Britam
With you every step of the way

Milele Health Plan

HealthforLife

1.MEDICAL INSURANCE APPLICATION FORM (COVID COVER)

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.

DETAILS	MAIN APPLICANT
FULL NAMES** First Name, Middle Name, Surname	
National ID No/Passport No **	
KRA Pin No.	
Date of Birth (DD/MM/YYYY)**	
Mobile No.**	
E-Mail Address**	
Occupation e.g. Teacher, Student **	
Postal Address, Code and town**	
Physical Address/Residence	
Height and Weight	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)	
FULL NAMES** First Name, Middle Name, Surname	
Mobile No.**	Email Address:
Relationship to Principal Member:	

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
1		D	D	M	M	Y	Y	M	F	
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	

3. 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. You may attach additional sheets if the space provided is not sufficient.	
	Questions	**Answer with YES/NO**
1.	Have you or anyone you are in close contact with travelled outside Kenya in the last 60 days or planning to travel outside Kenya within the cover period?	
2.	Have you been in close contact with anyone who has suffered from or treated for Covid 19?	
3.	Are you suffering from pre-existing, respiratory conditions?	
4.	Are you 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?	
5.	Are you on any medication?	
6.	Do you smoke? If yes, for how long?	

If any of your questions is YES kindly give more details and the consulting Doctor/facility.

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3. PLAN SELECTION (Tick Against the desired cover)

	Option 1	**Option 2**	**Option 3**	**Option 4**	**Option 5**	**Option 6**
Member	50,000	100,000	200,000	300,000	400,000	500,000
Tick Desired Plan						

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 Company 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…… / ……. /…….

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……/……. /…….**