



# Corporate Application Form

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

MPESA PAYBILL NO: 333200

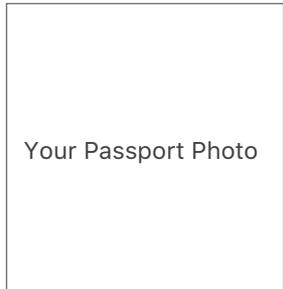
**PLEASE COMPLETE THIS APPLICATION AND ANSWER ALL QUESTIONS.**

**Data collection consent:** Pursuant to the data protection act, 2019 ("DPA") and the European Union General Data Protection Regulation ("EUGDPR"), AAR Insurance (K) Limited ("AAR Insurance"), in its capacity as a data controller and/or processor under the DPA and EU GDPR must obtain your explicit, affirmative, and informed consent before it can collect or process any personal data for a lawful basis. AAR Insurance shall only use your personal data to administer applied products and services requested from AAR Insurance. In order to provide you with the above services, AAR Insurance will need to collect, process and store your personal data for the duration of the product. If you consent to us storing your personal data for this purpose, please tick the check box.

I agree to AAR Insurance's collecting, processing and storage of my personal data.

**For Official Use**

Membership No:	
Serial No:	



**PRINCIPAL DETAILS**

Name Of Company: \_\_\_\_\_

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ NHIF No. : \_\_\_\_\_ ID/Passport No.: \_\_\_\_\_

KRA PIN: \_\_\_\_\_ Email: \_\_\_\_\_

P.O. Box: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Town: \_\_\_\_\_

Physical Address: \_\_\_\_\_ Mobile: \_\_\_\_\_

**DEPENDANTS DETAILS**

**ENTER DETAILS OF THE DEPENDANTS BELOW IN ORDER OF AGE (DESCENDING) WHERE APPLICABLE**

Category	Surname	First Name	Middle Name	Gender		Date Of Birth								Relationship	
				M	F	D	D	M	M	Y	Y	Y	Y		
01 Spouse															
02 Dependent															
03 Dependent															
04 Dependent															
05 Dependent															
06 Dependent															
07 Dependent															
08 Dependent															
09 Dependent															



**NEXT OF KIN**

Name	
ID	
Relationship	
Phone Number	

Name of previous health Insurer and the expiry date \_\_\_\_\_

**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 required to provide details of the medical condition in the comments section below. AAR Insurance may request you to provide a medical report

	00	01	02	03	04	05	06	07	08	09
1. Cancer, growths or tumors whether benign or malignant										
2. Cardiovascular (heart and blood vessels) disorders including high blood pressure										
3. Respiratory and Ear Nose and Throat (ENT) Disorders including asthma, tuberculosis, hearing & speech impairment, adenoids and any other										
4. Endocrine disorders including high cholesterol, diabetes, thyroid abnormalities, obesity										
5. Eye related disorders including glaucoma, blindness, cataracts and any other										
6. Gastro-intestinal disorders including peptic ulcer disease, heartburn reflux, haemorrhoids, pancreatitis, hepatitis, hernias and any other										
7. Gynecological & Obstetric disorder including caesarian section, fibroids ovarian cysts, infertility, pelvic inflammatory, menstrual irregularities, abnormal pap smear, hormone treatment, miscarriages and any other										
8. Genitourinary disorders including enlarged prostate, kidney failure, dialysis kidney stones and any other										
9. Musculoskeletal disorders including arthritis, gout, back problems, physical disabilities, joint problems and any other										
10. Neurological & psychological disorders including epilepsy, mental disabilities, paralysis, schizophrenia, depression, bipolar disorder, attempted suicide, alcohol or drug dependency/ addiction and any other										
11. Blood & connective tissue disorders including leukemia, HIV & AIDS, Systemic Lupus Erythematosus (SLE) and any other										
12. Congenital/inherited/hereditary disorders including birth defects, sickle cell disease, umbilical hernia										
13. Skin disorders including eczema, keloids, warts, acne, moles, melanoma and any other.										
14. Have you ever been hospitalized?										
15. Do you have any allergies?										

**COMMENTS**

**DECLARATION**

I, on behalf of myself and the members of my family proposed for insurance, hereby declare that I have not withheld or misstated any particular material fact. I understand that any misstatement or non disclosure of any material information in this form will jeopardize my membership. I hereby authorise the hospitals/medical practitioners who have treated me or any of my dependants to disclose to AAR Insurance Kenya Limited or their representative the records relating to such current or previous hospitalisation/medical treatment and allow AAR Insurance Kenya Limited to receive extracts from such

Signature of Principal Member: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Agent/Broker \_\_\_\_\_ Date \_\_\_\_\_