APPLICATION No

PIONEER ASSURANCE

Your Security For The Future

LIFE PROPOSED

PROPOSAL NUMBER

SURNAME — MR | MRS | MISS

FIRST NAMES — SINGLE | MARRIED | DIVORCED | WIDOWED

PRESENT ADDRESS

DATE OF BIRTH ___ / ___ / ___

AGE NEXT BIRTHDAY ___ SEX M F

IDENTITY CARD NO. (Attach Copy)

FORMER ADDRESS

PIN NUMBER

OCCUPATION

WORK TEL. NO.

RESIDENCE TEL. NO.

E-MAIL:

FINANCIAL QUESTIONARE

NET SALARY INCOME (A) (MONTHLY)	OTHER INCOME (B)	DISPOSABLE INCOME (C) A + B

GROSS PREMIUM FOR APPLICATIONS (D)		RATIO OF GROSS PREMIUM TO NET INCOME (E) D/C100% NOTE THAT (E) SHOULD NOT EXCEED 30%	

NEW BUSINESS

UNDERWRITER'S _____

COMMENTS _____

By: _____ **DATE:** _____

COMMENCEMENT DATE

(For official use only)

PLAN DESCRIPTION

POLICY NO.

PLAN CODE	POLICY PLAN	PARTICULARS OF INSURANCE		INITIAL SUM ASSURED	MONTHLY PREMIUM	ANNUAL PREMIUM
		TYPE OF POLICY	BENEFITS			
			BASIC			
			P.A.			
			W.P.			
			D.A.B			
			POLICY FEE			
			SUB-TOTAL			
			P.H.C.F. (0.25%)			
				Others		
				Total Premium		

MODE OF PAYMENT

NOTICE TO APPLICANT: No Agent of Pioneer Assurance Co. Ltd. or Broker is authorised to accept premiums other than first premium on behalf of the Company. All future Premium payments by cash or cheque must be paid directly to the Company at its Head Office or Agency offices in exchange for an official receipt.

Frequency of Payment

☐ **Annual** ☐ **Semi-Annual** ☐ **Quarterly** ☐ **Monthly** ☐ **Others**

Method of Payment

☐ **Cash** ☐ **Cheque** ☐ **Bankers Order** ☐ **Salary Deduction** ☐ **M-Pesa** Use Business No. 100500

BANK DETAILS

A/C Name..... **Bank / Branch** ..... **A/C No.** .....

BENEFICIARY DESIGNATIONS

1. BENEFICIARY

	NAME	RELATIONSHIP	DATE OF BIRTH	AGE	% SHARE	TEL. NUMBER
1.						
2.						
3.						
4.						

CONTINGENT BENEFICIARY

	NAME	RELATIONSHIP	DATE OF BIRTH	AGE	TEL. NUMBER
1.					
2.					

Special Instructions _____

2. OWNER/PAYER DETAILS

(a) IF IN BUSINESS

Name		Business Name	
Location		Street	
		Town	
P. O. Box		Postal Code	

(b) IF EMPLOYED

Name		Occupation	
Employer		Describe Duties	
Other Occupations-Part Time			

(c) OTHER INFORMATION

Relationship of payer to insured		ID No.	
Work Tel. No.		Residence Tel. No.	

HEALTH QUESTIONS FOR LIFE PROPOSED

Every indicated question must be put to the life proposed by the agent and the answer recorded by the agent

1. (a) Name and Address of your Doctor

(b) When and why was this doctor last consulted?

(c) If you have consulted or been examined by any other doctor within the last five years give name address, diagnosis and treatment.

2. (a) Height ____ Weight ____

(b) Have you lost/gained weight in the last twelve months **YES** ☐ **NO** ☐

If yes, give:
(I) Amount lost/gained
(ii) Reasons for Loss/ Gain

2.

	Family History	Age if Living	State of Health	Age at Death	Cause of Death
	Father				
	Mother				
	Brothers				
	Sisters				

HEALTH QUESTIONS

When any of the questions 4 to 14 hereunder is answered "YES" give complete information under **"details".** Specify the conditions, items or history and give dates, duration, treatment and name and address of each doctor consulted.

DETAILS

If "yes" use the space below to identify the question (s) & state fill details. Attach a separate sheet if space is inadequate.

4. Do you have any problems or are you taking treatment or medication of any kind? _____ **YES** ☐ **NO** ☐

5. (a) Have you smoked cigarettes within the last 12 months? **YES** ☐ **NO** ☐
(b) Have you used tobacco products or any habit-forming drugs within the last 10 years?
if yes, state type of product and average daily use. **YES** ☐ **NO** ☐

© What was your average daily consumption of alcohol over the past 5 years? _____ **YES** ☐ **NO** ☐

6. Has any member of your family ever suffered from diabetes, heart disease, mental illness or cancer of any sort? _____ **YES** ☐ **NO** ☐

7. Have you ever had or been told that you had:
(a) Dizziness, fainting spells, epilepsy, nervous disorder, depression, severe headaches, stroke.

or any disease or disorder of the brain or nervous system? _____ **YES** ☐ **NO** ☐

(b) Asthma, brochitis, spiting of blood, tuberculosis, or any disease or disorder of the lungs or respiratory system? _____ **YES** ☐ **NO** ☐

(c) High blood pressure, chest pain, heart attack shortness of breath, heart murmur or any disease or disorder of the heart or blood vessels or elevated serum cholesterol or triglycerides: _____ **YES** ☐ **NO** ☐

(d) Ulcer of the intestinal track, indigestion, diarrhoea, intestinal bleeding, disorder colitis, jaundice, nephritis kidney stones, albumin or blood in the urine or any disease of the stomach, intestines bowel, rectum, liver, gall bladder, pancreas, spleen, kidneys or bladder? _____ **YES** ☐ **NO** ☐

(e) Any disease of the prostate or testes if a male or of the breast, uterus or ovaries if a female? _____ **YES** ☐ **NO** ☐

(f) Goitre , enlarged glands, anaemia, syphilis, leukemia diabetes, sugar, the urine of any disease or disorder of the glands or blood? _____ **YES** ☐ **NO** ☐

(g) Backache, sciatica arthritis, gout, anaemia, rheumatism, rheumatic fever, or any disease or disorder of the bones joints or spine or any unusual skin lesions or unexpected infection, cancer or tumor or any other growth? _____ **YES** ☐ **NO** ☐

(h) Varicose veins, varicose ulcers, phlebitis or anaemia any disease or disorder of the eyes, ears, nose or throat or any allergies? _____ **YES** ☐ **NO** ☐

8. Have you ever had an x-ray electrocardiogram, blood studies or any other tests? _____ **YES** ☐ **NO** ☐

9. Have you any abnormality , family disease or disorder not mentioned above? _____ **YES** ☐ **NO** ☐

10. Have you ever or been advised to have an operation or to have treatment for Alcoholism or habit forming drugs? _____ **YES** ☐ **NO** ☐

11. (For females only) are you pregnant? If yes" give the number of weeks? _____ **YES** ☐ **NO** ☐

12. (For lives under 2 years only((a) birth weight, (b) Gain/loss in past year (c) Number of days in hospital after birth (d) if more than five days, give details _____ **YES** ☐ **NO** ☐

13. INSURANCE HISTORY

1. What other insurance do you have in force and pending?

Name of Company	Year Issued	Type of Insurance	Amount of Insurance	Accident death cover

14 Other Details

Have you:-

(a) Ever had an application or request for insurance declined, postponed rated or modified in any way? **YES** ☐ **NO** ☐

(b) Ever had renewal of an insurance coverage refused or modified? _____ **YES** ☐ **NO** ☐

(c) Ever claimed or received payment for any sickness, accident, or injury? _____ **YES** ☐ **NO** ☐

(d) Flown as a pilot or student pilot within the last 3 years or any such activity contemplated? _____ **YES** ☐ **NO** ☐

(e) Ever engaged in racing Underwater diving parachuting or any other hazardous sport or is any such activity contemplated _____ **YES** ☐ **NO** ☐

(If yes for (d) or (e) please give details on appropriate questionnaire form).

DO YOU KNOW OF ANY LIKELY CHANGE IN YOUR OCCUPATION OR LIFETSYLE WHICH MIGHT AFFECT YOUR INDURABILITY?

HEAD OFFICE PIONEER HOUSE, MOI AVENUE
P.O. Box 20333 - 00200 NAIROBI, KENYA.
Tel: 2220814 /5 (10 lines)
Fax No.2224985
Email:info@pioneerassurance.co.ke

NAME OF APPLICANT. _____

ADDRESS: _____

Dear applicant,

RE: APPLICATION FOR INSURANCE:

APPLICATION No. ☐

On my behalf and that of the entire Company, I would like to thank you for appointing us as your probable insurers.

Since 1930, Pioneer Assurance has been translating policy owners' dreams into realities through carefully designed products such as the one you have applied for. The policy document is under preparation and will be forwarded to you in due course.

If you don't hear from us within one month after the payment of the first premium please contact us. Carry this letter with you or send us a copy when making any enquiries.

I would like to wish you a happy association with us and assure you of our commitment to serve you at all time.

Yours Sincerely

MOSES N. KIMANI
MANAGING DIRECTOR

AGENCY OFFICE ☐

PHYSICAL ADDRESS ☐

AGENTS NAME AND CODE ☐

TYPE OF POLICY APPLIED FOR

LIFE ☐ **SCHOOL FEES** ☐ *(Tick one)*

Plan Code: ☐ Plan Description ☐ Term ☐

Total Sum Asured ☐ Total Premium ☐

PAYMENT DETAILS FREQUENCY OF PAYMENT *(tick one)*

Annual ☐ Semi Annual ☐

Quarterly ☐ Monthly ☐

BANK DETAILS *(where premium is to be paid by standing order or by direct debit)*

ACCOUNT HOLDER'S NAME ☐

BANK/BRANCH ☐ **ACCOUNT NO.** ☐

SALARY DEDUCTION *(Where premium is to be paid through the employer)*

DEPT ☐ **EMPLOYEE NO.** ☐

NAME OF EMPLOYER ☐

APPLICANT'S ADDRESS ☐

TEL: ☐ **EMAIL:** ☐

HEAD OFFICE

Pioneer House, Moi Avenue
P.O. Box 20333 - 00200
Nairobi, Kenya
Tel: 2220814/5 (10 Lines)
Fax No: 2224985
Email: info@pioneerassurance.co.ke
Website: www.pioneerassurance.co.ke

BRANCH OFFICES ACROSS THE COUNTRY

NAIROBI : 1
Finance House, 7th Floor
Loita Street.
P.O. Box 20333 - 00200,
NAIROBI
Tel: 020-2045502
Fax: 2224985

MALINDI
Malindi Complex
Lamu Road
P. O.Box 5101 - 80200
Malindi
Tel: 042-2120767

NAKURU
Giddo Plaza, Ground Floor
Nakuru - Eldoret Highway
P. O. Box 2625 - 00200
Nakuru
Tel: 020-2045506

MOMBASA
TSS Tower, 4th Floor
Nkurumah Road
P.O. Box 81029-80100
Mombasa
Tel: 020 - 2352323

BUNGOMA
Bungoma Municipality
Moi Avenue,
Opp. Co-operative Bank
P.O. Box 476-50200
Bungoma
Tel: 020-2045507

MERU
Meru Mwalimu Plaza
2nd Floor
P.O. Box 913-60200
Meru
Tel: 020-2045508

NAIROBI II
Re-Insurance Plaza
Podium Floor
P. O. Box 20333-00200
Nairobi
Tel: 020 - 8079798 / 9

VOI
Maghonyi Plaza
P. O. Box 186 - 80300
Voi
Tel: 020 - 2603580

KISUMU
Pioneer House
Oginga Odinga Street
P.O. Box 900-40100
Kisumu
Tel: 020-2045505

MACHAKOS
Mbitini House
Mbolu Malu Road
P.O. Box 477-90100
Machakos
Tel: 020-2045504

THIKA
Thika Arcade
5th Floor
P.O. Box 2562 -01000
Thika
Tel: 020-2045410

NYERI
Wakiawa House
Kanisa Road
P.O. Box 700 -10100
Nyeri
Tel: 020- 2045509

HOMABAY
Sonyaco Plaza
Bank Road
P. O. Box 436-40300
Homabay
Tel: 059-21486

ELDORET
Zion Mall Building
1st Floor
Ronald Ngara Street
P.O. Box 7185-30100
Eldoret
Tel: 053-2030578

KITALE
Mid Africa Plaza
1st Floor
Moi Avenue
P.O. Box 562 Kitale
Tel: 020 - 2352419

PIONEER ASSURANCE

Your Security For The Future

DECLARATIONS AND AUTHORIZATION

I, the premium payer/owner declare and agree that;

(1) This application is hereby made to Pioneer Assurance according to the Company's terms and conditions.

(2) The answers in this application are made complete and true.

(3) The statements made in this application and in any other documentation submitted in connection with this application form the basis of the policy applied for and shall constitute all representation made as a basis for the policy. I have checked those statements carefully and if there are any changes to the information in this form before the policy starts, I will tell Pioneer Assurance.

(4) No agent has the authority to waive a question in the application, making any promise or representation or by giving or receiving any information.

(5) I irrevocably authorize and request any Doctor or other person who may be in possession of or hereafter acquire any information concerning my health (where such information relates to the past or the future) to disclose such information to Pioneer Assurance Company Ltd, and I agree that this authority and request shall remain in force after my death as well as prior thereto.

HIV CONSENT

I _____ agree that the HIV test (if required) be performed and that the underwriting decision be based on the results. All test results will be reported to Pioneer Assurance Company Ltd and will be treated confidentially. At your written request, the test results may be disclosed to a doctor of your choice.

I, the premium payer/ owner acknowledge that I have read and understood these declarations.

Dated at _____ this _____

day of _____ 20 _____

Witness _____ Signature of the _____
(Not the agent) *life proposed*

Witness _____ signature of applicant_____
if not life proposed

Information regarding your insurability will be treated as confidential. The company or its reinsurers may however, release information in its file or other Life Insurance Companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AGENT'S DETAILS

Code: _____ **Agency** _____

Agent's Name

Agent's Signature **Date**

Unit Manager's Name

Unit Manager's Signature **Date**

Agency Manager's name

Agency Manager's Signature **Date**