

Flexi Maisha Umbrella Application Form

All questions must be answered in full and in BLOCK letters

Proof of identity of self and beneficiary(ies) is required. Provide copies of National Identity Card, Passport or Birth Certificate together with this application.

Full Names of Member Gender.....
 Postal address Postal Code
 Email address Occupation
 Residential address Private Mobile Number
 PIN Number ID Number

SECTION A. BENEFICIARIES

I hereby nominate the following person(s) to be considered for receipt of all benefits payable in the event of my death under this Scheme.

Full Names	Relationship	ID No.	Age	Mobile No.	Email Address	Postal Address	Benefit

If any of the above nominated person(s) has not attained the age of majority (18 years), section B must be completed naming a Guardian who must be over 18 years of age.

SECTION B. GUARDIAN

Full Names	Relationship	ID No.	Age	Mobile No.	Email Address

The % of benefit column must be completed with actual % whose total must add up to 100%. I understand that unless otherwise indicated any benefits from this policy will be divided equally among all persons who are nominated as beneficiaries and who survive me and have attained the age of majority OTHERWISE to the Guardian (on appointment by the High Court of Kenya where necessary).

BENEFIT OPTION SELECTED

BENEFIT	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
Life Cover	250,000	500,000	750,000	1,000,000	2,000,000	3,000,000	4,000,000	5,000,000
PTD (Accelerated)	250,000	500,000	750,000	1,000,000	2,000,000	3,000,000	4,000,000	5,000,000
Critical Illness (Accelerated)	125,000	250,000	325,000	500,000	1,000,000	1,500,000	2,000,000	2,500,000
Last Expense (Accelerated)	50,000	75,000	75,000	100,000	125,000	250,000	250,000	250,000
ANNUAL PREMIUM	1,000	2,000	3,000	4,000	8,000	12,000	16,000	20,000
Tick one preferred option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Underwritten by



GENERAL • LIFE • HEALTH

Medical History	Yes	No
a) Are you in good health?		
b) Have you consulted any doctor or medical facility either as an inpatient or outpatient in the last 3 years? If so, when and for what complaints?		
c) Are you currently taking any medication regularly or as needed?		
d) Height		
Weight		
e) How frequently, and in what quantity do you use intoxicating drink, tobacco or nicotine products or habit- forming drugs?	Freq.	Qty.
(i) Intoxicating drinks		
(ii) Tobacco or nicotine products		
(iii) Habit-forming drugs		
f) Have you been convicted of a felony within the last five (5) years or do you have charges currently pending? If so, give details.		

Note: I understand that the statements and all information provided herein are complete and true to the best of my knowledge and that it will form part of the policy. I understand that any misrepresentation of information on medical questions will lead to a claim being declined.

DECLARATION (PLEASE TICK IF IN AGREEMENT):

- ☐ I have understood the benefits covered under the umbrella scheme.
- ☐ I understand that the statements and all 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. No change in amount, classification or benefits shall be effective unless agreed to in writing by the life assured.
- ☐ 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 to and accepted by APA Life
- ☐ I understand that no intermediary has the authority to waive the answers to any of the questions in this application or to make or alter any contract for APA Life Assurance Limited.
- ☐ I have understood the benefits covered under the umbrella scheme.

Signed at _____ this _____ day _____ of _____ 20_____

Signature of proposed insured _____