

## INDIVIDUAL LIFE ASSURANCE APPLICATION FORM

To be filled by Britam Staff only

Policy Number:

Commencement Date:

Please fill clearly in BLOCK letters and tick (✓) where appropriate.

### 1. APPLICANT'S/POLICY OWNER DETAILS (As On National ID or Passport)

#### (a) Personal Information

 Title:  Mr  Mrs  Mrs  Other (Please Specify): \_\_\_\_\_

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Name(s): \_\_\_\_\_

 Date of Birth: \_\_\_\_\_ Gender:  Male  Female

National/Alien ID: \_\_\_\_\_ Nationality: \_\_\_\_\_

Passport Number: \_\_\_\_\_

Country of Residence: \_\_\_\_\_ KRA Pin: \_\_\_\_\_

 Marital Status:  Single  Married  Widowed  Other (Please Specify): \_\_\_\_\_

Postal Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Residential Address: \_\_\_\_\_ Town/City: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Email: \_\_\_\_\_

 Preferred Method of Contact:  Email  Telephone

 Do you hold or have ever held a political or high ranking public office?  Yes  No

 Do your close relatives/business partners hold or has ever held a political or high ranking public office?  Yes  No

#### (b) Life Proposed (If different from Policy Owner)

Name: \_\_\_\_\_ Relationship to Policy Owner: \_\_\_\_\_

 Date of Birth: \_\_\_\_\_ ID/Birth Cert No.: \_\_\_\_\_ Gender:  Male  Female

#### (c) Premium Payer's Details\* (If different from Policy Owner)

Name: \_\_\_\_\_ Tel No.: \_\_\_\_\_ ID No.: \_\_\_\_\_ KRA PIN No.: \_\_\_\_\_

Relationship to Policy Owner: \_\_\_\_\_ Premium Payer cannot be Britam sales agent. No cash accepted

#### (d) Policy Owner's Occupation Details

 Employed  Self Employed  Unemployed  Retired Other (Please Specify): \_\_\_\_\_

If self employed, state the business sector you operate in: \_\_\_\_\_

Town: \_\_\_\_\_ Street: \_\_\_\_\_ Building: \_\_\_\_\_

If employed, please provide the following information: Present Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

 Employment Industry:  Financial Services  Hospitality  Public Service/Government  Education  Student

 Entrepreneur  Arts  Legal/Accounting  Health

 Others (Please Specify): \_\_\_\_\_

**(e) Contact Person Details** (Details are for contacting purposes in case we cannot reach you via the contacts provided)

Name	Mobile Number	Postal Address	Postal Code	Town

Please note that Britam reserves the right to seek further information or documentation on the source of funds to be used for premium payment

**(f) Source of Funds for the Premium Payer**

<input type="checkbox"/> Rental/Property Sale	<input type="checkbox"/> Salary	<input type="checkbox"/> Dividends/Interest	<input type="checkbox"/> Pension	<input type="checkbox"/> Inheritace	<input type="checkbox"/> Gift
<input type="checkbox"/> Lottery/Betting	<input type="checkbox"/> Savings	<input type="checkbox"/> Sales of Shares	<input type="checkbox"/> Loan	<input type="checkbox"/> Maturing Investments	
<input type="checkbox"/> Others (Please Specify): _____					

**2. BENEFICIARY DETAILS**

Name of Beneficiary	Shares (%)	Relationship	Date of Birth	Tel No.	ID/Birth Cert No

Name of Nominee (if any of the beneficiaries is a minor): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Policy Owner: \_\_\_\_\_ Tel No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

**3. FINANCIAL QUESTIONNAIRE**

Net Salary Income (A)	Other Income (Farming, Business etc) (B)	Total Monthly Expenditure (D)	Disposable Income (D) = (A + B - C)
<b>Gross Premium for Application(s) (E)</b>		<b>Gross Premium (E) to Disposable Income (D) Ratio,(F) = E/D*100. F should not exceed 20%</b>	

**4. FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA)**

Are you a US Citizen or Resident?  Yes  No

If Yes, complete the US Indicia Form. US citizens and residents include persons; born in the US, or holders of a US Green Card, US residential address, US telephone number, standing order to a US Bank account, granted power of attorney or have signatory authority to a person with a US address

**Self-Certification (Tax Status)**

Are you registered for tax in Kenya?  Yes  No

Are you registered for tax in any other country?  Yes  No

If "Yes", please provide your Tax Identification Number for each country (or reason why none has been issued):

Country (ies) of Tax Residency	Tax Identification Number	Tax Number Not Applicable

Or Reason

## 5. PRODUCT TYPE AND PLAN DESCRIPTION

**Medical Tests Requirement**  With Medicals  Without Medicals

**Education**  Msingi Poa  Boresha Elimu  HF Elimu  Super E

**Savings**  Akiba  Money-back  Dhamana

**Protection**  Tegemeo  Family Income  Critical Illness  Elimu Smart

Plan Code	Description of Benefits	Term	Initial Sum Assured	Premium

Policy Fee: \_\_\_\_\_

Policyholder Compensation Levy: \_\_\_\_\_

Total Premium: \_\_\_\_\_

**E-Policy:** We shall send an e-policy through the email provided in Section 1(i)

## 6. PREMIUM FREQUENCY AND PAYMENT MODE

**Frequency**  Annual  Semi-Annual  Quarterly  Monthly

**Mode**  Cheque  Check-Off\*  DDA\* \*Fill in check-off deduction or DDA mandate form

M-Pesa Paybill 541400 Account Number: NEW or Policy Number or ID Number

## 7. BANKING INFORMATION (For DDA Payment)

Account Name: \_\_\_\_\_

Bank Name: \_\_\_\_\_ Branch & Town: \_\_\_\_\_ A/c No.: \_\_\_\_\_

## 8. HEALTH QUESTIONS FOR THE LIFE PROPOSED (All Questions Must Be Answered)

1. Have you consulted or been examined by any doctor within the last 10 years? If yes, give the name, address, diagnosis and treatment you received.

\_\_\_\_\_

2. Height (cm) \_\_\_\_\_ Weight (kg) \_\_\_\_\_

When any of the questions 3 to 7 hereunder is answered "YES" give full details. Specify the conditions, items or history and give dates, duration, treatment, name and address of each doctor consulted. **DETAILS:** Attach a separate sheet if space is inadequate, date and sign it.

3. (a) Do you have any health problems or are you taking treatment or medication of any kind?  Yes  No

\_\_\_\_\_

3. (b) Have you used tobacco products, alcohol or any habit-forming drugs within the last 10 years?  Yes  No

If yes, state the type of product and average daily use.

4. Have you ever had or any member of your family been advised to have a surgery, suffered from diabetes?  Yes  No

\_\_\_\_\_

5. Have you any abnormality, disease or disorder not mentioned above?  Yes  No

---

6. (For females only) Are you pregnant? If yes, give the number of weeks  Yes  No

---

7. Have you ever engaged in racing under water, diving, parachuting or any other hazardous occupation or sport or is any such activity contemplated?  Yes  No

---

## 9. CLIENT ACCOUNT INSTRUCTIONS (Pay Out Details)

I authorize Britam Life Assurance Co. (K) Ltd to pay all my future policy benefits to the Account below until advised otherwise in writing.

Account Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Branch: \_\_\_\_\_

Bank Code: \_\_\_\_\_

## 10. DATA PROTECTION & MARKETING CONSENT

I consent to Britam collecting and processing my personal data for policy and account administration, and for compliance with legal and regulatory obligations, in line with the Data Protection Act, 2019 (Kenya) and the company's Privacy Notice (available at [britam.com/legal/privacy-policy](http://britam.com/legal/privacy-policy)).

I consent to receive product updates and promotional messages from Britam about its insurance and investment products and services via SMS, email, calls, or digital platforms. (Optional – marketing consent can be withdrawn anytime).

I do not wish to receive product updates or promotional messages from Britam.

I confirm that I have read and understood, and hereby consent to the general terms and conditions, and hereby make the above declaration.

## 11. GENERAL TERMS AND CONDITIONS

(a) This application has been made to Britam Life Assurance Company (Kenya) Ltd according to the Company terms and conditions.

(b) I declare the above statements are to my knowledge and belief true and complete.

(c) The statements made in this application and in any other documentation submitted in connection with this application form the basis of the policy applied for and shall constitute all representations made as a basis for the policy. I have checked those statements carefully and if there are any changes to the information in this form before the policy starts, I will tell Britam Life Assurance Company (K) Ltd.

(d) No agent has the authority to waive a question in the application, modify the application or bind the Company by making any promise or representation or by giving or receiving any information.

(e) I irrevocably authorize and request any Doctor or other person who may be in possession of or hereafter acquire any information concerning my health (where such information relates to the past or the future) to disclose such information to Britam Life Assurance Company (K) Ltd. I agree that this authority and request shall remain in force after my death as well as prior thereto.

(f) The Company may recover any expenses incurred if I terminate the application for insurance before the contract is completed.

(g) The Company shall not be liable for having received and acted in good faith upon any and/or all instructions received through electronic communication purporting to come from me but which is subsequently discovered to, or may emanate from unauthorized individuals or in any other circumstances whatsoever and, I shall keep the Company indemnified at all times against all actions, proceedings, claims, loss, damage, costs, and expenses which may be brought against or incurred by the Company by reason of the Company accepting such instructions.

(h) I understand that information regarding my insurability will be treated as confidential. The Company or its reinsurers may however release information in its file to other insurance companies to whom I may apply for insurance cover, or to whom a claim for benefits may be submitted.

## 12. APPLICANT SIGN-OFF OF TERMS AND CONDITIONS, AND DATA PROTECTION ACT

Name of Applicant: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Witness: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 13. FOR BRITAM STAFF USE ONLY

#### 13.1 Please provide copies of the following:

- Official Identification Document or current passport or Alien ID.
- Tax (KRA) PIN Certificate.
- Proof of banking details (copy of ATM card, original cancelled cheque or certified letter from the bank or a bank statement not more than three months old).

Is this direct business?  Yes  No

If No, please populate the Financial Advisor/Intermediary Section below

#### 13.2 Financial Advisor/Intermediary

I confirm that all the above documents have been attached:

Name of Financial Advisor: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Agent Contract Number: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Manager: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Manager Contract Number: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### 13.3 Compliance Checks (Onboarding and Compliance)

- KYC
- Sanctions Screening
- PEP
- FATCA

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_