

CLARKSON NOTCUTT (INSURANCE BROKER) LTD.

MADISON INSURANCE HOUSE, UPPER HILL ROAD P.O. Box 30279 - 00100 GPO, NAIROBI

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INPATIENT /OUT PATIENT MEDICAL INSURANCE APPLICATION FORM

ALL INFORMATION SUPPLIED WILL BE TREATED IN STRICT CONFIDENCE.
TO BE COMPLETED IN BLOCK LETTERS IN EVERY DETAIL.

APPLICANT MR./MRS./MISS _____

ADDRESS _____

DATE OF BIRTH _____

DEPENDANTS TO BE INCLUDED IN THIS APPLICATION: -

<u>NAME</u>	<u>DATE OF BIRTH</u>	<u>RELATIONSHIP TO APPLICANT</u>
A) _____	_____	_____
B) _____	_____	_____
C) _____	_____	_____
D) _____	_____	_____
E) _____	_____	_____

NOTES:

Dependants are defined as: -

- (i) Applicant's Spouse
- (ii) Applicant's children aged from birth upto 18 years or 24 years with proof of full time schooling

DECLARATION

I hereby declare that the above information is correct and attach photos of myself and all my dependants.

Date Signature