



CIC INSURANCE
We keep our word

THE CO-OPERATIVE INSURANCE COMPANY OF KENYA LTD.
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WRITE NAME AT THE
BACK OF EACH
PHOTOGRAPH &
ATTACH WITH A CLIP
(do not use staple or pin)

THE CIC-MEDISURE CORPORATE MEDICAL COVER Corporate member Application Form

Please complete in full block letters. Attach one recent colour passport photograph for each proposed insured, print the name and sign on the back of each.

Personal particulars / occupation of principal member

Name of Insured Company _____

Title: Mrs. Miss Other

Surname

Other names

PP/ID No. Marital Status Gender Date of Birth

Blood Group Height (cm) Weight (kg)

Postal Address E-mail address (office) _____
E-mail address (personal) _____

Tel. No. Home/ Mobile

Date of employment

Specific Occupation Designation _____ Staff/Payroll No. _____

Particulars of dependants to be included on cover

No.	Full name of dependant (Surname first)	Dependant type (Spouse / Child)	Gender (M / F)	Date of birth	Blood Group	I.D no
1						
2						
3						
4						
5						
6						
7						

Note: Kindly indicate the National I.D number for your spouse and each child above 18 years of age (Please attach copies).

Health Questions(You must complete all questions)

		YES	NO
1	Have you or your dependants been hospitalized in the last 3 years?		
2	Have you or your dependants ever had an accident resulting in a permanent injury?		
3	Do you or any of your dependants suffer from any disease that is recurrent in nature?		
4	Are you or your dependants under any regular medication?		
5	Do you or your dependants have any kind of physical disability?		

	Please state whether you or any of your dependants have ever been treated, received treatment or expects to receive treatment for any of the following conditions / illnesses:	YES	NO
6	Heart and blood vessels disorders e.g. high blood pressure, heart disease, stroke, congenital(inborn) heart conditions, chest pains, arterial disease.		
7	Blood/ circulatory disorders e.g. Sickle cell anaemia, Varicose, Thrombosis, Kidney, Liver, Haemophilia, leukemia or any other blood disorder.		
8	Respiratory disorders e.g. Bronchitis, Tuberculosis, Asthma, cigarette smoking disorder, any other respiratory related problem.		
9	Neurological disorders e.g. Meningitis, stroke, brain or spinal cord disorder, epilepsy, any other neurological related disorder.		
10	Ear, Nose and Throat related problem e.g. throat surgery, sinuses.		
11	Eye disorders e.g. cataract, glaucoma, eye surgery, blindness.		
12	Gynecological or genitor-urinary disorders e.g. Pelvic Inflammatory disease, menstrual irregularities.		
13	Kidney disorders such as kidney failure, kidney stones, recurrent infections etc.		
14	Musculoskeletal disorders e.g. arthritis, back problems, joints, gout, etc.		
15	Endocrine diseases such as diabetes, thyroid disease, high cholesterol.		
16	Surgical such as appendectomy, tonsillectomy or any other surgical procedure.		
17	Other diseases/ disorders: cancer, alcohol/drug problem, hepatitis, ulcer, mental disorder, gall bladder disease, HIV infection.		

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

Qty	Name of applicant	Ailment/ disorder	Date diagnosed	Doctor & contact address	Current status

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

18. For female applicants / spouses only:

a. Have you ever delivered a child by Caesarean operation? Yes No

b. Is any member currently pregnant? Yes No

If yes give member name _____

If pregnant state number of weeks of pregnancy _____

19. Are you or any of your dependants allergic to drug(s)/ substances? Yes No

If YES give details _____

20. Have you been on medical insurance before? Yes No

If YES give the name of the insurer/ HMO _____

I hereby apply to join the above medical scheme. 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 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, medical treatment and to allow CIC to receive extracts from such records, and I undertake to assist in obtaining such information.

Signature of Principal Member..... Date.....

Agency Name & Stamp