

# LIFE POLICY



BANKER'S ORDER FOR LIFE POLICIES

**The Jubilee Insurance Company of Kenya Limited**  
**Head Office:**

Jubilee Insurance House, Wabera Street,  
P.O. Box 30376 - 00100 GPO, Nairobi, Kenya  
Email: jic@jubileekenya.com

**Mombasa:**

Jubilee Insurance Building, Moi Avenue,  
P.O. Box 90220 - 80100, Mombasa, Kenya  
Email: mombasa@jubileekenya.com

**Kisumu:**

Jubilee Insurance House, Oginga Odinga Road,  
P.O. Box 378 - 40100, Kisumu, Kenya  
Email: kisumu@jubileekenya.com

**DIRECTIONS:**

Please read carefully and fill out the entire form.

1. This form must be completely and legibly filled out in BLOCK letters, in the applicant's own handwriting or to his dictation.
2. Proof of age of the proposed life to be insured is required by submitting a copy of the National Identity Card, Passport or Birth Certificate together with this application.  
This form will remain strictly confidential.

AGENTS NAME \_\_\_\_\_ AGENTS CODE \_\_\_\_\_ PROPOSAL NO. \_\_\_\_\_  
BRANCH \_\_\_\_\_ MANAGER'S SIGNATURE \_\_\_\_\_

**POLICY OWNER**

(To be completed if the policy is to be effected by a person other than the life to be insured)

Surname  Other names   
Postal address  Postal code   
Telephone - Office  House  Mobile   
Relationship to proposed insured

**PROPOSED INSURED**

Surname  Other names   
Age next birthday (ANB)  Date of birth  Place of birth  Sex M  F   
Postal address  Postal code   
Email address  Occupation   
Specific duties   
Telephone - Office  House  Mobile   
Name and address of employer   
(f) Beneficiary

| Beneficiary Details |               |              | Guardian (if Beneficiary is under 18 years of age) |               |              |
|---------------------|---------------|--------------|--|---------------|--------------|
| Name                | Date of Birth | Relationship | Name   | Date of Birth | Relationship |
|                     |               |              |  |               |              |
|                     |               |              |  |               |              |
|                     |               |              |  |               |              |

**LIFE INSURANCE PROPOSED**

Type of Policy  Table Number   
 Sum Assured  KShs. Term  Years  
 Premium Payable  KShs.  
 Mode of payment - Monthly/Quarterly/Semi-Annual/Annual   
 Method of payment - Banker's Order/Cash/Salary Order/ Other (Specify)

Supplementary cover desired -

Accidental Death Benefit  KShs.  
 Total and Permanent Disability  KShs.  
 Last Expense (Main Life)  KShs.  
 Last Expense (Beneficiary child)  KShs.  
 Waiver of Premium (WOP)  KShs.  
 Personal Accident (PA)  KShs.  
 Child Accident Hospitalisation Rider (CAHR)  KShs.  
 Adult Accident Hospitalisation Rider (AAHR)  KShs.

*NB: In the event of the premiums being discontinued after 3 years the policy is to be kept in force under the automatic non-forfeiture clause.*

**MEDICAL HISTORY OF THE PROPOSED INSURED**

- (a) Are you now in good health? Yes  No
- (b) Have you consulted any doctor or medical facility either as an inpatient or outpatient in the last 3 years? Yes  No

If so, when and for what complaints?

- (c) Part (c) applicable to females only  
 Are you now pregnant? Yes  No   
 If 'Yes,' how far advanced?

- (d) Have you within the past six (6) months undergone any medical tests? Yes  No
- (e) Have you ever met with serious injury? Yes  No
- (f) Are you currently taking any medication regularly or as needed? Yes  No
- (g) Have you ever had, been tested for, received treatment or counselling from a medical professional for; or been told you have:  
 (Tick appropriate item and give details where applicable)
  - (i) Dizziness, fainting, convulsions, Epilepsy, paralysis, stroke or severe headaches? Yes  No
  - (ii) Depression, anxiety, Alzheimer's disease, mental or nervous disorder? Yes  No
  - (iii) Shortness of breath, Bronchitis, Emphysema, Asthma, Pleurisy, Pneumonia, Tuberculosis or persistent cough? Yes  No
  - (iv) Chest pain, angina, palpitations, irregular heart beat, high blood pressure, heart attack, congestive heart failure or coronary artery disease? Yes  No
  - (v) Heart murmur, heart valve disorder, oedema or disorder of the heart or blood vessels? Yes  No
  - (vi) Ulcer, intestinal bleeding, Colitis, Ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhoea, Hepatitis or any disorder of the stomach, intestines, spleen, liver, or rectum? Yes  No
  - (vii) Diabetes, high blood sugar or sugar in your urine? Yes  No
  - (viii) Blood or protein in your urine, any disorder of the kidneys, bladder, prostate or urinary system? Yes  No
  - (ix) Venereal disease or any disorder of the reproductive system? Yes  No
  - (x) Thyroid, Thymus, Pituitary or lymph gland disorder? Yes  No
  - (xi) Cancer, Sarcoidosis, tumour or any abnormal growth? Yes  No
  - (xii) Back pain, arthritis, Muscular Dystrophy or any disorder of the muscles, bones or joints? Yes  No
  - (xiii) Multiple Sclerosis, Parkinson's disease or any disorder of the brain or spinal cord? Yes  No
  - (xiv) Haemophilia, Sickle Cell anaemia, anaemia or any disorder of the blood? Yes  No
  - (xv) Any disease not mentioned above? Yes  No

- (h) Have you:
- (i) ever had or been advised to have a blood test for AIDS or an AIDS-related condition? Yes  No
- (ii) received a blood transfusion within the last 5 years? Yes  No

Please provide complete details of all 'Yes' answers above (including dates, details of treatment, medical institution where treated and name of treating doctor). Additional sheets, information or reports maybe attached to this form where required.

**ADDITIONAL QUESTIONS**

(a) Height  (ft/m)      Weight  (Kg/lbs)

- (b) Have you any intention or prospect of
- (i) Flying other than as fare paying passenger on a recognised airline on scheduled air routes? Yes  No
- (ii) Engaging in motor sport or water skiing or parachuting or gliding or mountain climbing as a hobby? Yes  No
- (iii) Engaging in any other hazardous occupation, sport or pastime? Yes  No

*Please provide complete details of all 'Yes' answers above.*

(c) How frequently, and in what quantity do you use intoxicating drink, tobacco or nicotine products or habit-forming drugs?

|                              |           |                      |          |                      |
|------------------------------|-----------|----------------------|----------|----------------------|
| Intoxicating drinks          | Frequency | <input type="text"/> | Quantity | <input type="text"/> |
| Tobacco or nicotine products | Frequency | <input type="text"/> | Quantity | <input type="text"/> |
| Habit-forming drugs          | Frequency | <input type="text"/> | Quantity | <input type="text"/> |

(d) Have you been convicted of a felony or misdemeanour within the last five (5) years or do you have charges currently pending? Yes  No

If so, give details.

**FAMILY HISTORY**

|          | Living      |                 | Dead         |                |                     |               |
|----------|-------------|-----------------|--------------|----------------|---------------------|---------------|
|          | Present Age | State of Health | Age at Death | Cause of Death | Duration of Illness | Year of Death |
| Father   |             |                 |              |                |                     |               |
| Mother   |             |                 |              |                |                     |               |
| Brothers |             |                 |              |                |                     |               |
| Sisters  |             |                 |              |                |                     |               |
| Spouse   |             |                 |              |                |                     |               |

Please give full details of poor health or cause of death if so indicated in the above table:

**PREVIOUS INSURANCE HISTORY**

(a) Have you ever applied for life insurance?

Yes  No

List all such applications/proposals below:

| Insurance Company | Date of Application / Proposal | Application / Proposal or Policy Number | Sum Assured | Extra Premium (or Special Terms) if any |
|-------------------|--------------------------------|---|-------------|---|
|                   |                                |   |             |   |
|                   |                                |   |             |   |
|                   |                                |   |             |   |
|                   |                                |   |             |   |

**DECLARATION**

Each of the undersigned declares that the statements and answers contained in this application, whether in their own handwriting or not, are complete and true to the best of their knowledge and belief and that they shall form part of the policy. No change in amount, classification or benefits shall be effective unless agreed to in writing by each of the undersigned. We understand that any misstatement on this application form could result in its non-acceptance or the repudiation of the contract.

It is also agreed that Jubilee Insurance will incur no liability under this application until:

- (a) the application has been received and approved;
- (b) the full modal premium has been paid to and accepted by Jubilee Insurance.

The policy must be issued and the full modal premium paid while the health, habits, avocations and occupation of the proposed insured are as stated in this application.

I (we) understand that no intermediary has the authority to waive the answers to any of the questions in this application or to make or alter any contract for Jubilee Insurance.

Signed at (Place) \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Policy Owner (if other than Proposed Insured)

\_\_\_\_\_  
Name, Signature and Address of Witness