GALLOWAY'S
INSURANCE CONSULTANCY AGENCIES

GALLOWAYS APPLICATION FORM

Please complete this form and attach a copy of the Principal member's ID, KRA PIN, Spouse's ID card, Dependant's birth Certificate, proof of schooling if over 18 and legal adoption papers if adopted.

Details

	Principal applicant - 00	**Dependant 1 - Spouse (If applicable)**
Name	_____	_____
National ID No./Passport No.	_____	_____
NHIF Member No.	_____	_____
KRA Pin No.	_____	_____
Date of birth (DD/MM/YYYY)	_____	_____
Occupation	_____	_____
E-mail address	_____	_____
Mobile number	_____	_____
Postal address & postal code	_____	_____
Physical address/residence	_____	_____
Next of kin name & ID No.	_____	_____

Measurements

- Height (cm): _____ Weight (Kg): _____
- Spouse Height (cm): _____ Weight (Kg): _____

NOMINATION OF BENEFICIARY

I hereby nominate the following person to be considered for receipt of the last expense benefit under this policy:

- Name: _____
- ID Number: _____
- Mobile Number: _____
- Relationship: _____

DEPENDANT DETAILS

No.	**Name**	**Date of Birth (DD/MM/YYYY)**	**Gender**	**Relationship**	**ID No. (If over 18)**	**Weight**	**Height (cm)**
01							
02							
03							
04							
05							

DETAILS OF PREVIOUS SCHEME MEMBERSHIP

- Name of scheme/plan: _____
- Principal applicant name: _____
- Date joined: From _____ To _____
- Spouse name: _____

a. Have you or any dependants ever been declined, loaded, or had exclusions applied by a medical scheme?

☐ Yes ☐ No

If Yes, give details: _____

b. Have you or any dependants lodged an inpatient or outpatient claim in the last one year?
☐ Yes ☐ No
If Yes, give details: _____

CONFIDENTIAL MEDICAL HISTORY
(Answer Yes or No per applicant No. 00 – 05. If Yes, give details.)
[List of medical conditions remains unchanged – fill per applicant.]

EXCLUSIONS
[Retain exclusions list – unchanged.]

INPATIENT & OUTPATIENT BENEFITS

- Inpatient: 300,000 | 500,000 | 1,000,000 | 2,000,000 | 3,000,000 | 5,000,000 | 7,500,000 | 10,000,000
- Outpatient (Optional): 30,000 | 50,000 | 80,000 | 100,000 | 120,000 | 250,000 | 500,000
- Dental (Optional): 10,000 | 15,000 | 20,000 | 50,000 | 100,000
- Optical (Optional): 10,000 | 15,000 | 20,000 | 50,000 | 100,000

Benefit(s) selected:

- Inpatient: _____
- Outpatient: _____
- Dental: _____
- Optical: _____

OFFICIAL USE

- Inpatient premium: _____
- Outpatient premium: _____
- Card charges: _____
- Levies: _____
- Total premium: _____

DEFINITIONS OF TERMS
(Pre-existing conditions, chronic conditions, congenital, co-payment remain same. Only company names replaced.)
Co-payment
A co-payment of KShs. 1,000 applies on all outpatient visits to the following hospitals under **Galloways**:

- Galloways University Hospital and affiliate clinics
- Galloways Hospital Mombasa and affiliate clinics
- Galloways Hospital Kisumu and affiliate clinics
- Galloways Hospital Nairobi and affiliate clinics

Reimbursement: 80% on eligible treatment from providers not in the **Galloways Health Panel**, subject to Galloways Insurance rates.

CONSENT
I ALLOW YOU TO USE THE DATA SUPPLIED LIMITED FOR THE PURPOSE OF PROCESSING INSURANCE
☐ YES ☐ NO

DECLARATION OF MEMBER
I hereby apply to be enrolled in the Galloways Medical Scheme together with my dependants listed above.
I declare that the information given is true and complete. I authorize **Galloways Health Insurance Limited** and its affiliates to seek medical or personal information necessary to process this cover.
I understand that cover will be effective upon written approval of **Galloways Health Insurance Limited**.

- Applicant's signature: _____ Date: _____
- Witness's signature (Galloways Official): _____ PF No.: _____ Date: _____