APPLICATION FORM

INDIVIDUAL/FAMILY MEMBER APPLICATION FORM

DIRECTIONS:

Please read carefully and fill out the entire form in **BLOCK LETTERS.**

1. Please attach a copy of a National ID/Passport and PIN copy of every adult applicant, dependents and beneficiary. Also attach Birth certificate/Birth notification copies for all child dependents (under 18 years).
2. Kindly complete all questions in full. Incomplete application forms cannot be processed.
3. You are required to complete the consent form for processing personal data.

(A) MAIN APPLICANT DETAILS

(Please note that the applicant will be the policyholder. You must notify us of any change of contact details so we can ensure correspondence reaches you.)

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Other ☐ _____

First Name _____ Surname _____ Other Name _____

Gender M ☐ F ☐ Date of Birth _____ Marital Status _____

Nationality _____ Country of Residence _____ ID/Passport No. _____

Expiry date of Passport (If passport number is provided) _____ NHIF Number _____

KRA Pin No. _____ Occupation _____

Employer Name _____

Contact Information of Main Applicant

Mobile No. _____ Office No. _____ Other No. _____

Email _____ Postal Adress _____ Postal Code _____

City _____ County _____ Residential _____

Existing and Past Health Insurance Policies

Name of Insurer _____

Name of Scheme/Plan _____

Policy No. _____ State No. _____ End Date _____

Principal Applicant Name _____

Spouse Name _____

Questionnaire

- Have you or any of your dependents ever been declined, loaded, or had exclusions applied on them by a medical scheme? Yes ☐ No ☐. *If "Yes" please provide details.* _____

  _____

- Have you or any of your dependents lodged a claim in the last one year? Yes ☐ No ☐. *If "Yes", please provide details.* _____

  _____

(B) DEPENDENT DETAILS

*Dependents can include your spouse and any children dependent of the applicant up to the day before their 18th birthday, In completing this section, you may be required to provide personal data relating to a child for instance providing details of your beneficiaries/ next of kin. Please note that a child is a person under the age of 18 years. In order for us to process any personal data relating to a child, we require your consent as the child's parent or legal guardian and proof of the child's age. Please note that if you do not provide us with your consent for our processing of the child's personal data or if you withdraw such consent, we may not be able to provide you or the child with our products and services. Such withdrawal of consent will not, however, affect the lawfulness of our processing of the child's personal data prior to the withdrawal.

By signing below, you confirm that you are the parent or legal guardian of the child whose personal data is being provided to us and that you consent to our processing the child's personal data in accordance with our Privacy Policy.

No.	Surname	First Name	Other Name	Date of Birth (DD/MM/YYYY)	ID/ Birth Certificate/ Birth Notification	Gender (Male/ Female)

(C) NEXT OF KIN DETAILS

The next of kin will be contacted by Fidelity Insurance in case the policy holder is incapacitated and cannot issue instructions with regards to this policy. The decision issued by the declared next of kin in such circumstances will be deemed legally binding.

First Name _____ Surname _____ Other Name _____

Relationship _____ Mobile No. _____ Email _____

ID/Passport No. _____ Expiry date of Passport (*If passport number is provided*) _____

(D) LAST EXPENSE BENEFICIARY

The last expense beneficiary is the person who will be paid the last expense benefit in case of demise of the policy holder. In case of demise of dependents, the beneficiary shall be the policy holder.

First Name _____ Surname _____ Other Name _____

Relationship _____ Mobile No. _____ Email _____

ID/Passport No. _____ Expiry date of Passport (If passport number is provided) _____

(E) MEDICAL HISTORY OF APPLICANTS & DEPENDENTS

Please state if anyone included in this application has ever been treated or is currently receiving treatment or expects to receive treatment or has experienced symptoms of any known or suspected medical condition. In completing the questions, please ensure that each question is answered fully and accurately.

_____

_____

_____

Applicants are numbered as per section 2. Answer YES of NO in each box. Note the main applicant is No. 1						
Question	**No. 1**	**No. 2**	**No. 3**	**No. 4**	**No. 5**	**No. 6**
1 a. Do you or any of your family proposed for this insurance already hold Life, Personal Accident or Medical Insurance policies?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
b. If yes, please provide name of insurer and policy number						
2. Are you or any member of your family proposed for this insurance currently under any type of medical treatment?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
3. Have you or any of your family proposed for this insurance suffered from any medical/health complaint which may necessitate a surgical operation or for which you reasonably anticipate the necessity of treatment?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
4. Have you or any member of your family proposed for this insurance suffered from: -	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
a. Blood disorder, sickle cell anaemia, cancer, growth or tumors whether benign or malignant?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
b. Cardiovascular (Heart and blood vessel) and respiratory related disorders, hypertension, deep vein thrombosis, respiratory disorders, asthma, tuberculosis, chronic obstruction pulmonary disease?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
c. Ear, nose, throat disorders, tonsils, adenoids, hearing or speech impairment, eye related disorders, glaucoma?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
d. Genito-urinary system disorders or abnormalities of the male or female reproductive system, kidney stones or kidney failure?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No

Applicants are numbered as per section 2. Answer YES of NO in each box. Note the main applicant is No. 1						
Question	**No. 1**	**No. 2**	**No. 3**	**No. 4**	**No. 5**	**No. 6**
e. Gastro - intestinal disorders, hernia, ulcer, piles	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
f. Gynecological and obstetrical related disorders, fibroids, menstrual irregularities, abnormal pap smear.	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
g. If currently pregnant please advise expected delivery date.	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
h. Musculo-skeletal related disorders e.g. gout, osteoporosis, jointproblems and fractures	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
i. Neurological related disorders, epilepsy, stroke, brain disorders, paralysis	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
j. Psychological related disorders, drug and/or alcohol dependency, anxiety, depression, stress	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
k. Skin disorders, eczema,	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
l. Sexually transmitted diseases, herpes,gonorrhea and HIV or AIDS and related conditions or tropicaldiseases such as leprosy, yellow fever, bilharzia	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
m. Congenital, hereditary disorders or birth defects	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
5. Have you or any of your family proposed for this insurance suffered from a chronic/long term medical condition or is there any known disability, abnormality or recurrent illness or injury?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
6. Are you or any member of your family proposed for insurance now under observation or taking treatment or education for any disease or disorder?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No

Applicants are numbered as per section 2. Answer YES of NO in each box. Note the main applicant is No. 1						
Question	**No. 1**	**No. 2**	**No. 3**	**No. 4**	**No. 5**	**No. 6**
Please state the name and address of your medical doctor/ physician or hospital.						

Note: If the answer is YES to any question above, please provide full details below (If the space provided is insufficient kindly attach additional information to this application.

Name and Relationship to The Applicant	Relevant Question	Medical Condition	Treatment and Consultations Received (With Date)	Name the Treating Doctor or Hospital and their Telephone Number or Address	Needs for Future Treatment or Consultation

N.B Any misrepresentation or non-disclosure of material or factual information will render all benefits granted by Fidelity Insurance null and void. In addition, any claims payment made due to such actions will be recoverable from the policy holder.

(F) MEDICAL PLAN DETAILS

a. Plan Details

Please tick the plan chosen and the riders (last expense and personal accident covers).

Benefit	Plan A		Plan B		Plan C		Plan D
Inpatient							
Outpatient							
Maternity							
Optical & Dental							

b. Premiums Computation

	Inpatient	Outpatient	Maternity	Dental & Optical	Total
Main Member					
Spouse					
Child I					
Child II					
Total Premiums					
Insurance Training Levy (0.2%)					
PCF Levy (0.25%)					
Stamp Duty					
Total Amount					

d. Commencement of Cover

Please indicate the date you require cover from _____

d. Disclaimer

Cover is valid upon issuance of the policy document. Members who are 50 years and above will be required to undertake a medical examination to facilitate the processing of your application. A letter requesting you to undertake a medical exam shall be issued on request through our contact.

e. Payments

Payments should be made annually and directly to Fidelity Insurance by the following means.

Please tick to indicate your preferred payment frequency and method:

Cheque ☐ Bank Transfer ☐ Mobile Money ☐ Visa/Credit card ☐

For mobile money; kindly follow the below steps;

- Go to M-PESA on your phone menu
- Select Payment services
- Select Pay Bill Option
- Enter Business Number
- Enter the account number
- Enter Member number for existing clients or full names for new clients*
- Enter the amount of the premium
- Enter your M-PESA PIN
- Confirm details are okay and press OK

(G) IMPORTANT NOTES TO YOUR MEMBERSHIP

1. Members over 65 years of age shall continue to be covered subject to acceptance of renewal terms provided by Fidelity.
2. Children who turn 19 years shall be covered under their own policy as adults.
3. Particular conditions may have waiting period before they are eligible for treatment in the policy and a sublimit in some cases. The applicant must ensure that they are clear about the product terms and conditions applicable.

There may be a limitation on the hospitals from which you can seek treatment depending on the benefit option that you choose and a co-payment for outpatient services may apply. Refer to the schedule of providers in the brochure applicable to your coverage and ensure that you are comfortable with the hospitals eligible to the plan you are enrolling into.

(F) PREMIUM TABLES

DECLARATION

a. General

I, the undersigned member:

i. Hereby apply for myself and my dependents to be registered on Fidelity Insurance Medical policy and have read, understood, and agree to abide by the Rules of the policy.

ii. Warrant that the contents of this application and any change in the state of health or illness suffered by myself or any of my dependents are true, correct and complete and should there be any change in the state of health or illness suffered by myself or any of my dependents from the date of signing this application form and the date of acceptance of the risk or by the insurer, notification of such change will be provided to the insurer in writing with full details of condition/ailment;

iii. Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non-disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null, and void and all premiums paid shall be forfeited.

iv. Understand and accept that no benefit will be payable by the policy unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary including the results of such medical examinations and tests that they may require me or my dependents to undertake.

v. Acknowledge and accept that the insurer reserves the right to cancel membership of the policy if any due premium is not paid on the due date; and

vi. Undertake to inform the insurer within 30 days should the situation stated above change.

b. Authority

i. Accepting that I am curtailing my and my dependents' right to privacy but in order to facilitate the assessment of the risks and the consideration of any claim, I irrevocably authorize.

ii. The insurer to obtain from any person whom I hereby authorize and direct to give, any information which the insurer deems necessary.

iii. I further authorize and instruct the insurer and any hospital concerned to give away information relating to myself and my dependents to the insurer for the purpose of ensuring that members of the policy receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources.

iv. I understand and accept that the above authorization constitutes a partial waiver of my and my defendants' right to privacy; and

v. I do hereby authorize the insurer to send the policy document electronically to the email address provided in this application form.

vi. I have appointed _____ as my Agent/Broker for this policy.

c. I declare that:

i. My dependant(s) is/are residing with me,

ii. I am liable for his/her family care,

iii. The dependant(s) is/are my immediate family (Must be a blood relative except spouse),

iv. I undertake to repay the insurer any amount by which claims paid out exceed benefits covered.

Signature of the Applicant: _____ Date: _____

d. Intermediary /Broker Details

1. Full Names _____

2. Trading Name _____

3. Telephone Number _____ KRA Pin No _____

5. Email Address _____

Intermediary/Broker Declaration

I hereby declare that I explained the benefits of this application and that the applicant is aware of the membership terms and conditions of Fidelity Insurance Limited.

Signature of Intermediary _____ Date _____