

GROUP PERSONAL ACCIDENT

Agency / Broker _____ Code _____

PIN Number: _____

PARTICULARS OF PROPOSER

Name of Proposer (in full) _____

Postal Address: P. O. Box _____ Postal Code _____ Town _____

Telephone Number(s) _____ Email Address: _____

ID Number / Passport (where applicable) _____ Pin No (KRA) (Mandatory) _____

Age (where applicable) _____ Profession / Occupation _____

Period of insurance: From _____ To _____ (both dates inclusive)

INSURANCE HISTORY

1. Has the insured been insured before ? (Yes/ No) _____
If YES, provide particulars of the policies and Name of the insurers _____

2. Is this insurance to be additional to any other existing Accident Policy or Employee scheme? (Yes/ No)
If YES, provide particulars of the other policies; Name of the insurers; and Sum Insured. _____

3. Has any company:
a) Declined to issue you with a policy? (Yes/ No) _____
b) Declined to renew your policy? (Yes/ No) _____
c) Imposed any special terms? (Yes/ No) _____
d) Cancelled your policy? (Yes/ No) _____
e) Declined any claim? (Yes/ No) _____

If the answer to any of the above is Yes provide brief details. _____

4. Have you ever claimed or received compensation under any Accident Policy? (Yes/ No) _____

If YES, give particulars of the claim(s) in the table provided

Year	Nature of claim (e.g. fatal)	Claim Amount

SCHEDULE OF BENEFITS

Based on Annual Earnings (A)

Benefit	Limits of cover (Kshs.)
Number of employees	
3 years earnings	
4 years earnings	
5 years earnings	
Medical Expenses	

Capital Benefits (B)

Benefit	Limits of cover (Kshs.)
Death	
Permanent Total Disablement	
Temporary Total Disablement	
Medical Expenses	
Others, Specify	

Provide the Estimated Annual Earnings per employee category if cover required is a multiple of earnings:

Job Category	Annual Earnings (Kshs.)

I/we consent that the data provided can be shared with third parties outside our jurisdiction for the purpose of provision and processing of the insurance.

Name

Signature