Britam
With you every step of the way

Milele Health Plan
Health for Life

1.MEDICAL INSURANCE APPLICATION FORM

Please complete in BLOCK letters. All fields are Mandatory to be filled. Please attach copy of the Principal Member's Identity Card or Valid Passport and KRA Pin. Also attach spouse's copy of ID.

Application date 14-11-2022 **Branch Name**..... **Membership No**.....

DETAILS	MAIN APPLICANT- 01	SPOUSE (If Applicable) Dependent 2
FULL NAMES** First Name, Middle Name, Surname	MATHEW WEKESA NAMANDA	
National ID No/Passport No **	30415360	
KRA Pin No.	A007023253H	
Date of Birth (DD/MM/YYYY)**	29-11-1992	
Mobile No.**	0714491668	
E-Mail Address**	MATCELOUS@GMAIL.COM	
Occupation e.g. Teacher, Student **	SOFTWARE ENGINEER	
Postal Address, Code and town**	2129-30200 KITALE	
Physical Address/Residence		
Height and Weight	HT..168.....cm, WT..62..... Kgs	HT.....cm, WT ..... Kgs
Blood Group A/B/AB/O and Rhesus factor +/-		

NEXT OF KIN (Person to be notified in case of an emergency and cover status when principal is hospitalized)

Name:..... Relationship .....Mobile no..... ..... Email address.....

BENEFICIARY (Person designated to receive funds as per cover benefits in the unfortunate event of loss of life – if beneficiary is below 18 years kindly nominate aguardian)

Name..ROBINSON N. NAMANDA..... Relationship..BROTHER.....Mobile no.0745921427..... Email address..ROBINSONNYONGESANAMANDA@GMAIL.COM

2. PARTICULARS OF DEPENDANTS TO BE INCLUDED ON COVER *(Provide copies of ID or Birth Certificates)*

	FULL NAMES (IN BLOCK LETTERS)	DATE OF BIRTH						GENDER		RELATIONSHIP
2		D	D	M	M	Y	Y	M	F	
3		D	D	M	M	Y	Y	M	F	
4		D	D	M	M	Y	Y	M	F	
5		D	D	M	M	Y	Y	M	F	
6		D	D	M	M	Y	Y	M	F	
7		D	D	M	M	Y	Y	M	F	

3. DETAILS OF PREVIOUS MEMBERSHIP

Name of Scheme/Plan - Principal Applicant

_____From: dd/mm/yy to: dd/mm/yy

Name of Scheme/Plan — Spouse

_____From: dd/mm/yy to: dd/mm/yy Have you or any of your dependents ever been declined, loaded, or had exclusions applied on them by a medical insurance? 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

4. CONFIDENTIAL MEDICAL HISTORY

State whether you or any of your dependents have ever been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including but not limited to: Kindly answer with YES/NO. N/A and blank spaces are not allowed.

	Please answer YES/N0 to all the questions below. blanks spaces are not acceptable. Answers are required for each applicant. You may attach additional sheets if the space provided is not sufficient.								
	Questions	**No. 1**	**No. 2**	**No. 3**	**No. 4**	**No. 5**	**No. 6**	**No. 7**	**No. 8**
1.	Have you had any surgeries, been confined or treated in a hospital, sanatorium of any other medical institution?	No							
2.	Do any of the persons to be covered know of any circumstances for which treatment may be necessary in The next twelve months (1 year)*		No						
3.	Have you suffered from or been treated for:			No					
a)	Respiratory ear, nose and throat disorders including Tuberculosis, Asthma, Cleft lip and palate, chronic obstructive pulmonary disease, hearing and speech impairment and any other								
b)	Eye disorder: Glaucoma, Reno blastoma, cataracts, blindness, keratoconus and any other.								
c)	Heart and blood vessel disorders to include: High blood pressure, arrhythmias, palpations, deep venous thrombosis, ischemic heart disease, coronary artery disease, aneurysms, angina pectoris. rheumatic fever, rheumatic heart disease and any other.								
d)	Cancer, growths and tumors whether benign or malignant								
e)	Genitourinary disorders to include: kidney failure, dialysis, enlarged prostate, bladder disorders. kidney stones, and any other.								
f)	Gynecological and obstetric disorders to include: Pelvic inflammatory diseases, fibroids, ovarian cysts, hormonal disorder								
g)	Endocrine disorders to include: elevated cholesterol, diabetes, thyroid abnormalities and any other.								
h)	Musculoskeletal disorders to include: Osteoporosis, arthritis, kyphosis, scoliosis, joint and back pains, gout and any other.								
i)	Skin disorders to include: Eczema, acne vulgaris, keloids, melanoma, Kaposi's sarcoma, burns and any other.								
j)	Congenital/ hereditary disorders to include: sickle cell disease, hemophilia, umbilical hernia birth abnormalities and any other.								
k)	Blood and connective tissue disorders to include: systemic lupus erythematous, HIV and AIDS, Leukemia an any other								
l)	Gastrointestinal disorders to include: Hepatitis, Gall bladder disease, Hernia, hemorrhoids, endoscopy, colonoscopy, pancreatic and any other.								
m)	Neurological and psychological disorders to include: Mental disabilities, Bipolar disorders, depression, manic disorders, schizophrenia, attention deficit disorder, anorexia, bulimia, epilepsy and any other								

4.	Have you been cleared of any chronic condition that you were on or not on treatment for?				No				
5.	Has your family(parents/brothers/sisters) ever suffered from diabetes, heart diseases, high blood pressure, stroke, kidney disease or cancer or suffered from any congenital (birth defect) or acquired physical defect or impairment or any other hereditary diseases?					No			
6.	**Investigations and/or specialized treatment: In and out of hospital**						No		
	A) Are you or any of your dependents currently undergoing or expect to undergo investigations for any medical condition and/ or symptoms not yet diagnosed?								
	B) Are you or any of your dependents currently receiving, or expect to receive specialized treatment (i.e. chemotherapy, radiotherapy, bone marrow transplant, mechanical ventilation, oxygen therapy, dialysis, psychotherapy or counseling, and others?								
7.	Are you or any of your dependents on any medication?							No	
8.	Do you or any of your dependents smoke? If yes, for how long?								No

If you answered YES to any of the questions above, please supply full details below

Q.NO.	Applicant Name	Date	Diagnosis	Treatment	Consulting Doctor

5. PLAN SELECTION

Variant Selected							
INPATIENT PLANS	**300,000**	**500,000**	**1,000,000**	**2,000,000**	**3,000,000**	**5,000,000**	**10,000,000**
OUTPATIENT PLANS	50,000	50,000	50,000	50,000	50,000	50,000	50,000
			100,000	100,000	100,000	100,000	100,000
					150,000	150,000	150,000
						200,000	200,000
MATERNITY STANDALONE	80,000	80,000	80,000	80,000	80,000	80,000	80,000
			100,000	100,000	100,000	100,000	100,000
				150,000	150,000	150,000	150,000
					200,000	200,000	200,000
						250,000	250,000
							300,000

CLIENT TO SELECT DESIRED PLAN FOR DENTAL AND OPTICAL. THESE ARE PER PERSON

DENTAL PLANS	10,000	20,000	30,000	40,000
OPTICAL PLANS	10,000	20,000	30,000	40,000

Important Things to note

1. Cover is not effective until your application is accepted in writing and the full annual premium paid.
2. Britam General Insurance Limited will not be liable for medical expenses resulting from excluded conditions or exceeded benefits (as per policy).
3. Applicants aged 50 years and above will be required to go for medical tests at their own cost.

6. GENERAL EXCLUSIONS

1. Self-referred or self-prescribed treatment,
2. Infertility & impotence
3. Intentional self-injury, chronic drunkenness, suicide or attempted suicide, drug and substance abuse,
4. Hazardous pursuits (sports and hobbies)
5. Cosmetic and beauty treatment (unless necessitated by accidental injury)
6. Experimental treatment or treatment subject to medical research
7. Weight management treatment and drugs
8. Diagnostic equipment (glucometers, BP Machines etc.
9. External surgical appliances (crutches and wheelchairs and prosthesis
10. Dental prosthesis, crowns, dentures, bridges and braces

11. Alternative medicine (acupuncture, chiropractor, herbal medicine) unless referred by a GP
12. Expenses recoverable under any other insurance or source e.g. NHIF
13. Treatment outside the appointed panel of service providers
14. Nutritional supplements unless prescribed as part of medical treatment of specified conditions
15. Costs of treatment for related to menopause, andropause, ageing, puberty and pre-menstrual tension syndrome
16. Expenses insured whilst the Insured is outside Kenya, except for a maximum of six weeks
17. Any claim where material information shall have been misstated or withheld at the time of application e.g. non declared pre-existing and chronic condition.
18. Treatment of obesity or slimming preparation
19. Cost of hearing aids
20. Expenses in excess of the specified policy limits and/or sub-limits
21. Cost of donor and related cost of donor transplant
22. Any other exclusion specified in the policy document.

4. DECLARATION

I hereby apply to be enrolled in the scheme. I declare to the best of my knowledge and belief that the information given in this application is true and complete. I consent to the Insurance company seeking information from my doctor, hospital or clinic I have consulted. I consent to the data being used and stored as per the requirement of any regulation. I understand that the extent of cover if any is determined by policy conditions. 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. Misrepresentation or non-disclosure of any material facts related to my health will result in termination of the policy, disqualification of claims made including non-refund of premium under the policy. I also understand that my cover will only commence once I have paid the full premium and that my membership will only become effective after approval of the application and written confirmation of terms by Britam; notwithstanding the fact that payment may have been received.

I CONFIRM THAT I HAVE FILLED THIS FORM AND IT HAS NOT BEEN FILLED ON MY BEHALF.

Signature of principal member…… DATE…14… / …11…. /.2022…

Signature of principal member…… DATE…14… / …11…. /.2022…

AGENT/BROKER DETAILS

Full Name of Financial Advisor/Agent/ Broker……

Telephone number……

Financial Advisor/Agent/Broker Number……

FOR OFFICIAL USE ONLY

Commencement date……

U/W Comments……

Underwritten by……

Signature …… Date……

Financial Advisor/Agent/ Broker Declaration

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

Signature of Intermediary……**DATE……../…… /……**