Sanlam

Sanlam General Insurance Ltd

Group Medical Application Form

Sanlam General Insurance Limited
Gateway Place, Jakaya Kikwete Road
P.O. Box 60656-00200 Nairobi, Kenya

T +254 (0)20 278 1000
M +254 (0)719 035 000
E info@sanlam.co.ke
w www.sanlam.co.ke

Section A - Employee details

Employer/Scheme Name: UNIQUE BRILLIANT SAFARIS LTD
Full Names of Employee: EMILY NYANDUKO BOSIRE
Date of Birth: 27th July 1995 Sex M ☐ F ☑
Occupation: TRAVEL CONSULTANT
Mobile No.: 0714785815 E-mail: emilybosire1995@gmail.com

Section B - Dependant details

	First Name	Middle Name	Surname	Date of Birth	Sex	Relationship
1.						
2.						
3.						
4.						
5.						
6.						
7.						

NB: Please use an additional form if dependants are more than 7 (Seven)

Health declaration by member

Please answer to the best of your knowledge or belief

1. Has any medical insurance application by you or your dependant (if within the last 10 years) been;

a) Accepted with extra premiums?
b) Accepted with specific exclusions?
c) Declined?

Please note to complete page 2 of this form

If the answer to any question is YES, identify question number and include diagnosis, dates, duration, degree of recovery, or results and names and addresses of all attending physicians and medical facilities in the space on the right.

Tick applicable items	Yes	No	
2. Are you under medical treatment by diet, medicine or other means?	☐	✓	
3. Have you ever had or sought advice for:			
a) chest pain, high blood pressure, heart murmur, heart or circulation disorder?	☐	✓	
b) asthma, chronic cough, shortness of breath or lung disorder?	☐	✓	
c) diabetes sugar in the urine?	☐	✓	
d) ulcer, colitis, liver or digestive disorder?	☐	✓	
e) cancer, tumor, or enlarged glands?	☐	✓	
f) anaemia, bleeding or blood disorder?	☐	✓	
g) dizzy or fainting spells, epilepsy, nervous system or mental disorder?	☐	✓	
h) urine, kidney or bladder disorder?	☐	✓	
i) arthritis or other joint disorder?	☐	✓	
j) any other illness, surgery or injury?	☐	✓	
k) have you or any of the insured dependants been diagnosed with a congenital condition?	☐	✓	
4. Have you:			
a) Received medical advice or treatment in connection with Aids or HIV related condition or sexually transmitted disease?	☐	✓	
b) Been told you have HIV/Aids or an HIV/Aids related complex?	☐	✓	
c) Had or been told you have a positive blood test for antibodies to the HIV Virus (Human Immune Deficiency Virus).	☐	✓	
d) Have any of the following, which are unexplained: fatigue,weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐	✓	
5. Have you within the past five (5) years:			
a) had any mental or physical disease or disorder not listed above?	☐	✓	
b) had a check-up, consultation, illness, injury or surgery?	☐	✓	
c) been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	✓	
d) had electrocardiogram, x-ray, other diagnostic test?	☐	✓	
e) been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	✓	
g) had a blood transfusion?	☐	✓	
6. Is any of the named members presently pregnant? *If yes, please give name*	☐	✓	
7. Are you aware of any condition in yourself or member of your family necessitating a medical, surgical, dental or optical treatment at present? If so, give full particulars.	☐	✓	

Declaration by member

I hereby declare that the statements in this form are true and complete. I further declare that I have not withheld any material information in regard to this application that ought to be disclosed to the company. I agree to abide by the rules governing the scheme and further agree that this declaration and the answers given in this application form shall be the basis of the contract between me and the insurance company.

I consent to the company seeking information from any doctor, hospital or clinic I have consulted or from any company I made a proposal for insurance and I hereby authorize the giving of such information.

Member's name EMILY NYANDUKO BOSIRE

Member's signature ~~EN~~ **Date** 27th July, 2021

Section C - To be completed by employer

As employer, I confirm that the information given in section 'A' above is correct. This employee and his/her dependants is/are to be included in the scheme with effect from (Date)

UNIQUE BRILLIANT SAFARIS LTD
29 JUL 2021
P.O. Box 2051-00502 NAIROBI

Signature & Stamp of Employer

Date of Signing

Sanlam

Sanlam General Insurance Limited
Gateway Place, Jakaya Kikwete Road
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Group Medical Application Form

Section A - Employee details

Employer/Scheme Name: UNIQUE BRILLIANT SAFARIS LTD
Full Names of Employee: MWENDE KITHINJI GRACE
Date of Birth: 17TH. NOVEMBER, 1997 Sex M ☐ F ✓
Occupation: TRAVEL CONSULTANT
Mobile No.: 0701373158 E-mail: gracesomwende@gmail.com

Section B - Dependant details

	First Name	Middle Name	Surname	Date of Birth	Sex	Relationship
1.						
2.						
3.						
4.						
5.						
6.						
7.						

NB: Please use an additional form if dependants are more than 7 (Seven)

Health declaration by member

Please answer to the best of your knowledge or belief

1. Has any medical insurance application by you or your dependant (if within the last 10 years) been;

a) Accepted with extra premiums?
b) Accepted with specific exclusions?
c) Declined?

Please note to complete page 2 of this form

If the answer to any question is YES, identify question number and include diagnosis, dates, duration, degree of recovery, or results and names and addresses of all attending physicians and medical facilities in the space on the right.

Tick applicable items	Yes	No	
2. Are you under medical treatment by diet, medicine or other means?	☐	✓	
3. Have you ever had or sought advice for:			
a) chest pain, high blood pressure, heart murmur, heart or circulation disorder?	☐	✓	
b) asthma, chronic cough, shortness of breath or lung disorder?	☐	✓	
c) diabetes sugar in the urine?	☐	✓	
d) ulcer, colitis, liver or digestive disorder?	☐	✓	
e) cancer, tumor, or enlarged glands?	☐	✓	
f) anaemia, bleeding or blood disorder?	☐	✓	
g) dizzy or fainting spells, epilepsy, nervous system or mental disorder?	☐	✓	
h) urine, kidney or bladder disorder?	☐	✓	
I) arthritis or other joint disorder?	☐	✓	
j) any other illness, surgery or injury?	☐	✓	
k) have you or any of the insured dependants been diagnosed with a congenital condition?	☐	✓	
4. Have you:			
a) Received medical advice or treatment in connection with Aids or HIV related condition or sexually transmitted disease?	☐	✓	
b) Been told you have HIV/Aids or an HIV/Aids related complex?	☐	✓	
c) Had or been told you have a positive blood test for antibodies to the HIV Virus (Human Immune Deficiency Virus).	☐	✓	
d) Have any of the following, which are unexplained: fatigue,weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐	✓	
5. Have you within the past five (5) years:			
a) had any mental or physical disease or disorder not listed above?	☐	✓	
b) had a check-up, consultation, illness, injury or surgery?	☐	✓	
c) been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	✓	
d) had electrocardiogram, x-ray, other diagnostic test?	☐	✓	
e) been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	✓	
g) had a blood transfusion?	☐	✓	
6. Is any of the named members presently pregnant? *If yes, please give name*	☐	✓	
7. Are you aware of any condition in yourself or member of your family necessitating a medical, surgical, dental or optical treatment at present? If so, give full particulars.	☐	✓	

Declaration by member

I hereby declare that the statements in this form are true and complete. I further declare that I have not withheld any material information in regard to this application that ought to be disclosed to the company. I agree to abide by the rules governing the scheme and further agree that this declaration and the answers given in this application form shall be the basis of the contract between me and the insurance company.

I consent to the company seeking information from any doctor, hospital or clinic I have consulted or from any company I made a proposal for insurance and I hereby authorize the giving of such information.

Member's name MWENDE KYATHOKI GRACE

Member's signature _____ **Date** 27TH JULY, 2021

Section C - To be completed by employer

As employer, I confirm that the information given in section 'A' above is correct. This employee and his/her dependants is/are to be included in the scheme with effect from (Date)

UNIQUE BRILLIANT SAFARIS LTD P.O. Box 2051-00502 NAIROBI 29 JUL 2021

Signature & Stamp of Employer _____ **Date of Signing** _____

Sanlam

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W www.sanlam.co.ke

Sanlam General Insurance Ltd

Group Medical Application Form

Section A - Employee details

Employer/Scheme Name: UNIQUE BRILLIANT SAFARIS LIMITED
Full Names of Employee: EDWIN NTAKUNDI ONGURE
Date of Birth: 15/02/1996 Sex M [V] F [ ]
Occupation: TRAVEL CONSULTANT
Mobile No.: 0703374465 E-mail: edwinchamakis@gmail.com

Section B - Dependant details

	First Name	Middle Name	Surname	Date of Birth	Sex	Relationship
1.						
2.						
3.						
4.						
5.						
6.						
7.						

NB: Please use an additional form if dependants are more than 7 (Seven)

Health declaration by member

Please answer to the best of your knowledge or belief

1. Has any medical insurance application by you or your dependant (if within the last 10 years) been;

a) Accepted with extra premiums? [ ]
b) Accepted with specific exclusions? [ ]
c) Declined? [ ]

**Please note to complete page 2 of this form*

If the answer to any question is YES, identify question number and include diagnosis, dates, duration, degree of recovery or results and names and addresses of all attending physicians and medical facilities in the space on the right.

Tick applicable items	Yes	No	
2. Are you under medical treatment by diet, medicine or other means?	☐	✓	
3. Have you ever had or sought advice for:			
a) chest pain, high blood pressure, heart murmur, heart or circulation disorder?	☐	✓	
b) asthma, chronic cough, shortness of breath or lung disorder?	☐	✓	
c) diabetes sugar in the urine?	☐	✓	
d) ulcer, colitis, liver or digestive disorder?	☐	✓	
e) cancer, tumor, or enlarged glands?	☐	✓	
f) anaemia, bleeding or blood disorder?	☐	✓	
g) dizzy or fainting spells, epilepsy, nervous system or mental disorder?	☐	✓	
h) urine, kidney or bladder disorder?	☐	✓	
I) arthritis or other joint disorder?	☐	✓	
j) any other illness, surgery or injury?	☐	✓	
k) have you or any of the insured dependants been diagnosed with a congenital condition?	☐	✓	
4. Have you:			
a) Received medical advice or treatment in connection with Aids or HIV related condition or sexually transmitted disease?	☐	✓	
b) Been told you have HIV/Aids or an HIV/Aids related complex?	☐	✓	
c) Had or been told you have a positive blood test for antibodies to the HIV Virus (Human Immune Deficiency Virus).	☐	✓	
d) Have any of the following, which are unexplained: fatigue,weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐	✓	
5. Have you within the past five (5) years:			
a) had any mental or physical disease or disorder not listed above?	☐	✓	
b) had a check-up, consultation, illness, injury or surgery?	✓	☐	
c) been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	✓	
d) had electrocardiogram, x-ray, other diagnostic test?	☐	✓	
e) been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	✓	
g) had a blood transfusion?	☐	✓	
6. Is any of the named members presently pregnant? *If yes, please give name*	☐	✓	
7. Are you aware of any condition in yourself or member of your family necessitating a medical, surgical, dental or optical treatment at present? If so, give full particulars.	☐	✓	

Declaration by member

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I consent to the company seeking information from any doctor, hospital or clinic I have consulted or from any company I made a proposal for insurance and I hereby authorize the giving of such information.

Member's name EDWIN NTAKUNDI ONGARE

Member's signature _____ **Date** 07/07/2021

Section C - To be completed by employer

As employer, I confirm that the information given in section 'A' above is correct. This employee and his/her dependants is/are to be included in the scheme with effect from (Date)

27/07/2021

Signature & Stamp of Employer

UNIQUE BRILLIANT SAFARIS LTD
27 JUL 2021
P.O. Box 2051-00502 NAIROBI

Date of Signing