CONSULTANCY & INSURANCE AGENCY LTD

Britam
With you every step of the way

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CO-OP MEDICARE INSURANCE APPLICATION FORM

ALL INFORMATION PROVIDED WILL BE TREATED IN STRICT CONFIDENCE

1. **Please complete in BLOCK letters. Please attach copy of the principle member's identity card or valid passport**
2. **Commencement date_____Branch Code_____Account Number._____**
3. **Full Name_____ID NO./PP NO_____**
4. **Marital status:_____Gender_____Date of Birth_____**
5. **Physical Address_____Postal Address P O Box_____Code_____**
6. **E-mail address_____Mobile number:_____Work Tel:_____**
7. **NHIF number_____Occupation (Specify)_____**
8. **PARTICULARS OF DEPENDANTS TO BE INCLUDED IN THIS APPLICATION**

FULL NAME		DATE OF BIRTH						GENDER		RELATIONSHIP
01		D	D	M	M	Y	Y	M	F	
02		D	D	M	M	Y	Y	M	F	
03		D	D	M	M	Y	Y	M	F	
04		D	D	M	M	Y	Y	M	F	
05		D	D	M	M	Y	Y	M	F	
06		D	D	M	M	Y	Y	M	F	
07		D	D	M	M	Y	Y	M	F	

9. **MEDICAL HISTORY**

ANSWER THE QUESTION BELOW WITH A 'YES' OR "NO" FOR THE MEMBER (00) AND FOR EACH DEPENDANT '01' TO '07'

	Question	00	01	02	03	04	05	06	07
1.	In the last three years, have you had any surgeries, been confined or treated in hospital, sanatorium or other medical institution?								
2.	Do any of the persons to be covered know of any circumstances for which hospital treatment may be necessary in the next twelve months?								
3.	In the last three years, have you suffered from or been treated for Tuberculosis, Anemia or blood disease, Diabetes mellitus, Rheumatic fever, Hepatitis, Respiratory or other lung disorder, Heart condition, Raised blood fats, Varicose veins,								

	High blood pressure, Venereal disease, Cancer or tumors, Epilepsy, Anxiety, depression, mental or psychiatric disorders, Disorders of the alimentary canal, bowel, liver or gall bladder, Kidney, Blood circulation, Pancreas genito-urinary system, Bone, joint ligament, muscle, Skin ailment, Hernia, Gynecological disorder or HIV/AIDS & related conditions								
4.	Are you or any of your dependants about to undergo or do you suspect any of you might be about to undergo investigation, treatment, advice or counseling in respect of any of the conditions listed in question 3?								
5.	Have your parents ever suffered from diabetes, heart trouble, high blood pressure, stroke, kidney disease or cancer before age 60?								
6.	Has any of your parents, brothers or sisters died from any medical condition, or suffered from any medical condition which is likely to recur or suffered from any congenital (birth defect) or acquired physical defect or impairment?								
7.	Has any proposal to cover you for life, accident or medical scheme been refused or accepted on special terms?								

IF YOU OR ANY OF YOUR DEPENDANTS HAVE ANSWERED 'YES' TO ANY OF THE QUESTIONS ABOVE, KINDLY GIVE DETAILS BELOW:

_____

_____

_____

_____

10. NAME AND ADDRESS OF THE FAMILY ATTENDING PHYSICIAN(S)

_____

_____

DECLARATION

I hereby apply to be enrolled in the scheme together with my dependants listed above. I declare to the best of my/our knowledge and belief that the information given in this application is true and complete. I/we hereby authorize any medical practitioner who has observed, treated or attended to me or my dependants to give full particulars to British American Insurance. I/we understand that the extent of cover if any is determined by policy conditions. In the event of admission into hospital, I/we undertake to notify BRITISH AMERICAN within the first 48 hours. It is agreed that this declaration and the information given in this application, shall form the basis of the contract between the Insured

Person and the Insurer. Mis-representation or non disclosure of any material fact related to your health will result in disqualification of claims made under the policy.

Signature of applicant……..Date……