Benevolent [Last Expense Plan]: Membership Application Form

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PLEASE COMPLETE IN BLOCK LETTERS OR TICK (√) APPROPRIATE BOX UNLESS OTHERWISE INDICATED

A: APPLICANT DETAILS…

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Nationality Gender: M F Marital Status: Single Married Other Specify

Mobile No: Work Telephone:

Email Address: PIN No:

Postal Address: Code: County: Country:

B: EMPLOYMENT DETAILS…

Employer: Occupation:

Employment Date: Annual Salary: Employee No:

Mobile No: Work Telephone:

Email Address:

Postal Address: Code: County: Country:

C: COVER OPTIONS…

Tick Your Preferred Cover

Relation/Premium	KShs. 300 Per Month	KShs. 600 Per Month	KShs. 900 Per Month	KShs. 1,200 Per Month
Self	100,000	200,000	300,000	400,000
Spouse [1]	100,000	200,000	300,000	400,000
Parents	50,000	80,000	140,000	150,000
Children [4]	50,000	80,000	140,000	150,000
Brother/Sister [4]	20,000	40,000	60,000	80,000
Parent In Laws [2]	50,000	80,000	140,000	150,000

NO REFUNDS | NO OF CLAIMS IS FIVE [5] PER YEAR | NUCLEAR FAMILY CLAIM IS ONE [1] MONTH, DEPENDANTS IS THREE [3] MONTHS

D: SPOUSE DETAILS (WHERE APPLICABLE) …

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

E: CHILDREN DETAILS (WHERE APPLICABLE) ...

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

F: BROTHERS & SISTERS DETAILS (WHERE APPLICABLE) ...

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

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G: PARENT-IN-LAW DETAILS (WHERE APPLICABLE) ...

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

First Name: Surname: Other Names:

ID No Passport No Date of Birth: DD MM YYYY

Relationship: Gender: M F

ATTACH LEGAL IDENTIFICATION DOCUMENTS FOR THE MEMBERS COVERED

- ID/PASSPORT FOR ADULTS,
- BIRTH CERTIFICATES FOR CHILDREN,
- KRA PIN CERTIFICATE OF THE PRINCIPAL MEMBER.

H: NOMINATED BENEFICIARY

I hereby request my employer to pay any benefits in my name which shall become due in the event of my death under the rules of this scheme to:

SURNAME	OTHER NAMES	RELATIONSHIP	PROPORTION [%]	CONTACT MOBILE NO

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I hereby apply for admission to the above scheme and agree to be bound by the rules of the scheme. I further declare that I am in perfect good health at present and was not absent from my employment during the last two months due to illness, injury, or any type of incapacity.

Please answer (Yes) or (No) to the following questions

Question		
Have you ever had any unexplained recurrent or persistent fever or skin disorder?	☐ Yes	☐ No
Have you ever had any persistent unexplained night sweats?	☐ Yes	☐ No
Have you ever had any unexplained weight loss?	☐ Yes	☐ No
Have you ever had unexplained infections or swollen glands?	☐ Yes	☐ No
Have you ever had any chronic or recurrent diarrhea?	☐ Yes	☐ No
Have you ever had any persistent cough?	☐ Yes	☐ No
Have you ever had Hepatitis B or any sexually transmitted diseases including genital sores or discharges?	☐ Yes	☐ No
Have you ever had or been advised to have a blood test for AIDS or any AIDS related condition?	☐ Yes	☐ No
Have you ever been refused as a blood donor?	☐ Yes	☐ No
Have you received a blood transfusion within the last 5 years?	☐ Yes	☐ No

If you answered **YES** to any of the above questions, please provide additional Information below

I: DECLARATION…

I, the life to be assured do hereby declare that all the foregoing statements and answers are true and complete, that I have not concealed or withheld anything within which QONA SACCO Limited ought to be acquainted in order to assess my eligibility for membership of the scheme and that I am willing to be medically examined, if required.

I consent to QONA SACCO Limited seeking medical information from any doctor, who at any time has attended me or seeking information from an office to which I have at any time made a proposal for life or sickness or accident insurance and I authorize the giving of such information to QONA SACCO Limited.

Signature of Applicant: ____________ Date: DD MM YYYY

Authorized Officer of Proposer/Employer:

Name

Signature

Stamp Here