



COMPLETE WHERE APPLICABLE USING BLOCK LETTERS OR TICK

FUND NAME:

EMPLOYER'S NAME:

EMPLOYER BRANCH NAME OR NUMBER: FUND NO:

1. Employee Details

Surname & title: Member ref. no.:

First name and initials: Wage/paysheet no.:

Identification number: Date of birth:

Residential address:

Tel no.: Postal code:

Email:

2. Dread Disease Details

1. What illness/impairment has led to this claim?

Heart attack	<input type="checkbox"/>	Renal failure	<input type="checkbox"/>
Coronary artery surgery	<input type="checkbox"/>	Paraplegia	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Major organ transplant	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Blindness	<input type="checkbox"/>

2. Describe fully the extent of your illness/impairment:

3. Please complete if illness/impairment arose from an accident.

Date of accident:

Place of accident:

Nature of accident:

Nature of injury and body part affected:

In the case of a road accident, address of police station where accident was reported and case number:

If a formal enquiry was conducted, please state by whom and give details of result:

4. Please complete if illness/impairment arose from an illness.

Date of first symptoms:

Have you suffered from this illness/impairment previously? YES NO

If YES, give full details.

5. Who is your regular family doctor?

Name and address:

Since what date has he/she been your family doctor?

When was your last consultation?



6. Who was your previous family doctor?
Name and address:

7. When did you see a doctor about the illness/impairment for the first time? D D M M Y Y Y Y
Who was this doctor?
Name and address:

8. Please state dates, names and addresses of all medical practitioners and specialists consulted in connection with your illness/impairment.

_____	D D M M Y Y Y Y
_____	D D M M Y Y Y Y
_____	D D M M Y Y Y Y
_____	D D M M Y Y Y Y
_____	D D M M Y Y Y Y

9. Are you presently under medical care? YES NO

10. Are you confined to your bed/home? YES NO
If YES, give full details.

11. Have you been hospitalised? YES NO
If YES, give full details.

Name of institution: _____

Your hospital number: _____

Date admitted: D D M M Y Y Y Y

Date discharged: D D M M Y Y Y Y

12. What type of treatment are you receiving and what is the result of the treatment? Is any further treatment recommended?

13. Have you been confined to an intensive care unit? YES NO
If YES, please state: From D D M M Y Y Y Y To D D M M Y Y Y Y

14. Complete the following only if you have been a member of the scheme for less than 24 months.
Have you consulted any medical practitioner or clinic, received medical attention, taken medication for any illness or injury during the 24 months immediately prior to your membership of the fund. YES NO

If YES give full details of:

Duration of illness/injury: _____

Nature of illness/injury: _____

Name of medical practitioner or institution: _____

Address: _____

_____ Postal code: _____

Tel no.: _____



15. Do you have dread disease (trauma) insurance with any other insurance companies? YES NO
If YES, state:

Name of company	Sum Insured	Inception Date							
<input type="text"/>	<input type="text"/>	D	D	M	M	Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	D	D	M	M	Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	D	D	M	M	Y	Y	Y	Y

16. Please provide any further information which, in your opinion, may affect the claim:

3. Payment Details

Payment by cheque: Payment directly into bank or building society account:

Name of bank/building society:

Branch office: Branch no: (Bank only)

Account number: Account type: Transmission, cheque, etc

Declaration

I declare that, to the best of my knowledge, the particulars provided in the above form are true and complete.
I further authorise any medical practitioner, hospital, my employer or any other person who may have any information relating to my illness/injury to provide Metropolitan Life Insurance Kenya Ltd (the insurer) with such information.

Signature of Member

Date

Signature of Legal Representative
(if member is incapacitated)

Date

