MADISON Insurance

Madison Insurance Company Kenya Ltd

HEAD OFFICE

Upper Hill Close,
P.O Box 47382 - 00100, Nairobi
Tel: 020 - 2721970 /1, 2864000
Fax: 020 - 2723344

Email: madison@madison.co.ke
Web: www.madison.co.ke

# MEDICAL INSURANCE APPLICATION FORM

COMPLETE IN BLOCK LETTERS

## Employee details

| | |
|---|---|
| Names | Employer |
| Date of birth | Occupation |
| ID No. Tel No. | Category |
| Address | Scheme No. |
| Allergies | Blood group |
| Sex | Weight |

## Dependants details

| Full Names | Relationship | Sex | Date of birth | Dependant's ID Number | Blood Group | Allergies |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Service providers visited within the last 12 months

| |
|---|
| |
| |
| |

## Has any medical insurance application by you or your dependant:

| | |
|---|---|
| Been accepted with extra premium? | Yes/No |
| Accepted with specific Exclusions? | Yes/No |
| Declined? | Yes/No |

## If the answer is Yes, give reasons

______________________________

______________________________

| | |
|---|---|
| Do you participate in any activities, sports or pursuits, which could be reasonably thought to be hazardous? | Yes/No |
| If yes please give details | |
| | |

## Have you ever had?

| | |
|---|---|
| Unexplained recurrent or persistent fever or skin disorders | Yes/No |
| Unexplained recurrent or persistent night sweats | Yes/No |
| Unexplained weight loss | Yes/No |
| Unexplained infections or swollen glands | Yes/No |
| Chronic or recurrent diarrhoea | Yes/No |
| Persistent cough | Yes/No |
| Hepatitis B or Sexually transmitted Disease, including genital sores or discharge | Yes/No |
| Have you ever been advised to have a blood test for AIDS or an AIDS related condition | Yes/No |

If yes on any of the above, state duration ______________________________

Please give the past medical information as requested by ticking the appropriate box for you and your dependant:-

| | Principal | Dependant 1 | Dependant 2 | Dependant 3 | Dependant 4 | Dependant 5 | Dependant |
|---|---|---|---|---|---|---|---|
| | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ | YES ☐ NO ☐ |
| *a) Any chronic / Recurring disease eg. Asthma, Chest problems, Fits, Fainting Ulcers, Heart disease, Nervous disorders, Kidney related problems Cancer, High Bloodpressure, Diabetes, Other (Please specify below)* | | | | | | | |
| *b) Veneral Disease* | | | | | | | |
| *c) Aids and HIV related illness* | | | | | | | |
| *d) Spinal Injury, Slipped Disc, Injuries from accident or other fractures.* | | | | | | | |
| *e) Disorders of Reproductive system* | | | | | | | |
| *f) Skin Diseases* | | | | | | | |
| *g) Any other condition not mentioned.* | | | | | | | |
| *h) consulted a doctor in the past twelve months?* | | | | | | | |
| *i) Under regular medications ?* | | | | | | | |
| *j) Been hospitalised in the past three yea* | | | | | | | |
| *k) Are you pregnant?* | | | | | | | |

If yes to any of the above details below:

| Medical conditions (illness/Injury) | Details |
|---|---|
| | |
| | |
| | |

Declaration

I declare that to the best of my knowledge and belief the above statements are true and that no intentional information has been with held. I accept to the company seeking medical information from any doctor whom my dependants or I have consulted in the past and may consult in the future or from any insurers, who have previously received application from me or my dependants for medical insurance.

I agree to the attendance by me and/or my dependants for a medical examination if required.

I, principal member agree to reimburse Madison Insurance Co. (K) Ltd. Any amount incurred by me or my dependants on myself over and above our entitlements (Limits) or for excluded conditions.

Signed ______________________(EMPLOYEE) Signed______________________(EMPLOYER)

DATE______________________ DATE______________________

***NB:*** Misrepresentation of facts will lead to automatic disqualification from scheme membership

***FOR OFFICIAL USE ONLY***

1. Is Underwriting criteria fulfilled? ☐ Yes ☐ No

If NO Comments

______________________________________________

Signed by ______________________________ Date ______________________

2. Are Medical Details acceptable? If NO ☐ Yes ☐ No

If NO Comments

Signed by______________________________ Date ______________________