PACIS
INSURANCE COMPANY LTD
For Comfort & Peace in Life

Centenary House, 2nd Floor Off Ring Rd, Westlands
P.O. Box 1870 - 00200, NAIROBI
Tel: +254 20 4247000/+254 20 3504174/+254 204452560
Fax: +254 20 4452561 Cell: 0733 777717, 0720 113122
Email: medical@paciskenya.com Website: www.pacisinsurance.com

INDIVIDUAL POLICY APPLICATION FORM

PRINCIPAL APPLICANT'S PERSONAL DETAILS: (Please give accurate details and attach copies of ID, PIN and photos)

Full Name: .....PIN .....

ID No.: ..... Marital Status: Married Single Gender: Male Female Date of Birth: .....

Postal Address: ..... Code: ..... City/Town: .....

Physical Address: .....

Email Address: .....

Telephone Number: Work: ..... Home: ..... Mobile: .....

OCCUPATION DETAILS:

Company Name: .....Date of Employment: .....

Postal Address: .....NHIF Number: .....

Specific Occupation: .....

DEPENDANT(S) DETAILS:

No.	FULL NAME			DATE OF BIRTH	GENDER		RELATIONSHIP			LIVING WITH YOU	
	Surname	First Name	Other Names	DD/MM/YYYY	Male	Female	Spouse	Son	Daughter	Yes	No
02											
03											
04											
05											
06											
07											

Please indicate your spouse's ID ☐☐☐☐☐☐☐☐☐☐

If any dependant is not living with you, please state country town and their address.....

Name of Previous medical insurer.....

MEDICAL HISTORY:

All questions **MUST** be answered to qualify for a cover (Blank spaces are not acceptable).

1. (a)Are you or any of your dependants suffering from any physical defect? **Yes** ☐ **No** ☐
   (b) If so please state the nature of the defect.
   .....
2. (a) Are you or any of your dependants currently ill? **Yes** ☐ **No** ☐
   (b) If so please state the nature of the illness.
   .....
3. (a)Have you or your dependants recently consulted a doctor? **Yes** ☐ **No** ☐
   (b) If yes, state nature of illness, operation or accident (add an additional sheet if necessary)
   ..... Date.....

4. Please state if you or your dependants at any time had any of the following medical conditions. Answer **YES (Y)** or **NO (N)**.

	Medical Condition	01	02	03	04	05	06	07
a.	Asthma							
b.	Diabetes							
c.	Hypertension							
d.	Convulsions/ Epilepsy							
e.	Gastric or Duodenal Ulcers							
f.	Heart Disease							
g.	Leukemia or Sickle cell Disease							
h.	Neurological Disease							
i.	Gallstones							
j.	Psychiatric illness							
k.	Recurrent Tonsillitis							
l.	Arthritis							
m.	Fibroids							
n.	Menstrual Disorders							
o.	Cancer							
p.	Others (please specify)							

If you answered Yes to the questions above, please provide details (You may attach an extra sheet)

.....

.....

5. State any allergies .....

Surgery and Hospital Admissions

Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past, and /or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future?

Hospital/ Doctor	Surgical procedure/ hospital admission	Date	Diagnosis

	Habits and Lifestyles	01	02	03	04	05	06	07
6.	Do you smoke (Yes/No)							
7.	Do you consume alcohol (Yes/No)							
8.	Are you currently using medication for medical or any other reasons							
	If yes, please specify							

9. Are there any other circumstances in your current or past medical history not mentioned above which may result in hospitalization in the future? .....

.....

10. Female members only (member or spouse)

a) Has any member of your family ever delivered a child through caesarean operation? **Yes** ☐ **No** ☐

b) Is any member currently pregnant? **Yes** ☐ **No** ☐

State name, address and phone number of your medical practitioner.....

Please enroll me on the following cover option: .....

.....

N.B: Any misrepresentation or non-disclosure of material or factual information will render all benefits granted by Pacis Insurance Ltd null and void. In addition, any claims payment made due to such actions will be recoverable from the policy holder.

MEDICAL PLAN DETAILS:

Medical Plan Details

Inpatient is a core benefit. Outpatient and Maternity are optional benefits. Please tick ( ) the cover limits you require.

Plan Options		
Inpatient per family	**Out Patient per person**	**Maternity**
500,000	50,000	50,000
1,000,000	100,000	100,000
2,000,000	150,000	150,000
3,000,000		

Premium payable	
Total Premium Payable	
Training and policy holders Levies 0.45%	
Stamp duty Ksh 40	
Total Premiums including levies	

PAYMENT DETAILS:

Full Premium must be paid before cover commences.
Payments can be made through Cheque, Cash, Mpesa and bank deposits to Pacis Insurance Company Ltd Only

Important information

1. All acute illness claims have a **30 days waiting period**
2. Surgical cases have a **90 days** waiting period
3. Maternity benefit if purchased will have a waiting period of **one year**
4. All other waiting periods apply as highlighted on the brochure and the policy document.
5. Maximum joining age is **64 years**
6. Medical examination reports will be required for persons who attain **55 years and above**
7. There may be a limitation on the medical providers from which you can seek treatment depending on your cover limit.
8. There will be no reimbursement of claims from non-panel providers
9. Outpatient benefits cannot be purchased alone or to specific family members.
10. Members will be required to present their Pacis medical cards to access services at the service providers.
11. Eligibility- Adults between the age of **19 years** and **64 years**. Children between the age of 3 months and 18 years. Dependants will include one spouse, own or legally adopted children from the age of 3 months to 18 years.
12. Cover commences on 1st or 15th of every month.

BENEFICIARY DETAILS:

(Person/entity entitled to receive funds as per cover benefits in the unfortunate event of loss of life)

Name: …… ID Number: …… Relationship: …… Mob. No.: ……

DECLARATION:

I hereby apply to join the above mentioned plan. I understand that any mis-statements or non-disclosure of any material information in this form will jeopardize my membership. I warrant that the answers in this form are true, correct and complete and I acknowledge that such answers are all material.

I hereby authorize any doctor, hospital, clinic or medical provider, any company, institution or person who has record or information about me and/or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

Name:……Signature:……Date:……

DOCUMENT ISSUANCE:

Pacis Insurance Ltd confirms that upon receipt of full premium the following documents will be issued within 30 days.
The policy holder should contact Pacis Insurance Ltd if the same is not received. The documents that will make up the policy membership pack will include a cover note, Medical cards for each member, the provider panel and policy document

INTERMEDIARY DETAILS:

Full name of Intermediary.....

Telephone.....Email.....

PIN No.....ID NO.....

INTERMEDIARY DECLARATION:

I hereby declare that I explained the benefits of this application and that the applicant is aware of the membership terms and conditions of the purchased medical cover of Pacis Insurance Company Limited.

Signature.....Date .....

OFFICIAL ONLY:

Cover acceptance Yes ..... No..... More information required.....

Commencement Date..... Day..... Month.....Year.....

PHOTO SHEET

Dated .....

Main Member photograph

Spouse photograph

Main Member:

NAME (As per ID/Passport):.....

DOB: .....

ID No.:.....

PIN No.:.....

Spouse

NAME (As per ID/Passport):.....

DOB.....

ID No.....

PIN No.: .....

PHOTO SHEET

Dated .....

Second Dependant photograph

Third Dependant photograph

Second Dependant:

NAME (As per ID/Passport):.....

DOB: .....

ID No.:.....

PIN No.:.....

Third Dependant:

NAME (As per ID/Passport):.....

DOB.....

ID No.....

PIN No.: .....

PHOTO SHEET

Dated .....

Fourth Dependant photograph

Fifth Dependant photograph

Fourth Dependant:

NAME (As per ID/Passport):.....

DOB: .....

ID No.:.....

PIN No.:.....

Fifth Dependant:

NAME (As per ID/Passport):.....

DOB.....

ID No.....

PIN No.: .....

OFFICIAL ONLY:

POLICY COMMENCEMENT DATE

Commencement Date: Day_____ Month_____ Year_____

Subject always to Declaration section of this application form, the commencement date of this Policy will be the date on which this application is accepted in writing by us. Please note the commencement date can be no more than 30 days from the date of completion of this application. Under no circumstances will Policies be backdated.

Note: Cover is conditional upon full payment of premium and acceptance of your application that is only confirmed when an acceptance letter is issued to you.