First Assurance

FIRST MED

A Healthy Choice!

Standard Application Form

Membership Number

Policy No. _____

Broker Name _____ Broker Code _____

For Underwriting Use Only	Exclusion (s) and sub-limits
☐ 1 Month Waiting Period	1 _____
☐ 3 Month Waiting Period	2 _____
☐ 12 Month Waiting Period	3 _____
☐ 24 Month Waiting Period	4 _____
	5 _____
	6 _____

Other underwriting comments: _____

_____

Underwriter's Signature: _____ Date: _____

Section A - Company/Employer/University Details

Company Name _____

Business _____

Company Address _____

Tel (code:_____) _____ Fax (code:_____) _____

Postal Address _____

Section B - Member Details

Title _____ Initials _____ First Names _____

Surname _____ Nationality _____

Physical Address _____

_____

Postal Address _____ Postal Code _____

Telephone Numbers (H) (code:_____) _____ (W) (code: _____) _____

Fax (***required**) (code:_____) _____ Cell Phone _____ Email _____

Date of Birth D D M M Y Y Y Y I.D. / Passport Number _____

*Copy of ID/Passport book to be attached to the application form - legally required

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Proposed Date of Joining D D M M Y Y Y Y

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Section C - Beneficiaries to be Covered

Recent passport size photos and copies of ID/Passport books MUST be attached.(Birth notification certificate or Birth certificate for new born babies will be accepted)

Whenever possible attach copies of marriage certificates

First Name	Surname	Passport/ID no.	Relation	Gender	Date of Birth
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y
					D D M M Y Y Y Y

Relationship abbreviations: PM - Principal Member, SP - Spouse, CD - Child Dependant, AD - Adult Dependant

Section D - Previous Medical Membership

Supply details of previous Medical Insurance membership and attach proof of previous membership
Whenever possible attach membership certificates. Membership cards or copies thereof will not be accepted

Membership Period			Names of previous Cover
Date Joined	Date left	Number	
D D M M Y Y Y Y	D D M M Y Y Y Y		
D D M M Y Y Y Y	D D M M Y Y Y Y		
D D M M Y Y Y Y	D D M M Y Y Y Y		

Section E - Choice of Cover

Main product:

Additional Options:

Section F - Bank details (For Electronic Claim Refunds and/or premium payments)

IMPORTANT NOTE: Compulsory to supply. Please specify whether payment is Debit Order, Claim refund, or both DETAILS Claims Premiums Both

Name of Account Holder_____

Branch Name_____ Bank_____ Country_____

Branch Code Account Number

Type of Account: Current ☐ Savings ☐ Credit Cards ☐

Payment Method: Bank Transfer ☐ Cheque ☐ Credit Card ☐ Debit Card ☐

Currency: Kshs ☐ Pound £ ☐ Euro ☐ US$ ☐ Other ☐

Total Premium

Signature of Account Holder_____

Attach proof for verification of bank details
Member subscription will be debited in advance on the first day of the month upon acceptance

Section G: Declaration by Applicant/Principal Member

In this declaration the singular shall imply the plural

1. I the undersigned, hereby apply for myself and my beneficiaries to join as a member of First Med.
2. I declare that this application, and declaration together with statements made by me, whether in writing or not, are true and correct and agree that such statements together with any forms, reports or other information completed or supplied by me or any other party on my behalf shall form the basis of this contract.
3. I agree to be bound and to abide by the rules, standard terms, conditions and any rules ordinarily used by First Assurance for types of benefits for which I have applied, and First Assurance shall not be bound in any way by any representations or undertakings made or given by any person or agent save in the Registered Rules of the Policy.
4. It is further agreed and understood that, notwithstanding any statements made to the contrary by any person, membership will not commence and no liability whatsoever will attach to First Assurance unless express written notice of acceptance of risk is given by First Assurance.
5. It is also agreed and understood that membership will only commence on the 1st day of the month following receipt of payment by First Assurance.
6. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information which may be related to my occupation, physical or mental health, including the results of any tests, to First Assurance and I agree that this authorisation shall remain in force after my death.
7. I will indemnify First Assurance and its creditors, agents and employees against any claim of whatever nature, which may be made against them as a result of or arising out of disclosure, medical information or any other costs incurred as a result of being a member of this Medical Scheme.
8. I further accept that the provisions of any declaration made have been read and understood by me and will also apply mutates mutandis to and form part of this application.
9. I authorise First Assurance to debit my bank account, details of which have been provided to First Assurance, for any amount due in terms of the membership applied for.
10. I undertake to advise First Assurance of any change in the status of health of myself, or any of my beneficiaries, which occurs prior to my receiving acceptance of this application.
11. I declare that no material fact has been withheld, misstated or concealed by me and that I will disclose all material facts prior to acceptance of the risk and I agree that any misstatements and/or omission of any material information will render my membership null and void, and in such event all monies paid in respect thereof shall be forfeited.
12. I hereby acknowledge that any credit extended by First Assurance to myself or my dependants whilst being members of First Med, will become payable in full upon termination of my membership of First Med and that interest may be charged on all amounts due and owing to First Assurance.
13. I further acknowledge that on termination of membership, any amounts owing to First Assurance will be deducted from any amounts due to me from my Employer. For this purpose I hereby permit First Assurance to advise my Employer of any amounts due to First Assurance.
14. I acknowledge that in the event of any modification or variation of this standard form, First Assurance will regard this form as being invalid and of no force and effect.

Signed at _____ on this _____ day of _____ 20 _____

Principal Member name _____

Principal Member signature _____

Section H: Broker Declaration

I _____ herewith enrol the member on the First Med Medical Plan and understand that the Medical Plan has the right to apply underwriting subject to the terms and conditions of the Medical Plan.

Signed at _____ on the _____

Day of _____ 20 ____

_____

Name and signature of Broker / Consultant

_____

Client Signature (new member)

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Emergency Numbers

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www.firstassurance.co.ke

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Annexure B:

Underwriting Information for acceptance of cover

Supply full details on questions. Where an answer to a question is "yes" - provide details in the space provided below
Questions pertain to Applicant and ALL beneficiaries

Application by:_____ (Principal member) Signature_____

Have you/your spouse or any one of your beneficiaries ever experienced any of the following?
Please initialize the relevant box

			Answer	
			Yes	No
1	Cardio Vascular	Chest pain/angina, heart attack, heart failure, heart valve disease, rheumatic fever, high blood pressure, (hypertension), high cholesterol, heart murmurs, circulatory problems/disorders, varicose veins, deep vein thrombosis (DVT), or any other heart or circulatory problems.		
2	Respiratory & Breathing	Asthma, difficulty with breathing, bronchospasm, tuberculosis (TB), coughing up blood, emphysema, pneumonia, cystic fibrosis, pthisis, chronic bronchitis, shortness of breath, any other breathing problems.		
3	Bladder & Kidneys	Blood in urine, kidney failure, polycystic kidneys, kidney or bladder infections, removal of kidney (nephrectomy), kidney stones, abnormal kidney or urine tests or any other kidney problems.		
4	Reproductive & Gynae	Endometriosis, infertility, ovarian cysts, hysterectomy, abnormal PAP smear, laser treatment, cervix and breast biopsies, fibro-adenosis of the breast, laparoscopies, hormone replacement therapy, prostate infections or surgery, prostate enlargement or any other reproductive problems.		
5	Digestive System	Duodenal ulcers, gastric ulcers, peptic ulcers, hiatus hernia, colon problems, crohn's disease, ulcerative colitis, gall bladder problems, liver problems or any other digestive problems.		
6	Ear, Nose and Throat	Deafness, ear infections, sinus problems, nasal surgery, throat surgery.		
7	Dental	Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, or any other such surgery.		
8	Eyes	Blindness (partial or full), eye surgery, lens implant, cataracts, glaucoma, renitis pigmentosa, retinal detachment, impaired vision, or any other eyesight problems.		
9	Endocrine	Diabetes melitus or insipidus, underactive thyroid, overactive thyroid, thyroid surgery, cushing's syndrome, addison's disease, pituitary gland, gland problems or any other glandular problems.		
10	Back and Muscles	Neck or back problems or operations, recurrent back pain, osteoporosis, ankylosing spondylitis, rheumatoid arthritis, osteo-arthritis, disease, or any other bone or skeletal disorders.		
11	Neurological	Epilepsy, stroke (CVA), migraine, brain or head injuries, spinal cord injuries, paralysis, multiple sclerosis, mental retardation, narcolepsy, motor neuron disease, parkinson's disease, alzheimer's disease, or any other neurological problems.		
12	Psychological	Depression, anxiety, psychosis, suicide attempts, bipolar disorders, manic depression, "Stress", schizophrenia, tourete's syndrome, anorexia nervosa, received advice, counselling or hospitalisation for alcohol or drug abuse, attention deficit disorders, Bulimia or any other psychological conditions.		
13	Tumours and Growths	Benign or malignant growths or lumps or tumours including melanoma, lymph gland cancer, leukaemia, breast cancer or any other tumours, growths and cancers.		
14	Blood	Blood or bleeding disorders e.g. haemophilia, christmas factor deficiency, platelet or any other blood clotting disorders.		
15	Skin	Eczema, ance, dermatovositis, psoriasis, scleroderma, or any other skin disorders		
16	Sexually Transmitted Disease	Advice, treatment or counselling for any of the following: HIV/AIDS, syphilis, gonorrhoea, herpes, genital ulcers, pelvic infectious disease, genital warts, hepatitis B or any other sexually transmitted disease or disorder.		
17	Hospitalisation	Have you, your spouse or any dependants ever been hospitalised? If yes how frequently?		
18	Treatment & Surgery	Are you, your spouse or any dependants expecting any medical or dental advice, treatment, or are you planning any such treatment within the next three to six months?		
19	Dangerous Pastimes	Are you, your spouse, or any dependants participating in any hazardous sport or occupations, e.g. motor or motorbike or motorboat racing, dragster racing, bungee jumping, skydiving, scuba diving or any other hazardous pursuits?		
20	Pregnancy	Are you, your spouse, or any dependants currently pregnant? Should the answer be "yes", when is the expected date of delivery (yyyy/mm/dd)		
21	Other	Are there any other factors related to you or your beneficiaries' health that is not disclosed above?		
22	Planned Treatment	During the last 12 months, have you, your spouse or any dependants had any special dentistry treatment or are you planning any such treatment within the next six months?		

Question number	Name of person suffering from condition	Nature and duration of condition or symptoms. Date of diagnosis and duration of treatment	Dates symptoms were last experienced	Exact dates of treatment/hospitalisation	Medication/ treatment and monthly cost thereof

_____ Underwriting approved by First Assurance

_____ Date

First Assurance's Acceptance number