

SOMA SURE EDUCATION PLAN APPLICATION FORM

To be filled by Britam Staff only	Policy Number: _____	Commencement Date: _____
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Please print clearly in BLOCK letters and tick (✓) where appropriate.

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

(i) Personal Information

Title: Mr Mrs Ms 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 Number: _____

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

Does your close relatives/business partner hold or has ever held a political or high ranking public office Yes No

(ii) Life Proposed *(If different from Policy Owner)*

Name _____ Relationship to Policy Owner _____

Date of Birth _____ ID/Birth Cert No _____ Gender M F

(iii) 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**

(iv) 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): _____

(v) 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

(v) Source of Funds for the Premium Payer

Rental/Property Sale Salary Dividends/Interest Pension Inheritance Gift
 Lottery/Betting Savings Sale of Shares Loan Maturing Investments
 Other (Please Specify): _____

2. BENEFICIARY DETAILS

Name of Beneficiary	Share (%)	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 (C)	Disposable Income (D) = (A + B - C)
Gross Premium for Application(s) (E)		Gross Premium (E) to Disposable Income (D) Ratio,(F) = E/D*100. F should not exceed 20%	

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	Or Reason	Tax Number Not Applicable

5. PRODUCT TYPE AND PLAN DESCRIPTION

MEDICAL TESTS REQUIREMENT With Medicals Without Medicals

EDUCATION Soma Sure Savings WoP on Death

OPTIONAL BENEFITS WoP on Redundancy WoP on PTD Last Expense Death Cover
 PTD Benefit

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

(b) Have you used tobacco products, alcohol or any habit-forming drugs within the last 10 years? if Yes, state type of product and average daily use. Yes No

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. COMPLIANCE WITH THE DATA PROTECTION ACT

By checking this box, I consent to Britam's Privacy Policy, and hereby authorize Britam to collect, use, disclose, and/or process our personal data or information without further notification to me/us, confidentially with its affiliated companies, third party service providers, business partners and/or other parties which may be sited outside of Kenya, for setting up and administering your insurance policy with Britam, customer services and to allow Britam and/or its business partners to perform marketing and related activities, until Britam receives our written instruction to the contrary. Britam's Privacy Policy is available at <https://ke.britam.com/privacy-policy>

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: _____