

APPLICATION FOR:

# Hatua Plan

**METROPOLITAN**  
LIFE KENYA



Please write clearly using BLOCK letters and tick appropriate blocks

Contract Number	<input type="text"/>	<input type="checkbox"/> Contract alteration
<input type="checkbox"/> New business	<input type="checkbox"/> Change of Premium Payer	<input type="checkbox"/> Addition of Disability Premium Waiver Benefit
<input type="checkbox"/> Replacement of an existing contract	<input type="checkbox"/> Addition of Death Premium Waiver Benefit	<input type="checkbox"/> Addition of Lump Sum Disability Benefit
<input type="checkbox"/> Replacement of a lapsed contract	<input type="checkbox"/> Addition of Cash Withdrawal Benefit	<input type="checkbox"/> Addition of Accident Benefit

## 1. Policy Owner, Life Insured and Premium Payer

### Personal particulars

Title	<input type="text"/>	Surname	<input type="text"/>
First names	<input type="text"/>	Maiden name	<input type="text"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Date of birth	<input type="text"/>	Place of birth	<input type="text"/>

### Individual profile (MANDATORY: Attach copy of Identification Document & PIN)

Occupation	<input type="text"/>	Employer*	<input type="text"/>	Nationality	<input type="text"/>
* If operating your own business, indicate industry/type of business <input type="text"/>					
National identity document	<input type="checkbox"/> Passport <input type="checkbox"/>	No.	<input type="text"/>		
PIN No.	<input type="checkbox"/>	No.	<input type="text"/>		
Gross income per month	<input type="text"/>				
Education	O Levels <input type="checkbox"/>	3 or 4 year Diploma or 3-year Degree <input type="checkbox"/>	K.C.P.E. <input type="checkbox"/>	K.C.S.E. <input type="checkbox"/>	
	A Levels <input type="checkbox"/>	4-year Degree or Professional Qualification or more <input type="checkbox"/>			

### Addresses

Postal: (if workplace address, specify branch or department below)	Residential:
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"/>

## 1.1 Premium Payer (Complete only if the Premium Payer is not the Policy Owner)

Surname	<input type="text"/>	Title	<input type="text"/>	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
First names	<input type="text"/>	Marital status	Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/>		
Maiden name	<input type="text"/>	<input type="checkbox"/> National identity document <input type="checkbox"/> Passport <input type="checkbox"/> PIN No.			
Occupation	<input type="text"/>	No.	Attach copy of Identification Document		
Home address	<input type="text"/>	Date of birth (dd mm yyyy)	<input type="text"/>		
Town/District	<input type="text"/>	Place of birth	<input type="text"/>		
Tel. no. (h) <input type="text"/> (w) <input type="text"/>	Postal address: PO Box <input type="text"/>	Town <input type="text"/>	Code <input type="text"/>		
Fax no. <input type="text"/> (Cell) <input type="text"/>	Relationship to Insured Life	Spouse <input type="checkbox"/> Blood relation Yes <input type="checkbox"/> No <input type="checkbox"/>			
Email <input type="text"/>	Define relationship	<input type="text"/>			





## 4.1 Insurability questions (Life Insured)

Complete questions 1 to 11 for cover amounts KSh 100 000 ≤ KSh5 000 000 and questions 1 to 13 for cover > KSh5 000 000

<p>1. Do you currently consume alcohol? If "yes", state quantity</p> <table border="0"> <tr> <td>Yes</td> <td>No</td> <td>*Beer (bottles)</td> <td>Wine (glasses)</td> <td>Spirits (tots)</td> <td>Daily</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> <tr> <td colspan="2"></td> <td>* 340 ml or less</td> <td><input type="text"/></td> <td><input type="text"/></td> <td>Weekly</td> </tr> </table>	Yes	No	*Beer (bottles)	Wine (glasses)	Spirits (tots)	Daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				* 340 ml or less	<input type="text"/>	<input type="text"/>	Weekly	<p>2. Do you smoke? If "yes" state quantity.</p> <table border="0"> <tr> <td>Yes</td> <td>No</td> <td>Pipe</td> <td>Cigarettes</td> <td>Other</td> <td>Quantity</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td colspan="2"></td> <td colspan="2">3. Height <input type="text"/> <input type="text"/> feet</td> <td>Weight <input type="text"/> <input type="text"/> <input type="text"/> kilograms</td> <td></td> </tr> </table>	Yes	No	Pipe	Cigarettes	Other	Quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			3. Height <input type="text"/> <input type="text"/> feet		Weight <input type="text"/> <input type="text"/> <input type="text"/> kilograms	
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																																
		3. Height <input type="text"/> <input type="text"/> feet		Weight <input type="text"/> <input type="text"/> <input type="text"/> kilograms																																	

4. Do you currently engage in any of the following:

4.1 Flying other than as a far-paying passenger of a recognised airline on a scheduled route?	Yes	No
4.2 Any hazardous sport, pursuit or occupation such as boxing, diving, motor-racing, hang gliding or handling of explosives?	<input type="checkbox"/>	<input type="checkbox"/>

5. 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:

6. Are you currently in good physical health, actively at work and are you able to perform your normal daily activities like dressing, washing, eating, toileting and walking without assistance?  Yes  No

7. Has any application for insurance on your life ever been declined, postponed, withdrawn, or accepted on special terms by any insurance company?  Yes  No

8. During the past five years have you been diagnosed with, hospitalised, or received specialised treatment from a clinic, hospital or doctor for any of the following conditions:

8.1 Heart disease or heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
8.2 Lung disease or any respiratory disorder including tuberculosis or asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8.3 Kidney disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8.4 High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
8.5 Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
8.6 Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
8.7 Infectious diseases like Hepatitis B or any sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>
8.8 Mental diseases or disorders like depression, anxiety, stress-related disorders, epilepsy, blackouts, paralysis or loss of vision?	<input type="checkbox"/>	<input type="checkbox"/>

9. During the past 5 years, did your doctor prescribe medicine or tablets that you had to take for two weeks or longer?  Yes  No

10. During the past 5 years, have you been asked to come back to a clinic, hospital or doctor for regular treatment or needed to visit one regularly because of feeling ill?  Yes  No

11. With reference to the list of medical conditions just mentioned, are you aware of any medical condition that may require treatment during the next 8 weeks?  Yes  No

12. Have two or more of your immediate family members (i.e. father, mother, brothers or sisters) died before the age of 50, due to the same medical condition, namely:

12.1 Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
12.2 Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
12.3 Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
12.4 Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>

13. Have you ever been medically advised to stop using or reduce your intake of alcohol?  Yes  No

## 4.2 Insurability questions (Complete only if a Premium Waiver Benefit is added and the Life Insured is not the Premium Payer.)

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"/> 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 Life Insured/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"/>





## 6. Beneficiary (continued)

<b>2. Personal Details</b>						
Title	<input type="text"/>	Surname	<input type="text"/>			
First names	<input type="text"/>	Maiden name	<input type="text"/>			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Life Insured	<input type="text"/>	Benefit	<input type="text"/>	%
<input type="checkbox"/> National identity document	<input type="checkbox"/> Passport	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.						

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

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

## 7. Needs analysis Kindly complete the mandatory Financial Needs Analysis form

## 8. Declaration

<p>1. I warrant that the information in this application and in all documents submitted to Metropolitan Life Insurance Kenya Ltd (hereafter 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 to 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><i>(Please see checklist overleaf)</i></p>	<p>3. I agree that if any material information concerning the risk on the Premium Payer 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 date of the commencement date of the contract issued by Metropolitan. I agree that there will be a refund of all premiums paid.</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 an old and new premium.</p> <p>5. <b>Replacement of contract:</b> 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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## 9. Information to be completed by Intermediary

<b>Intermediary:</b> 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"/>  <div style="border: 1px solid black; height: 20px; width: 100%;"></div> 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	<b>Sales manager/Broker consultant:</b> 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"/>  <div style="border: 1px solid black; height: 20px; width: 100%;"></div> 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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## 10. 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)

1. Have you provided the following information to the contract owner:		Yes	No
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"/>
<b>ADVICE</b>			
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"/>
<b>APPLICATION STAGE</b>			
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"/>

<div style="border: 1px solid black; height: 25px; width: 90%; margin: 0 auto;"></div> 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	<div style="border: 1px solid black; height: 25px; width: 90%; margin: 0 auto;"></div> 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**

