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INDIVIDUAL AND FAMILY APPLICATION FORM

MPesa Paybill number No.:333200

PLEASE COMPLETE THIS APPLICATION AND ANSWER ALL QUESTIONS.

Data collection consent: Pursuant to the data protection act, 2019 ("DPA") and the European Union General Data Protection Regulation ("EUGDPR"), AAR Insurance (K) Limited ("AAR Insurance"), in its capacity as a data controller and/or processor under the DPA and EU GDPR must obtain your explicit, affirmative, and informed consent before it can collect or process any personal data for a lawful basis. AAR Insurance shall only use your personal data to administer applied products and services requested from AAR Insurance. In order to provide you with the above services, AAR Insurance will need to collect, process and store your personal data for the duration of the product. If you consent to us storing your personal data for this purpose, please tick the check box.

☐ I agree to AAR Insurance's collecting, processing and storage of my personal data.

Details of The Proposer

1. Name of Proposer ______________________ Nationality ______________
2. Postal Address ______________ Postal Code ______________ Town ______________
3. Telephone No. (Office) ______________ Mobile No ______________
4. Marital Status ______________ Email Address ______________
5. Pin No. ______________ ID No / Passport number ______________ (Attach Copy Of Each)
6. Occupation / Nature of business ______________________
7. Source of income ______________________
8. Current permanent address & physical/residential address ______________________

Enter details of the spouse (01) and all dependants to be included in the application for membership in order of age (descending) where applicable

Category	Surname	First Name	Middle Name	Gender M	Gender F	Date of Birth DD MM YYYY	Height (Cm)	Weight (Kg)
00 Principal				☐	☐			
01 Spouse				☐	☐			
02 Dependant				☐	☐			
03 Dependant				☐	☐			
05 Dependant				☐	☐			
05 Dependant				☐	☐			
06 Dependant				☐	☐			
07 Dependant				☐	☐			
08 Dependant				☐	☐			
09 Dependant				☐	☐			

Next of Kin Details (Beneficiary)

Name	ID	Relationship	Phone Number

Cover Options

							Scope	
Inpatient Cover Options (Tick Option)	Platinum ☐	Gold ☐	Silver Plus ☐	Silver ☐	Bronze ☐	Cover Me ☐	Per Family ☐	Per person ☐
Outpatient Cover Options (Tick Option)	250,000 ☐	200,000 ☐	150,000 ☐	100,000 ☐	75,000 ☐	50,000 ☐	Per Family ☐	Per person ☐

Name of current/previous health insurer and the expiry date ______________________

Previous Membership Number: ______________________

Have you or any of you dependants ever been declined or premium loaded by any health insurer? ______________________

State which one: ______________________

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Confidential Medical History

Have you or any of your dependants ever had (been diagnosed and/or treated for) any of the following medical conditions? Kindly answer YES or NO to all the questions below answers are required for each applicant. (ask a doctor for assistance if needed)

NOTE: if the answer is YES to any of the questions which follow, you will be requiredto provide details of the medicalcondition. AAR Insurance may request you to provide a medical report, without which your application may be delayed.

Questions

Questions	00	01	02	03	04	05	06	07	08	09	10
1. Blood group (If known)											
2. Cancer, growth or tumors whether benign or malignant											
3. Cardiovascular (heart and blood vessels) disorders including high blood pressure											
4. Respiratory and ear nose and throat (ENT) disorders including asthma, tuberculosis, hearing & speech impairment, adenoids and any other											
5. Ednocrine disorders including high cholesterol, diabetes, thyroid abnormalities, obesity											
6. Eye related disorders including glaucoma, blindness, cataracts and any other											
7. Gastro-intestinal disorders including peptic ulcer disease, heartburn reflux, haemorrhoids, pancreatitis, hepatitis, hernias and any other											
8. Gynecological & Obstetric disorder including caeserian section, fibroids, ovarian cysts, infertility, pelvic inflammatory, menstrual irregularities, abnormal pap smear, hormone treatment, miscarriages and any other											
9. Genitourinary disorders including enlarged prostate. Kidney failure, dialysis, kidney stones and any other											
10. Musculoskeletal disorders including arthritis, gout, back problems, physical disabilities, joint problems and any other											
11. Neurological & psychological disorders including epilepsy, mental disabilities, paralysis, schizophrenia, depression, bipolar disorder, attempted suicide, alcohol or drug dependency/ addiction and any other											
12. Blood & connective tissue disorders including leukemia, HIV & AIDS. systemic Lupus Erythematosus (SLE) and any other											
13. Congenital/inherited/hereditary disorders including birth defects, sickle cell disease umbilical hernia											
14. Skin disorders including eczema, keloids, warts, acne, moles, melanoma and any other.											
15. Have you ever been hospitalized?											
16. Have you had any other medical conditions not mentioned above? Please state											
17. Do you have any allergies?											

COMMENTS

I have appointed ______________________________ to be my Agent/Broker for this policy

Agent/Broker Declaration

I confirm that I have explained to the client the benefits, terms & conditions, and exclusions of AAR Insurance Company Limited.

Full name of Agent / Broker: ______________________________ Tel: ______________

Signature of Agent / Broker: ______________________________ Date: ______________

AAR Insurance

DECLARATION

IMPORTANT: The following in conjunction with the policy document of the membership constitutes the contract with aar insurance, sign below, unless anything is not clear in which case kindly seek further advice from aar insurance. Note that all reference to the singular includes the case dependants, all those under 18 years. The policy holder must sign the declaration on his/her own behalf and on behalf of all other dependants under 18 years.

i). I declare that all those persons named in the application form are members of my immediate family for whose membership I am responsible.

ii). I am applying for the service combination of AAR membership as marked on the first page.

iii). My country of residence is within the territory as declared in this application form and I will inform if it ceases to be so.

iv). I have declared all material facts whether or not asked, i understand that AAR has reserved the right to reject my application or terminate membership at the end of any benefit year without divulging any reason for doing so. I agree to notify AAR on any subsequent changes in my medical condition and understand that such changes in my medical condition and understand that such changes may cause AAR to modify or discontinue my membership. I understand and agree in particular that:

a). I become a Member from my commencement date and understand that if membership is not renewed my membership shall be terminated and I shall reapply for membership and shall be treated as a new member.

i). Renewals shall be effected upon receipt by AAR of written confirmation with the appropriate premium payment from the member. Failure to renew before the end of the benefit year, the member shall forfeit his policy cover and submit and execute a new membership and shall be treated as a new member application form. The member shall forfeit his no claim discount.

b). If I am a new member, AAR does not pay any costs of hospital admission for illness, nor for related Rescue and Evacuation, during the first 60 days of membership. A similar restriction applies in respect of the additional benefits available on upgrading my service combination for 60 days from the appropriate date of upgrading. If any medical conditions arise during these 60 days whether in East African or abroad, of which AAR was not aware of the appropriate date of upgrading. If any medical conditions arises during these 60 days whether in East African or abroad, of which AAR was not aware of the appropriate commencement date and might have affected AAR's decision to accept my membership, AAR may place an exclusion or cancel my membership and refund my fees.

c). AAR will only provide service outside my country of residence during the first 45 days of absence from country of residence in any one visit.

d). If I travel out of my geographical region I must notify AAR at least 48 hours before my date of travel.

e). I must arrange my scheduled hospitalization with AAR at least 48 hours prior to admission, and in the event of an emergency I must contact AAR within 24 hours of admission. Once AAR has agreed, they will provide medical services directly and will not reimburse me for any medical bill paid by me or on my behalf.

f). Any misrepresentation, fraudulent act, false statement or non disclosure of material in this application form will render my membership invalid, and I will then forfeit my membership fees and be liable to refund to AAR on demand all cost incurred by it in connection with rescue, evacuation, hospitalization or other services provided by it.

g). AAR has the sole discretion in all cases to decide which doctor from its panel of doctors, hospitalsor rescue facilities should be used in any particular case. Where a member insists on using a doctor, hospital or rescue facility outside the choice of AAR, AAR should only be liableto cover the costs chargeable by its panel doctors, hospital or facility of choice.

h). I will only be entitled to benefits from the commencement date and subject to the cover limits of the selected combination.

i). AAR will not refund any premium unless I wish to cancel my membership within 30 days of my initial commencement date. In that case I may apply for a refund provided no service have been rendered by AAR on my behalf.

j). I understand that medical evaluation is a mandatory requirement at the inception of this contract, if I or any of the dependants has attained 45 years of age. However, regardless of the age of the applicants for membership, AAR may at its own discretion require a medical evaluation of any applicant. It is a mandatory requirement to undergo a medical evaluationon a yearly basis or at such other frequency as AAR may at its own discretion decide if I or any dependant attains the age of 65 years.

k). I understand that if my membership is not renewed on or before the expiry date this contract shall be deemed to have been terminated. I further understand in renegotiating a new contract, AAR may at its discretion require my fulfilment of new conditions to join including but not limited to medical examination and AAR's decision thereon and revised membership fees.

l). I hereby consent to AAR contacting my doctor or medical information about me and I hereby authorize such doctor or institution to make full disclosure of such information to AAR or its advisers, and to provide access to my complete medical and hospital records whenever required.

I consent to my phone and email contacts being used to receive:

1. Communication related to my policy. ☐
2. Company communication and marketing information. ☐

Signature of Policy Holder: ______________________ Date: ______________

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Kenya

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