii. Multiple Sclerosis, Parkinson's disease or any disorder of the brain or spinal cord?		
	xiv. Hemophilia, sickle cell anemia, anemia, or any other blood disorder?		
	xv. Any disease not mentioned above?		
h)	Have you received a blood transfusion in the last 5 years?		
i)	Height (m)		
j)	Weight (Kgs)		
k)	Have you any intention or prospect of:		
	i. Flying other than as a fare paying passenger on a recognised airline on scheduled air routes?		
	ii. Engaging in motor sport or water sailing or parachuting or glinding or mountain climbing as a hobby?		
	iii. Engaging in any other hazardous occupation sport or pastime?		
l)	How frequently and in what quantity do you use intoxicating drinks, tobacco or nicotine products or habit-forming drugs?		
m)	Have you been convicted of a felony within the last 5 years or do you have any charges pending? If so, give details.		

SECTION 5: FAMILY HISTORY

Please give full details of poor health or cause of death if so indicated in the table below:

	Alive		Deceased			
Member	Present Age	State of Health	Age at Death	Cause of Death	Duration of Illness	Year of Death
Father						
Mother						
Brothers						
Sisters						
Spouse						

SECTION 6: AUTHORISATION TO OBTAIN INFORMATION

Furthermore, I authorise the association of Kenya Insurer's life registry or any physician, medical practitioner hospital, clinic, medically related facility or insurance company having any records or knowledge pertaining to me or my health, to provide APA Life or its reinsures with any information sought.

Information obtained with this authorisation may only be:

1. Used to determine insurability
2. Released to reinsurance companies
3. Sent to the Association of Kenya Insurer's life registry
4. Used as lawfully required
5. Used as I may further authorise

I agree that a photocopy of this authorisation shall be as valid as the original. I request that any findings resulting in a rating postponement or declination of any or all coverage requested on this application be forwarded directly to the below named doctor/medical facility.

Name of the doctor or medical facility:	
Physical address:	
Telephone number:	
Date and signature of proposed insured:	

Association of Kenya Insurer's Life Registry

Information regarding your insurability will be treated as confidential. We may however, make a brief report thereon to the Association of Kenya Insurer's life registry. We may also release information in our file to the other insurance companies to whom you apply for life or health insurance to which a claim for benefits may be submitted.

SECTION 7: ADDITIONAL NFORMATION

Please use the space provided below to provide any additional information necessary.

SECTION 8: DECLARTION

I understand that the statements and all number information provided in this application form are complete and true to the best of my knowledge and that it will form part of the policy number. Change in amount, classification or benefits shall be effective unless agreed to in writing by the policy owner.

It is also agreed that APA Life will incur no liability under this application until:

- The application has been received and approved
- The premium has been paid and accepted by APA Life

I understand that no intermediary has the authority to waive the answers to any of the question in this application or to make or alter any contract for APA Life Assurance.

I declare that I am in good health and I am able to go about my day to day activities.

Submitted requirements: Copy of ID ☐ Proof of PIN ☐ Direct Debit or Check Off Form ☐

M-PESA PayBill 527600 (for first and non-monthly premium)

Signed at ..... D D M M Y Y Y Y

....

Signature of Proposed Insured Signature of Policy Owner

SECTION 9: OFFICIAL USE ONLY

Branch:

Agent's Name: Agent's Signature:.....

Unit Manager's Name: Unit Manager's Signature : .....

Agency Manager's Name: Agency Manager's Signature: .....

APA LIFE
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Fax: 254 020 364 1100 | **Email:** insurance@apalife.co.ke | **Website:** www.apalife.co.ke
BRANCH OFFICES: Mombasa | Nairobi | Nakuru | Kisumu | Eldoret | Naivasha| Thika | Meru | Nyeri | Embu | Kisii | Machakos

*Terms and conditions apply.