

APPLICATION FOR:

Elimu Paa

METROPOLITAN
LIFE KENYA



Please write clearly using BLOCK letters and tick appropriate blocks

Contract Number

- | | | |
|--|---|--|
| <input type="checkbox"/> New business | <input type="checkbox"/> Contract alteration | <input type="checkbox"/> Addition of Disability Premium Waiver Benefit |
| <input type="checkbox"/> Replacement of an existing contract | <input type="checkbox"/> Change of Premium Payer | <input type="checkbox"/> Addition of Funeral Benefit |
| <input type="checkbox"/> Replacement of a lapsed contract | <input type="checkbox"/> Addition of Death Premium Waiver Benefit | <input type="checkbox"/> Addition of Cash Withdrawal Benefit |

1. Policy Owner and Premium Payer

Personal particulars

Title Surname

First names Maiden name

Gender Male Female Marital status Single Married Divorced Widowed

Date of birth Place of birth

y y y y m m d d

Individual profile

Occupation Employer* Nationality

* If operating your own business, indicate industry/type of business

National identity document Passport No.

PIN No. No. **MANDATORY: Attach copy of Identification Document & PIN.**

Addresses

Postal: (if workplace address, specify branch or department below)

Branch/ Department Residential: Building/ Village

PO Box Street/ Location

Town Town/ District

Code

Email

Telephone numbers

Work Home

Mobile Fax

2. Life Insured (Child)

Personal particulars

Title Surname

First names

Gender Male Female

Date of birth Place of birth

y y y y m m d d

Relationship to Policy/Contract Owner Own child Legally adopted child Other



3. Method of Premium Payment

Please indicate method of payment:

- Salary deduction (Please complete salary deduction form)
 Bank debit order (Please complete relevant bankers order form)
 Standing order (Please complete relevant standing order form)
 Cash

Salary deduction (latest salary slip compulsory, please complete salary deduction form)

I hereby authorise my Employer mentioned below to deduct the premium for this contract and to remit it to Metropolitan. This authorisation must be kept in force until such time as I cancel this authority or submit a replacement authority in writing.

Name of employer Employee's ref. number

Date of first deduction

y	y	y	y	m	m	d	d

Date employment started

y	y	y	y	m	m	d	d

Employment terms Temporary Permanent Contract

Job title

Signature of premium payer

Date

y	y	y	y	m	m	d	d

Bank details (the bankers order/standing order form should also be completed)

Bank account information

Bank Branch name

Account type Current Savings Other

Account holder Account no.

Date

y	y	y	y	m	m	d	d

Signature of account holder

Cash deposit(s) NOTE: We do not receive cash in the office

Kindly pay your initial premiums via:

1. Initial premium can be deposited at Equity Bank, Moi Avenue branch, A/C No **047 029 313 9292**.
2. Deposit in Cooperative Bank, Aga Khan Walk branch, account number **011363 057 046 00** (account name Metropolitan Life Insurance). Attach deposit slip to the application form.
3. M-PESA paybill no. **808900** (indicate ID as account number and M-PESA code on the application form).

4. Contract details

Payment frequency	AIM (Tick one)	Rider benefits	Premium
(cannot be changed after policy issue)			
<input type="checkbox"/> Monthly	<input type="checkbox"/> 0%	<input type="checkbox"/> Funeral Benefit* (maximum cover KSh50 000)	<input type="text" value="KSh"/>
<input type="checkbox"/> Quarterly	<input type="checkbox"/> 5%	<input type="checkbox"/> Death Premium Waiver Benefit*	<input type="text" value="KSh"/>
<input type="checkbox"/> Half-yearly	<input type="checkbox"/> 10%	<input type="checkbox"/> Disability Premium Waiver Benefit*	<input type="text" value="KSh"/>
<input type="checkbox"/> Annually	<input type="checkbox"/> 15%	<input type="checkbox"/> Cash Withdrawal Benefit	<input type="text" value="KSh"/>
<input type="checkbox"/> Single premium (Premium required before issue)		Total Rider benefits premium (B)	<input type="text" value="KSh"/>
Term <input type="text" value=""/> <input type="text" value=""/> years (Minimum 8 years)		(*Insurability questions will need to be completed if this rider benefit is selected.)	
Basic premium (A)	<input type="text" value="KSh"/>		
Total premium (A + B)	<input type="text" value="KSh"/>		



5.1 Insurability (For the Policy Owner: complete only if a Premium Waiver Benefit is added)

1.	Is the Premium Payer currently engaged in any of the following:	Yes	No
	1.1 Flying other than as a fare-paying passenger of a recognised airline on a scheduled route?	<input type="checkbox"/>	<input type="checkbox"/>
	1.2 Any hazardous sport, pursuit or occupation such as boxing, diving, motor-racing, hang gliding or handling of explosives?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has any application for insurance in respect of the Premium Payer ever been declined, postponed, withdrawn or accepted on special terms by any life insurer?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has there been any application for insurance, or application for reinstatement of a lapsed contract, in respect of the Premium Payer with Metropolitan or any other life insurer during the past 12 months? If "yes", please furnish the name of the insurer, entry/amended date and sum insured in section below.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does the Premium Payer consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Does the Premium Payer smoke?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Height <input type="text"/> <input type="text"/> <input type="text"/> feet Weight <input type="text"/> <input type="text"/> <input type="text"/> kilograms		
7.	Is the Premium Payer on any permanent medication or has he/she seen a medical practitioner, gone to a medical facility or institution regarding health problems or habits affecting his/her health, either physically or mentally during the past 5 years (excluding minor ailments and surgery)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Is the Premium Payer suffering from any illness, deformity or disability of whatever nature or is the Premium Payer in poor physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>

If the answers to the above questions, except for questions 4 to 6 are "yes", please complete below:

Question	Particulars
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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y y y y m m d d

Signature of Premium Payer

5.2 Insurability (For the Child: complete only if a Funeral Benefit is added)

1.	Is the Life Insured currently engaged in any of the following:	Yes	No
	1.1 Flying other than as a fare-paying passenger of a recognised airline on a scheduled route?	<input type="checkbox"/>	<input type="checkbox"/>
	1.2 Any hazardous sport, pursuit or occupation such as boxing, diving, motor-racing, hang gliding or handling of explosives?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has any application for insurance in respect of the Life Insured ever been declined, postponed, withdrawn or accepted on special terms by any life insurer?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has there been any application for insurance, or application for reinstatement of a lapsed contract, in respect of the Life Insured with Metropolitan or any other life insurer during the past 12 months? If "yes", please furnish the name of the insurer, entry/amended date and sum insured in section below.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Does the Life Insured consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Does the Life Insured smoke?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Height <input type="text"/> <input type="text"/> <input type="text"/> feet Weight <input type="text"/> <input type="text"/> <input type="text"/> kilograms		
7.	Is the Life Insured on any permanent medication or has he/she seen a medical practitioner, gone to a medical facility or institution regarding health problems or habits affecting his/her health, either physically or mentally during the past 5 years (excluding minor ailments and surgery)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Is the Life Insured suffering from any illness, deformity or disability of whatever nature or is the Life Insured in poor physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>

If the answers to the above questions, except for questions 4 to 6 are "yes", please complete below:

Question	Particulars
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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y y y y m m d d

Signature of Policy Owner



6. Particulars of doctor of Premium Payer

Particulars of doctor			
Name of doctor or clinic	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>	Town <input type="text"/>	Postal code <input type="text"/>
Telephone	<input type="text"/>	Fax	<input type="text"/>

7. Beneficiary (If more than one beneficiary is nominated, please complete Beneficiary Nomination Form.)

7.1 Personal Details			
Title	<input type="text"/>	Surname	<input type="text"/>
First names	<input type="text"/>		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Life Insured	<input type="text"/>
Form of identification	<input type="checkbox"/> Identity document <input type="checkbox"/> Passport <input type="checkbox"/>	No.	<input type="text"/>
Date of birth	<input type="text"/>	Place of birth	<input type="text"/>
	y y y y m m d d		
Attach copy of Identification Document.			

Addresses	
Postal: (if workplace address, specify branch or department below)	Residential: (optional)
Branch/ Department <input type="text"/>	Building/ Village <input type="text"/>
PO Box <input type="text"/>	Street/ Location <input type="text"/>
Town <input type="text"/>	Town/ District <input type="text"/>
Code <input type="text"/>	
Email <input type="text"/>	

Telephone numbers	
Work <input type="text"/>	Home <input type="text"/>
Mobile <input type="text"/>	Fax <input type="text"/>

8. Needs analysis Kindly complete the mandatory Financial Needs Analysis form

9. Declaration

<p>1. I warrant that the information in this application and in all documents submitted to Metropolitan Life Insurance Kenya Ltd (herein referred to as Metropolitan) in connection with it, whether in my handwriting or not, is true, correct and complete and will form the basis of the proposed contract.</p> <p>2. In order to facilitate the assessment of the risk, and for the consideration of any claim, I irrevocably authorise Metropolitan:</p> <p>(a) to obtain from any person, any information which Metropolitan deems necessary, and</p> <p>(b) to share with other insurers that information and any information contained in this proposal or in any related contract or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Metropolitan or by the operators of such database.</p> <p>I understand and accept that my right of privacy may be infringed to the extent permitted by me in this authorisation and I waive my right to privacy to that extent.</p> <p>Signature of Policy Owner <input type="text"/></p> <p>(Please see checklist overleaf)</p>	<p>3. I agree that if any material information concerning the risk on my life has not been fully disclosed, or if I have given any untrue, incorrect or incomplete answers, Metropolitan reserves the right to cancel my cover and I shall forfeit all premiums paid.</p> <p>4. I understand that I am entitled to cancel this application within 30 days of the commencement date of the contract issued by Metropolitan. I agree that there will be a refund of all premiums paid, less the cost of any cover or investment enjoyed by me.</p> <p>I understand that this right applies also to any application to increase the premium on an existing contract and that any refund refers to the difference between old and new premium.</p> <p>5. Replacement of contract: I understand that it is not in my best interest to replace an existing contract with a new contract.</p> <p>6. I agree that Metropolitan will deduct any premium debt or arrear premiums from the benefit amount if there is no investment component on the policy.</p> <p>Date <input type="text"/></p> <p>y y y y m m d d</p>
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10. Information to be completed by Intermediary

Intermediary: Name <input style="width: 90%;" type="text"/> Level code <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="K"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input style="width: 95%; height: 25px;" type="text"/> Signature Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> y y y y m m d d	Sales manager/Broker consultant: Name <input style="width: 90%;" type="text"/> Level code <input type="text" value="0"/> <input type="text" value="0"/> <input type="text" value="K"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input style="width: 95%; height: 25px;" type="text"/> Signature Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> y y y y m m d d
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11. Agent Disclosure checklist

The contract owner has the right to the following information. Kindly confirm that this has been provided.

AGENT STATUS (indicate with a tick in the yes or no box)

	Yes	No
1. Have you provided the following information to the contract owner:	<input type="checkbox"/>	<input type="checkbox"/>
a) Your full name and title?	<input type="checkbox"/>	<input type="checkbox"/>
b) Office details (physical and postal address)?	<input type="checkbox"/>	<input type="checkbox"/>
c) Telephone and email contact details?	<input type="checkbox"/>	<input type="checkbox"/>
ADVICE		
2. a) Have you taken the circumstances of the contract owner into account to satisfy their financial needs?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you done a sufficient needs analysis?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you disclosed the following information to the contract owner:		
a) Name and type of policy?	<input type="checkbox"/>	<input type="checkbox"/>
b) The premium?	<input type="checkbox"/>	<input type="checkbox"/>
c) Type, extent and limitations of benefits?	<input type="checkbox"/>	<input type="checkbox"/>
d) That commission is payable on this policy and answered any commission related questions?	<input type="checkbox"/>	<input type="checkbox"/>
e) The 30-day cooling off period?	<input type="checkbox"/>	<input type="checkbox"/>
f) Claims notification procedure?	<input type="checkbox"/>	<input type="checkbox"/>
g) Cancellation procedure and surrender?	<input type="checkbox"/>	<input type="checkbox"/>
APPLICATION STAGE		
4. Is the contract owner satisfied with the advice and disclosure that you have given?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the policyholder completed and signed the application form?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you, the agent signed the application form?	<input type="checkbox"/>	<input type="checkbox"/>

<input style="width: 95%; height: 25px;" type="text"/> Signature of Policy Owner <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> y y y y m m d d	<input style="width: 95%; height: 25px;" type="text"/> Signature of Intermediary <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> y y y y m m d d
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FOR OFFICE USE ONLY

AUTHORISATION AND CHECK BY MANAGER

Accept Application which is:

Complete Not able to be spot checked Spot checked

Signature

Date
 y y y y m m d d

NEW BUSINESS

UNDERWRITER'S COMMENTS
