INDIVIDUAL AND FAMILY APPLICATION FORM

(For membership to be considered this declaration must be completed in full and all questions answered)

MPESA PAYBILL NO: 333200

PART A: DETAILS OF THE PROPOSER

Surname: _____ First Name: _____ Middle Name: _____

Marital Status: _____ Occupation: _____ PIN No. (Provide Copy) _____

ID/Passport No. (Provide Copy) _____ P.O. Box: _____

Town: _____ Postal Code: _____

Email: _____

Physical Address: _____ Mobile: _____

Dependants Details

ENTER DETAILS OF THE SPOUSE (01) AND ALL DEPENDANTS TO BE INCLUDED IN THE APPLICATION FOR MEMBERSHIP IN ORDER OF AGE (DESCENDING) WHERE APPLICABLE

Category	Surname	First Name	Middle Name	Gender		Date of Birth								Height	Weight
				M	F	D	D	M	M	Y	Y	Y	Y	(Cm)	(Kg)
00 Principal				☐	☐										
01 Spouse				☐	☐										
02 Dependant				☐	☐										
03 Dependant				☐	☐										
04 Dependant				☐	☐										
05 Dependant				☐	☐										
05 Dependant				☐	☐										
06 Dependant															
07 Dependant															
08 Dependant															

Next Of Kin Details (Beneficiary)

Name	ID	Relationship	Phone Number

Cover Options

Inpatient Cover Options	Platinum	Gold	Silver Plus	Silver	Bronze	Cover Me
(Tick Option)	☐	☐	☐	☐	☐	☐
Outpatient Cover Options	250,000	200,000	150,000	100,000	75,000	50,000
(Tick Option)	☐	☐	☐	☐	☐	☐

Scope	
Per Family	☐
Per Family	☐

Name of current/previous health insurer and the expiry date; _____

Previous Membership Number: _____

Have you or any of you dependants ever been declined or premium loaded by any health insurer?

State which one; _____

CONFIDENTIAL MEDICAL HISTORY

Have you or any of your dependants ever had (been diagnosed and/or treated for) any of the following medical conditions? Kindly answer YES or NO to all the questions below.answers are required for each applicant.

(ask a doctor for assistance if needed)

NOTE: if the answer is YES to any of the questions which follow, you will be requiredto provide details of the medicalcondition. AAR Insurance may request you to provide a medical report, without which your application may be delayed.

QUESTIONS	00	01	02	03	04	05	06	07	08	09		
1. Blood group (If known)												
2. Cancer, growth or tumors whether benign or malignant												
3. Cardiovascular (heart and blood vessels) disorders including high blood pressure												
4. Respiratory and ear nose and throat (ENT) disorders including asthma, tuberculosis, hearing & speech impairment, adenoids and any other												
5. Ednocrine disorders including high cholesterol, diabetes, thyroid abnormalities, obesity												
6. Eye related disorders including glaucoma, blindness, cataracts and any other												
7. Gastro-intestinal disorders including peptic ulcer disease, heartburn reflux, haemorrhoids, pancreatitis, hepatitis, hernias and any other												
8. Gynecological & Obstetric disorder including caeserian section, fibroids, ovarian cysts, infertility, pelvic inflammatory, menstrual irregularities, abnormal pap smear, hormone treatment, miscarriages and any other												
9. Genitourinary disorders including enlarged prostate. Kidney failure, dialysis, kidney stones and any other												
10. Musculoskeletal disorders including arthritis, gout, back problems, physical disabilities, joint problems and any other												
11. Neurological & psychological disorders including epilepsy, mental disabilities, paralysis, schizophrenia, depression, bipolar disorder, attempted suicide, alcohol or drug dependency/ addiction and any other												
12. Blood & connective tissue disorders including leukemia, HIV & AIDS. systemic Lupus Erythematosus (SLE) and any other												
13. Congenital/inherited/hereditary disorders including birth defects, sickle cell disease umbilical hernia												
14. Skin disorders including eczema, keloids, warts, acne, moles, melanoma and any other.												
15. Have you ever been hospitalized?												
16. Have you had any other medical conditions not mentioned above? Please state												
17. Do you have any allergies?												

COMMENTS

I have appointed _____ to be my Agent/Broker for this policy

AGENT / BROKER DECLARATION

I confirm that I have explained to the client the benefits, terms & conditions, and exclusions of AAR Insurance Company Limited.

Full name of Agent / Broker: _____ Tel: _____

Signature of Agent / Broker: _____ Date: _____

OUR OFFICES

KENYA

HEAD OFFICE

Real Towers, Ground Floor,
Hospital Road, Upper Hill
P.O. Box 41766 - 00100, Nairobi
Tel: +254 020 2895000
Cell: +254 703 063000
+254 730 633000

Kisumu Branch:

Al Imran Plaza, 1st Floor,
Oginga Odinga Street
Cell: +254 731 191069
Tel: +254 057 2023535

Eldoret Branch:

Saito Centre, 1st Floor,
Oloo Street, Eldoret
Tel: +254 053 2030636
Cell: +254 731 945772
Fax: +254 53 2060812

Nairobi Super Branch:

Real Towers, 7th Floor,
Hospital Road, Upper Hill
P.O. Box 41766 - 00100, Nairobi
Tel: +254 020 2895000
Cell: +254 703 063000
+254 730 633000

Nyeri Branch:

2nd Floor,Rupshi Chambers,
Kimathi Way
Tel: +254 61 2031512
Cell: +254 731 191073

Ngong Road Branch:

Silk Wood Office Suites, 3rd Floor
Adams Arcade, Ngong Road
Tel: +254 020 341203
+254 020 2215582
Cell: +254 731 191065

Kakamega Branch:

Mega Mall, 2nd Floor,
Webuye Road,
Opposite Muliro Gardens
Tel: 056 2031796
Cell: 0733 200208

Kericho Branch:

Imarisha Sacco, 2nd Floor
Kericho Nakuru Road
Tel: 0739 710 247

Malindi Branch:

Off Lamu Road, StanChart Arcade,
Cell: 0731 091 072 | 042 2131492
P.O. Box 87858 - 80100, Mombasa

Nakuru Branch:

Giddo Plaza, Ground Floor,
George Morara Rd
Off Nakuru - Eldoret Highway
Tel: +254 051 2215599
+254 051 2216739
Cell: +254 731 669915

Mombasa Branch:

Imaara building, 4th floor
Dedan Kimathi Avenue, Mombasa
Tel: +254 041 2226697

Thika Branch:

4th Floor,Thika Arcade,
Kenyatta Rd
Tel: +254 67 22269
Cell: +254 731 191074

Naivasha Branch:

Eagle Centre, 1st Floor,
Mbaria Kanio Rd
Cell: +254 731 466367

REGIONAL OFFICES

Tanzania:

Plot 74 Serengeti Rd, Warioba Street Off
Mwai Kibaki Rd, Mikocheni
P.O. Box 9600, Dar Es Salaam
Tel: +255 022 2780020
+255 022 2780651
Fax: +255 022 2781472
+255 022 2781204
Email: info@aar.co.tz

Uganda:

Plot 16A Elizabeth Avenue
Kololo, Kampala
Direct Line: +256 414 560 900
Tel: +256 312 261318
Fax: +256 414 258615
Tel: +256 414 560900
Email: info@aar.co.ug

Kenya:

Email: info@aar.co.ke
www.aar-insurance.com

DECLARATION

IMPORTANT: The following in conjunction with the policy document of the membership constitutes the contract with aar insurance, sign below, unless anything is not clear in which case kindly seek further advice from aar insurance. Note that all reference to the singular includes the case dependants, all those under 18 years. The policy holder must sign the declaration on his/her own behalf and on behalf of all other dependants under 18 years.

i). I declare that all those persons named in the application form are members of my immediate family for whose membership I am responsible.

ii). I am applying for the service combination of AAR membership as marked on the first page.

iii). My country of residence is within the territory as declared in this application form and I will inform if it ceases to be so.

iv). I have declared all material facts whether or not asked, i understand that AAR has reserved the right to reject my application or terminate membership at the end of any benefit year without divulging any reason for doing so. I agree to notify AAR on any subsequent changes in my medical condition and understand that such changes in my medical condition and understand that such changes may cause AAR to modify or discontinue my membership. I understand and agree in particular that:

a). I become a Member from my commencement date and understand that if membership is not renewed my membership shall be terminated and I shall reapply for membership and shall be treated as a new member.

i). Renewals shall be effected upon receipt by AAR of written confirmation with the appropriate premium payment from the member. Failure to renew before the end of the benefit year, the member shall forfeit his policy cover and submit and execute a new membership and shall be treated as a new member application form. The member shall forfeit his no claim discount.

b). If I am a new member, AAR does not pay any costs of hospital admission for illness, nor for related Rescue and Evacuation, during the first 60 days of membership. A similar restriction applies in respect of the additional benefits available on upgrading my service combination for 60 days from the appropriate date of upgrading. If any medical conditions arise during these 60 days whether in East African or abroad, of which AAR was not aware of the appropriate date of upgrading. If any medical conditions arises during these 60 days whether in East African or abroad, of which AAR was not aware of the appropriate commencement date and might have affected AAR's decision to accept my membership, AAR may place an exclusion or cancel my membership and refund my fees.

c). AAR will only provide service outside my country of residence during the first 45 days of absence from country of residence in any one visit.

d). If I travel out of my geographical region I must notify AAR at least 48 hours before my date of travel.

e). I must arrange my scheduled hospitalization with AAR at least 48 hours prior to admission, and in the event of an emergency I must contact AAR within 24 hours of admission. Once AAR has agreed, they will provide medical services directly and will not reimburse me for any medical bill paid by me or on my behalf.

f). Any misrepresentation, fraudulent act, false statement or non disclosure of material in this application form will render my membership invalid, and I will then forfeit my membership fees and be liable to refund to AAR on demand all cost incurred by it in connection with rescue, evacuation, hospitalization or other services provided by it.

g). AAR has the sole discretion in all cases to decide which doctor from its panel of doctors, hospitalsor rescue facilities should be used in any particular case. Where a member insists on using a doctor, hospital or rescue facility outside the choice of AAR, AAR should only be liableto cover the costs chargeable by its panel doctors, hospital or facility of choice.

h). I will only be entitled to benefits from the commencement date and subject to the cover limits of the selected combination.

i). AAR will not refund any premium unless I wish to cancel my membership within 30 days of my initial commencement date. In that case I may apply for a refund provided no service have been rendered by AAR on my behalf.

j). I understand that medical evaluation is a mandatory requirement at the inception of this contract, if I or any of the dependants has attained 45 years of age. However, regardless of the age of the applicants for membership, AAR may at its own discretion require a medical evaluation of any applicant. It is a mandatory requirement to undergo a medical evaluationon a yearly basis or at such other frequency as AAR may at its own discretion decide if I or any dependant attains the age of 65 years.

k). I understand that if my membership is not renewed on or before the expiry date this contract shall be deemed to have been terminated. I further understand in renegotiating a new contract, AAR may at its discretion require my fulfilment of new conditions to join including but not limited to medical examination and AAR's decision thereon and revised membership fees.

l). I hereby consent to AAR contacting my doctor or medical information about me and I hereby authorize such doctor or institution to make full disclosure of such information to AAR or its advisers, and to provide access to my complete medical and hospital records whenever required.

Signature of Policy Holder: _____ Date: _____

AAR INSURANCE KENYA LIMITED
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AAR Insurance
You're in control