PACIS
INSURANCE COMPANY LTD
For Comfort & Peace in Life

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HEALTH INSURANCE APPLICATION FORM

PRINCIPAL APPLICANT'S PERSONAL DETAILS: (Please give accurate details)

Title | First Name | Middle Name

Surname | Marital Status M S D W | Gender M F

ID No. | P No. | D.O.B D D M M Y Y Y Y

Code | Number

Telephone (W)

Telephone (H)

Mobile No.

E-Mail Address

Number | Postal Code | Town

Postal Address

Physical Address

Hse/Flat No. | Road | Town

OCCUPATION DETAILS:

Company Name

Date of Employment: D D M M Y Y Y Y | NHIF Number:

Number | Postal Code | Town

Postal Address:

Specific Occupation:

DEPENDANT(S) DETAILS:

No.	FULL NAME			DATE OF BIRTH	GENDER		RELATIONSHIP			LIVING WITH YOU	
	Surname	First Name	Other Names	DD/MM/YYYY	Male	Female	Spouse	Son	Daughter	Yes	No
02											
03											
04											
05											
06											
07											

Please indicate your spouse's ID

If any dependant is not living with you, please state country.....

Name of Previous medical insurer.....

MEDICAL HISTORY:

All questions **MUST** be answered to qualify for a cover (Blank spaces are not acceptable).

1. (a)Are you or any of your dependants suffering from any physical defect? **Yes** **No**
   (b) If so please state the nature of the defect.
   .....
2. (a) Are you or any of your dependants currently ill? **Yes** **No**
   (b) If so please state the nature of the illness.
   .....
3. (a)Have you or your dependants recently consulted a doctor? **Yes** **No**
   (b) If yes, state nature of illness, operation or accident (add an additional sheet if necessary)
   ..... Date.....

4. Please state if you or your dependants at any time had any of the following medical conditions. Answer **YES (Y)** or **NO (N)**.

	Medical Condition	01	02	03	04	05	06	07
a.	Asthma							
b.	Diabetes							
c.	Hypertension							
d.	Convulsions/ Epilepsy							
e.	Gastric or Duodenal Ulcers							
f.	Heart Disease							
g.	Leukemia or Sickle cell Disease							
h.	Neurological Disease							
i.	Gallstones							
j.	Psychiatric illness							
k.	Recurrent Tonsillitis							
l.	Arthritis							
m.	Fibroids							
n.	Menstrual Disorders							
o.	Cancer							
p.	Others (please specify)							

If you answered Yes to the questions above, please provide details (You may attach an extra sheet)

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5. State any allergies .....

	Medical Condition	01	02	03	04	05	06	07
6.	Do you smoke **Yes** ☐ **No** ☐							
7.	Do you consume alcohol **Yes** ☐ **No** ☐							
8.	Are you currently using medication for medical or any other reasons							
	If yes, please specify							

9. Are there any other circumstances in your current or past medical history not mentioned above which may result in hospitalization in the future? .....

.....

10. Female members only (member or spouse)

a) Has any member of your family ever delivered a child through caesarean operation? **Yes** ☐ **No** ☐

b) Is any member currently pregnant? **Yes** ☐ **No** ☐

State name, address and phone number of your medical practitioner.....

Please enroll me on the following cover option: .....

BENEFICIARY DETAILS:

(Person/entity entitled to receive funds as per cover benefits in the unfortunate event of loss of life)

Name: Middle Name:

Surname: Relationship:

ID No. P No. Mobile No.:

NEXT OF KIN DETAILS:

(Person entitled to be notified in case of emergency while member is hospitalized)

Name: Middle Name:

Surname: Relationship:

ID No. P No. Mobile No.:

DECLARATION:

I hereby apply to join the above mentioned plan. I understand that any mis-statements or non-disclosure of any material information in this form will jeopardize my membership. I warrant that the answers in this form are true, correct and complete and I acknowledge that such answers are all material.

I hereby authorize any doctor, hospital, clinic or medical provider, any company, institution or person who has record or information about me and/or my family members to provide my insurer with complete information including copies of their records with reference to my sickness or accident any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

Name:.....Signature:.....Date:.....