CIC GENERAL INSURANCE LTD.

CIC FAMILY MEDISURE MEMBER APPLICATION FORM

CIC GROUP

WRITE NAME AT THE BACK OF EACH PHOTOGRAPH AND ATTACH WITH A CLIP

(PLEASE, DO NOT USE STAPLE OR PIN)

SEE ATTACHED PHOTO SHEET

A. PERSONAL PARTICULARS OF THE APPLICANT

TITLE ☐ Mr. ☐ Mrs. ☐ Miss. Other ☐ PROPOSAL COMMENCEMENT DATE Day ☐☐ Month ☐☐ Year ☐☐☐☐

SURNAME ☐☐☐☐☐☐☐☐☐☐ OTHER NAMES ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ID/PASSPORT NUMBER ☐☐☐☐☐☐☐☐☐☐

GENDER ☐☐ MARITAL STATUS ☐☐☐☐ DATE OF BIRTH ☐☐ ☐☐ ☐☐☐☐ MOBILE NUMBER ☐☐☐☐☐☐☐☐☐☐ ALTERNATIVE PHONE NUMBER ☐☐☐☐☐☐☐☐☐☐

POSTAL ADRESS ☐☐☐☐☐☐ POSTAL CODE ☐☐☐☐☐ TOWN OF RESIDENCE ☐☐☐☐☐☐☐☐☐☐ TOWN OF RESIDENCE ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EMAIL ADRESS ☐☐☐☐☐☐☐☐☐☐☐ HEIGHT(CM) ☐☐☐☐☐ WEIGHT(KG) ☐☐☐☐☐ BLOOD GROUP AB O A B RHESUS FACTOR + -

SPECIFIC OCCUPATION/DESIGNATION ☐☐☐☐☐☐☐☐☐☐☐☐ NAME OF EMPLOYER/BUSINESS ☐☐☐☐☐☐☐☐☐☐☐☐ STAFF PAYROLL No. WHERE APPLICABLE ☐☐☐☐☐☐☐☐☐☐☐☐

KRA PIN NUMBER ☐☐☐☐☐☐☐☐☐☐☐

B. PARTICULARS OF THE APPLICANT'S DEPENDANTS TO BE INCLUDED ON COVER

1. FULLNAMES ☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ GENDER M F

   ID/PASSPORT NUMBER ☐☐☐☐☐☐☐☐☐ DATE OF BIRTH D D M M Y Y Y Y Relationship: Child ☐ Spouse ☐ Living with you: ☐ Yes ☐ No

   HEIGHT(CM) ☐☐☐☐☐ WEIGHT(KG) ☐☐☐☐☐ BLOOD GROUP AB O A B RHESUS FACTOR + -

2. FULLNAMES ☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ GENDER M F

   ID/PASSPORT NUMBER ☐☐☐☐☐☐☐☐☐ DATE OF BIRTH D D M M Y Y Y Y Relationship: Child ☐ Spouse ☐ Living with you: ☐ Yes ☐ No

   HEIGHT(CM) ☐☐☐☐☐ WEIGHT(KG) ☐☐☐☐☐ BLOOD GROUP AB O A B RHESUS FACTOR + -

3. FULLNAMES ☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ GENDER M F

   ID/PASSPORT NUMBER ☐☐☐☐☐☐☐☐☐ DATE OF BIRTH D D M M Y Y Y Y Relationship: Child ☐ Spouse ☐ Living with you: ☐ Yes ☐ No

   HEIGHT(CM) ☐☐☐☐☐ WEIGHT(KG) ☐☐☐☐☐ BLOOD GROUP AB O A B RHESUS FACTOR + -

4. FULLNAMES | GENDER (M F)
ID/PASSPORT NUMBER | DATE OF BIRTH (D D M M Y Y Y Y) | Relationship: Child ☐ Spouse ☐ | Living with you: ☐ Yes ☐ No
HEIGHT(CM) | WEIGHT(KG) | BLOOD GROUP (AB O A B) | RHESUS FACTOR (+ -)

5. FULLNAMES | GENDER (M F)
ID/PASSPORT NUMBER | DATE OF BIRTH (D D M M Y Y Y Y) | Relationship: Child ☐ Spouse ☐ | Living with you: ☐ Yes ☐ No
HEIGHT(CM) | WEIGHT(KG) | BLOOD GROUP (AB O A B) | RHESUS FACTOR (+ -)

6. FULLNAMES | GENDER (M F)
ID/PASSPORT NUMBER | DATE OF BIRTH (D D M M Y Y Y Y) | Relationship: Child ☐ Spouse ☐ | Living with you: ☐ Yes ☐ No
HEIGHT(CM) | WEIGHT(KG) | BLOOD GROUP (AB O A B) | RHESUS FACTOR (+ -)

Note: Kindly indicate the NATIONAL ID NUMBER for your spouse and each child above 18 years of age.
(Attach copies)for dependants not living with you, indicate their town of residence and alternative address

C. CONFIDENTIAL MEDICAL HISTORY OF THE APPLICANT AND DEPENDANTS LISTED

Please answer all the questions, Blank spaces are not acceptable.
You may attach an additional sheet if the space provided is insufficient

1. Has any of you or your above dependants been hospitalized in the last 3 years? Yes ☐ No ☐
2. Have any of you or your above dependants ever had an accident resulting in a permanent injury? Yes ☐ No ☐
3. Do any of you suffer from any disease that is recurrent in nature? Yes ☐ No ☐
4. Are any of you on regular medication? Yes ☐ No ☐
5. Do any of you have any kind of physical disability? Yes ☐ No ☐
6. Are there any circumstances in your(or your dependants) current or past medical history that may result in hospitalization or surgery in the near future? Yes ☐ No ☐

Please state whether any of you proposed for inclusion on cover has ever been treated, received treatment or expects to receive treatment for any of the following conditions / illness:

7. Heart and Blood vessels disorders e.g. high blood pressure, heart disease, stroke, congenital (inborn) heart conditions, chest pains, arterial disease. Yes ☐ No ☐
8. Blood/ circulatory disorders e.g. Sickle cell anemia, Varicose, Thrombosis, Kidney, Liver, Hemophilia, leukemia or any other blood disorder. Yes ☐ No ☐
9. Respiratory disorders e.g. Bronchitis, Tuberculosis, Asthma, cigarette smoking disorder, any other respiratory related disorder. Yes ☐ No ☐
10. Neurological disorders e.g. Meningitis, stroke, brain or spinal cord disorder, epilepsy, any other neurological related disorder. Yes ☐ No ☐
11. Ear, Nose and Throat related problem e.g. throat surgery, sinuses. Yes ☐ No ☐
12. Eye disorders e.g. cataract, glaucoma, eye surgery, blindness. Yes ☐ No ☐
13. Gynecological or genitor-urinary disorders e.g. Pelvic Inflammatory disease, menstrual irregularities. Yes ☐ No ☐
14. Kidney disorders such as kidney failure, kidney stones, recurrent infections etc. Yes ☐ No ☐
15. Musculoskeletal disorders e.g. arthritis, back problems, joints, gout, etc. Yes ☐ No ☐
16. Endocrine diseases such as diabetes, thyroid disease, high cholesterol. Yes ☐ No ☐
17. Surgical such as appendectomy, tonsillectomy or any other surgical procedure. Yes ☐ No ☐
18. Other diseases/ disorders: cancer, alcohol/drug problem, hepatitis, ulcer, mental disorder, gall bladder disease, HIV infection. Yes ☐ No ☐
19. Is there any other ailment or condition not listed above that you or your dependants may be suffering from? Yes ☐ No ☐

If you answered YES to any of the questions 1 to 17, kindly give more details in the table below.

No	Name of Applicant	Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	Current status

If the space is not adequate, fill in a separate plain paper and staple it to the form

20. a) Have you / your spouse ever delivered a child by Caesarean operation? Yes ☐ No ☐
If yes please give details

b) Are you / your spouse currently pregnant? Yes ☐ No ☐
If yes please state number of weeks of pregnancy

21. Have you been on medical insurance before? Yes ☐ No ☐
If yes give the name of the Insurer/HMO, expiry date and special exclusions.

22. Any additional information not stated above, relating to your medical history

D. COVER BENEFITS SELECTED

1. Medical cover plan selected (please tick only one)

CIC Essential **300K** IP | OP | MAT | DTL & OPT ☐ CIC Standard **500K** IP | OP | MAT | DTL & OPT ☐

CIC Comprehensive **1M** IP | OP | MAT | DTL & OPT ☐ CIC Superior **2M** IP | OP | MAT | DTL & OPT ☐

CIC Premier **3.5M** IP | OP | MAT | DTL & OPT ☐ CIC Prestige **5M** IP | OP | MAT | DTL & OPT ☐ CIC Platinum **10M** IP | OP | MAT | DTL & OPT ☐

2. Optional rider cover selected (please tick). Each rider cover selected attracts additional premium.

Personal Accident cover ☐

NEXT OF KIN (Must be over 18 years of age)

FULLNAMES GENDER M | F

ID/PASSPORT NUMBER DATE OF BIRTH D D M M Y Y Y Y RELATIONSHIP

MOBILE NUMBER

POSTAL ADDRESS POSTAL CODE TOWN OF RESIDENCE

LAST EXPENSE BENEFICIARY (Must be over 18 years of age)

FULLNAMES GENDER M | F

ID/PASSPORT NUMBER DATE OF BIRTH D D M M Y Y Y Y RELATIONSHIP

MOBILE NUMBER

POSTAL ADDRESS POSTAL CODE TOWN OF RESIDENCE

Important things to note:

1. Cover is not effective until your application is assessed and accepted in writing and the full annual premium paid.
2. Any pre-existing conditions for the applicant and his/her dependants must be declared on the application form, and cover confirmed by CIC in writing.
3. Applicants aged 50 years and above will be required to go for specified medical test at their own cost.
4. CIC Insurance will not be liable for medical expense resulting from excluded conditions or exceeded benefits (as per policy)

INTERMEDIARY DETAILS

Intermediary Name: _____

Trading As: _____ Tel: _____

KRA PIN No: _____ IRA No: _____ Email: _____

Bank A/c No: _____ Bank Name: _____ Branch: _____

INTERMEDIARY DECLARATION

I hereby declare that I explained the benefits of this application and that the applicant is aware of the membership terms and conditions of CIC Insurance Company Limited.

Signature of Intermediary: _____ Date: _____

DECLARATION

I hereby apply to join the **CIC FAMILY MEDISURE**. I understand to the best of my knowledge and belief that all the answers given above are true, that I have not concealed or withheld any material information which the underwriter ought to know in order to assess me or my family members for medical insurance.

I know that only misrepresentation of information could result in my policy being rendered null and void.

I hereby authorize the hospitals, medical or dental practitioners who have treated me or any of my dependants to disclose to CIC Insurance the records relating to such current or previous hospitalizations or medical treatment and to allow CIC Insurance to receive extracts from such records, and I undertake to assist in obtaining such information.

Signature of the Applicant: _____ Date: _____

E. FOR OFFICIAL USE ONLY

CIC Relationship Officer (Name where applicable)

FULLNAMES

POLICY NUMBER

POLICY COMMENCEMENT DATE Day Month Year

GROUP (Where Applicable)

RECEIVED/PROCESSED BY:

Name: _____ Date: _____ Signature _____

CONFIRMED BY:

Name: _____ Date: _____ Signature _____

APPROVED BY:

Name: _____ Date: _____ Signature _____