




APPLICATION No: 288862



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APPLICATION FORM**LIFE ASSURED DETAILS**

NAME:					
DATE OF BIRTH:		GENDER:		MARITAL STATUS:	
EMAIL ADDRESS:					
POSTAL ADDRESS:		TOWN:		CODE:	
PHYSICAL ADDRESS((Residential)Include RD. Name, Estate, Subcounty & County)					
ID/PASSPORT NUMBER:		KRA PIN NUMBER:			
SOCIAL MEDIA:   					

EMPLOYMENT INFORMATION

STATE YOUR OCCUPATION:		SPECIFIC DUTIES:	
EMPLOYER'S NAME		EMPLOYMENT NO:	

BENEFICIARY DETAILS

NAME	RELATIONSHIP	DATE OF BIRTH	% SHARE	CONTACT

NB: In the event that the Beneficiaries are under the legal age, claim benefits will be paid to the guardian. Add if any. For additional Beneficiary(s) Attach a list with same details

POLICY/PRODUCT TYPE

TYPE OF POLICY	OPTION	TERM(Years)	SUM ASSURED

SUPPLEMENTARY COVERS (Write YES or NO)

Personal Accident	Funeral Cover	Waiver of Premium	Critical Illness	TOTAL PREMIUM PAYABLE(KSHS)

FREQUENCY OF PAYMENT

MONTHLY QUARTERLY SEMI ANNUAL ANNUAL LUMP SUM

SOURCE OF PREMIUM

Please Indicate Source of Premium for this policy: Salary Business Other _____

METHOD OF PAYMENT:

MPESA CHECK-OFF BANK STANDING ORDER DIRECT DEBIT AUTHORITY

BANK DETAILS (PERSONAL)

A/C NAME		BANK NAME	
BRANCH		A/C NUMBER	

AGENT DETAILS

AGENT NAME		AGENT CODE		DATE		SIGN	
AGENCY MANAGER		BRANCH		DATE		SIGN	

MEDICAL HISTORY

- (a) Do you have any known medical condition? YES NO
- (b) Are you currently taking any medication regularly or as required? YES NO

DETAILS OF YES ANSWERS ABOVE (if below space is not sufficient, kindly fill the details on the back page)

Question No.	Details including, dates, details of treatment, medical institution where treated and treating doctor

(c) In the box below, please disclose all diagnosed ailments you have had in the Last 3 years

Details including, dates, details of treatment, medical institution where treated and treating Doctor

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ADDITIONAL QUESTIONS

- (i) Do you consume alcohol? YES NO if YES, state the type and weekly quantity: Type _____ Quantity _____
- (ii) Do you smoke? YES NO if YES, how many cigarettes/pipe/cigars per day: _____
- (iii) Have you been convicted of felony or demeanor within the last five (5) years or do you have any charges pending? YES NO
- (iv) Has any proposal for life, sickness, accident or disability insurance on your life ever been declined, deferred, withdrawn or accepted on special terms? YES NO
- (v) What is your height and weight? Height: Feet _____ Inches _____ Weight (Kgs): _____
- (vi) What are your hobbies? _____

DETAILS OF YES ANSWERS IN ABOVE (If below space is not sufficient, kindly fill the details at the back page)

Question No.	Complete Details

DECLARATION AND AUTHORISATION

- This application is hereby made to Pioneer Assurance according to the Company's terms and conditions.
- Each of the undersigned declares that the statement and answer 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.
- It is also agreed that Pioneer Assurance will incur no liability under this application until the application has been received, approved and full premium has been paid to and accepted by Pioneer Assurance. The policy must be issued and full modal premium paid while the health, habits, vocations and occupation of the proposed Assurance are as stated in this application.
- I (We) understand that no intermediary has authority to waive the answer to any of the questions in this application or to make or alter any contract for Pioneer Assurance.
- I the proposed life insured give express, unequivocal, free, specific and further authorize the Association of Kenya insurers Life Registry, Insurance company or any other physical/medical practitioner, hospital, clinic, medical or medically related facility having any records or knowledge pertaining to me or my health, to provide Pioneer Assurance or its reinsurers with any information sought. Information with this authorization will be treated as confidential and may only be used to determine insurability, sent to the Association of Kenya Insurers Life Registry, released by Association of Kenya Insurers to insurance company to whom I apply for Life or health insurance or to whom a claim for benefits may be submitted, used as lawfully required and/ or used as I may further authorize. I agree that a photocopy of this authorization shall be Valid as the original.

POLICY DOCUMENT

I consent to have my policy document delivered to me through electronic email indicated in this proposal. I also understand that my policy document will be considered delivered once dispatched to this email.
In case you require a hard copy policy document, please contact Pioneer Assurance or your nearest branch office.

PREMIUMS

CAN BE PAID VIA MPESA PAYBILL NO. 100500 / ACCOUNT NO. PROPOSAL OR POLICY NO. _____

DETAILS OF POLICY OWNER/ PAYER (If Different from Life assured)

NAME	RELATIONSHIP	OCCUPATION

Signature of Proposed Insured _____ Date: _____

Signature of Policy Owner/Payer _____ Date: _____