APA Insurance Ltd
P.O.Box 30065-00100
Nairobi,Kenya.
Tel No. 286 2000
Fax No. 286 2200
E-Mail. Info@apainsurance.org

Attach 1 passport photo each of you and your dependants on the photo sheet

EMPLOYEE'S MEDICAL APPLICATION FORM

TO BE FILLED IN BLOCK LETTERS

SECTION A - Employee Details

Company Name _____

Full Names of Employee _____ (Surname) _____ (First Name) _____ (Middle Name)

Date of Birth _____ (DAY) _____ (MONTH) _____ (YEAR) Male ☐ Female ☐

Occupation _____ Employee No. _____

ID/Passport No. _____ Phone No _____

Email Address _____ Box No _____ Postal code _____

SECTION B

DEPENDANTS TO BE INCLUDED TO THE MEDICAL COVER:

NAME: (underline surname)	DATE OF BIRTH DAY	MONTH	YEAR	SEX M	F	RELATION SHIP TO YOU (wife, son, etc.)

SECTION C - To be completed by Employer

As Employer I confirm that the information given in setion 'A' above is correct.

This Employee is to be included in the medical scheme with effect from _____ (DAY) _____ (MONTH) _____ (YEAR)

Signature & Stamp of Employer _____

Date of signing _____ Position in Company _____

HEALTH DECLARATION BY MEMBER

PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE OR BELIEF

1. a) Name and Address of your present doctor _____ (*If none, so state*)

   b) Date and reason last consulted (If within last 5 years) _____

   c) What treatment was given or medication prescribed? _____

(TICK ✓ APPLICABLE ITEMS)

If the answer to any question is "Yes", identify question number and include diagnosis, dates, duration, degree of recovery or results and names and addresses of all attending physicians and medical facilities.

	YES	NO
2. Are you or any of your dependants under medical treatment by diet, medicine or other means?		
3. Have you or any of your dependants ever had or sought advice for: -		
(a) chest pain, high blood pressure, heart murmur, heart or circulation disorder?		
(b) asthma, chronic cough, shortness of breath or lung disorder?		
(c) diabetes or sugar in the urine?		
(d) ulcer, colitis, liver or digestive disorder?		
(e) cancer, tumor or enlarged glands?		
(f) anaemia, bleeding or blood disorder		
(g) dizziness or fainting spells, epilepsy, nervous system or mental disorder?		
(h) urine, kidney or bladder disorder?		
(i) arthritis or other joint disorder		
(j) any other illness, surgery or injury?		
4. Have you had any change in weight in the past year? Current weight..... Height.....		
5. Have you ever been adviced to stop drinking or to drink less?		
6. Have you or any of your dependant(s)		
(a) Received medical advice or treatment in connection with AIDS or an HIV/AIDS related condition or sexually transmitted disease		
(b) Have HIV/AIDS or an HIV/AIDS related complex?		
(c) Have any of the following which are unexplained: Fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?		
7. Have you or any of your dependant(s) within the past 5 years :		
(a) Had any mental or physical disease or disorder not listed above		
(b) Had a check-up, consultation, illness, injury or surgery		
(c) Been a patient in a hospital, clinic, sanatorium, or other medical facility?		
(d) had electrocardiogram, X-ray, other diagnostic test?		
(e) Been advised to have any diagnostic test, hospitalization, or surgery which was not completed.		
(f) Had a blood transfusion?		
8. Do you or your dependant(s) have any other medical insurance cover?		

I declare that the answers to the above questions are true and complete and that I have not withheld any material information and agree that such answers shall be the basis of the insurance contract . I acknowledge on behalf of all persons to be insured that benefits will not apply to treatment from any existing injuries, ailments or conditions.

I authorise the insurance Company to obtain medical information from any doctor ,hospital or clinic I have consulted and shall submit to any medical examination(s) if so required by the Company.

MEMBER NAME.....

DATE.....

.....

MEMBER'S USUAL SIGNATURE