CIC GENERAL INSURANCE LTD.

CIC COOPCARE
PROPOSAL FORM

CIC GROUP

WRITE NAME AT THE BACK OF EACH PHOTOGRAPH AND ATTACH WITH A CLIP

(PLEASE, DO NOT USE STAPLE OR PIN)

Please complete in block letters. Attach one recent colour passport photograph for each proposed insured, write the name and sign on the back of each.

Personal Particulars of The Applicant

Name of Insured Company

TITLE ☐ Mr. ☐ Mrs. ☐ Miss. Other ☐ PROPOSAL COMMENCEMENT DATE Day ☐☐ Month ☐☐ Year ☐☐☐☐

SURNAME ☐☐☐☐☐☐☐☐☐☐ OTHER NAMES ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ID/PASSPORT NUMBER ☐☐☐☐☐☐☐☐☐☐

GENDER ☐☐ MARITAL STATUS ☐☐☐☐☐☐☐☐ DATE OF BIRTH ☐☐ ☐☐ ☐☐☐☐ MOBILE NUMBER ☐☐☐☐☐☐☐☐☐☐ ALTERNATIVE PHONE NUMBER ☐☐☐☐☐☐☐☐☐☐

POSTAL ADRESS ☐☐☐☐☐☐☐ POSTAL CODE ☐☐☐☐☐ TOWN OF RESIDENCE ☐☐☐☐☐☐☐☐☐☐ EMAIL ADRESS (OFFICE) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EMAIL ADRESS (PERSONAL) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ HEIGHT(CM) ☐☐☐☐☐ WEIGHT(KG) ☐☐☐☐☐ BLOOD GROUP AB O A B

SPECIFIC OCCUPATION/DESIGNATION ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ DATE OF EMPLOYMENT ☐☐ ☐☐ ☐☐☐☐ STAFF PAYROLL No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

KRA PIN NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐ SACCO MEMBERSHIP No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Particulars of Dependants To Be Included On Cover

No.	Full Name or Dependant (Surname First)	Dependant type (Spouse/Child)	Gender (M/F)	Date of Birth	Blood Group	I.D No.	PIN No.

Health Questions (You Must Complete All Questions)

1. Has any of you or your above dependants been hospitalized in the last 3 years? Yes ☐ No ☐
2. Have any of you or your above dependants ever had an accident resulting in a permanent injury? Yes ☐ No ☐
3. Do any of you suffer from any disease that is recurrent in nature? Yes ☐ No ☐
4. Are any of you on regular medication? Yes ☐ No ☐
5. Do any of you have any kind of physical disability? Yes ☐ No ☐

Please state whether any of you proposed for inclusion on cover has ever been treated, received treatment or expects to receive treatment for any of the following conditions / illness:

6. Heart and Blood vessels disorders e.g. high blood pressure, heart disease, stroke, congenital (inborn) heart conditions, chest pains, arterial disease. Yes ☐ No ☐
7. Blood/ circulatory disorders e.g. Sickle cell anemia, Varicose, Thrombosis, Kidney, Liver, Hemophilia, leukemia or any other blood disorder. Yes ☐ No ☐
8. Respiratory disorders e.g. Bronchitis, Tuberculosis, Asthma, cigarette smoking disorder, any other respiratory related disorder. Yes ☐ No ☐
9. Neurological disorders e.g. Meningitis, stroke, brain or spinal cord disorder, epilepsy, any other neurological related disorder. Yes ☐ No ☐
10. Ear, Nose and Throat related problem e.g. throat surgery, sinuses. Yes ☐ No ☐
11. Eye disorders e.g. cataract, glaucoma, eye surgery, blindness. Yes ☐ No ☐
12. Gynecological or genitor-urinary disorders e.g. Pelvic Inflammatory disease, menstrual irregularities. Yes ☐ No ☐
13. Kidney disorders such as kidney failure, kidney stones, recurrent infections etc. Yes ☐ No ☐
14. Musculoskeletal disorders e.g. arthritis, back problems, joints, gout, etc. Yes ☐ No ☐
15. Endocrine diseases such as diabetes, thyroid disease, high cholesterol. Yes ☐ No ☐
16. Surgical such as appendectomy, tonsillectomy or any other surgical procedure. Yes ☐ No ☐
17. Other diseases/ disorders: cancer, alcohol/drug problem, hepatitis, ulcer, mental disorder, gall bladder disease, HIV infection. Yes ☐ No ☐

If you answered YES to any of the questions 1 to 17, kindly give more details in the table below.

No	Name of Applicant	Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	Current status

If the space is not adequate, fill in a separate plain paper and staple it to the form

18. For female applicants / spouses only:
    a) Have you / your spouse ever delivered a child by Caesarean operation? Yes ☐ No ☐

If yes please give member name: _____

b)Is any member currently pregnant? Yes ☐ No ☐
If yes please state number of weeks of pregnancy _____

19. Is any of you allergic to drugs? Yes ☐ No ☐

If yes give details _____

20. Have you been on medical insurance before? Yes ☐ No ☐

If yes give the name of the Insurer/HMO, expiry date and special exclusions: _____

I hereby apply to join the above medical scheme. I understand to the best of my knowledge and belief that all the answers given above are true, that I have not concealed or withheld any material information which the underwriter ought to know inorder to assess me or my family members for medical insurance. I hereby authorize the hospitals, medical or dental practitioners who have treated me or any of my dependants to disclose to CIC General Insurance Ltd. The records relating to such current or previous hospitalizations, medical treatment and to allow CIC to receive extracts from such records, and I undertake to assist in obtaining such information.
By signing this proposal form I hereby grant CIC General Insurance Limited (the Insurer) and all its contracted third-party processors authority to process my personal information/ data, for the purpose of performing the insurance contract as per my proposal herein. I am aware that I may withdraw my consent at any time by writing directly to the Insurer and that such a withdrawal may affect the ability of the insurer to provide the Insurance cover.

Signature of Principal Member: _____ Date: _____

Agency Name & Stamp: _____

Note: Kindly indicate the National I.D number for your spouse and each child above 18 years of age. (Please attach copies)