

# Individual enrollment form

## Employee Benefits

METROPOLITAN  
LIFE KENYA



Please write clearly using block letters and tick  appropriate blocks

Scheme name	<input type="text"/>		
Employer name	<input type="text"/>		
Employee number	<input type="text"/>	Scheme number	<input type="text"/>

### A - Particulars to be filled in by Employer

Employee's full name	<input type="text"/>						
Occupation	<input type="text"/>				Date of birth (yyyy/mm/dd)	<input type="text"/>	
Date of appointment (yyyy/mm/dd)	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>
Date of admission to scheme (yyyy/mm/dd)	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>
Annual salary/wages	<input type="text"/>						
This is to certify that the name and date of birth of the employee has been checked with him/her (please tick appropriate boxes below) and has been found to be correct.							
Birth certificate	<input type="checkbox"/>	Passport	<input type="checkbox"/>	National Identification Card	<input type="checkbox"/>	Other	<input type="checkbox"/> (please specify)
Date (yyyy/mm/dd)	<input type="text"/>						
Signature over Company's rubber stamp	<input type="text"/>						
(Authorised official)							

### B - Employer to attach photocopy of identification documents.



## C - Particulars to be filled in by the employee

Application for admission to (Name of employer)

I, Mr./Mrs./Ms. (Please insert full names in BLOCK letters)

hereby apply for admission to the above scheme and agree to be bound by the rules of the scheme.

1. Are you now in perfectly good health? (If "no", please provide full details)

Yes  No

2. Have you been absent from employment during the last two months due to illness, injury or any other type of incapacity? (If "yes", please provide full details)

Yes  No

3. Have you ever had:

a) Unexplained, recurrent or persistent fever or skin disorder?

Yes  No

b) Persistent, unexplained night sweats?

Yes  No

c) Unexplained weight loss?

Yes  No

d) Unexplained infections or swollen glands?

Yes  No

e) Chronic or recurrent diarrhoea?

Yes  No

f) Persistent cough?

Yes  No

g) Hepatitis B or any sexually transmitted disease, including genital sores or discharge?

Yes  No

4. Have you ever had or been advised to have a blood test for HIV or an HIV related condition?

Yes  No

5. Have you ever been refused as a blood donor?

Yes  No

6. Have you received a blood transfusion within the last 5 years?

Yes  No

If "yes", to any of the above, please provide full details.

I HEREBY DECLARE that all statements and answers to the above questions are complete and true, and I agree that they shall form part of my application for life insurance. I authorise any physician, medical practitioner, hospital, clinic, medical or medically related facility or insurance company having any records or knowledge pertaining to me or my health to provide Metropolitan Life Insurance Kenya or its reinsurers with any information sought.

Full name of beneficiary

Address

Relationship

Guardian (if the beneficiary is a minor)

Date of birth (yyyy/mm/dd)

Signature

