Policy number:_____

MORTGAGE PROTECTION APPLICATION FORM

1. Name of Scheme _____

2. Applicant's full name _____Sex_____

3. Identity card/passport number_____

4. Contact details:

   Address_____

   Telephone_____Mobile No._____

5. Name of Employer _____Occupation_____

6. Date of Birth _____ Age _____

7. Income bracket: Upto shs.60,000❑ shs.60,001-199,999❑above shs.200,000❑

8. Smoker yes ❑ No ❑

9. If joint cover required:

   Name of spouse _____Occupation_____

   Date of birth _____ Age_____

   Identity card/passport number_____

   Address (if different from above) _____

   Telephone _____Mobile_____

   Smoker yes ❑ No ❑

10. Income bracket: Upto shs.60,000❑ shs.60,001-199,999❑ above shs.200,000❑

11. Amount of mortgage Kshs. _____Term_____

12. Rate of interest applicable _____% p.a.

12. Mode of payment: Direct Debit ❑ Cash ❑

13. **Bank details**

Bank_____ Branch _____A/c number_____

14. Frequency/ Premium: Single ❑ kshs._____
    monthly❑ quarterly ❑ Semi annual ❑ annually ❑ Kshs._____
    (x2.98) (x5.88) (x11.49)
15. Do you have a life policy with British American Insurance Company? _____

    If yes, policy number(s) _____

16. Please answer each of the following questions by **"YES"** or **"NO":**

    a) Have you been prevented from working within the last one year for reasons of sickness or accident? **YES/NO**
    b) Is there anything wrong with your health or physical condition? **YES/NO**
    c) Have you consulted or been treated by a Physician during the past 12 months? **YES/NO**
    d) Are you presently aware that you will have to be hospitalized? **YES/NO**
    e) Are you now pregnant? **YES/NO**
    f) Do you engage in any pastime that may render you especially liable to accident? **YES/NO**
    g) Within the last two years has any accident or ailment prevented you from working for ten days or more? **YES/NO**

17. Have you ever had

    h) Unexplained, recurrent or persistent fever or skin disorder? **YES/NO**
    i) Persistent, unexplained night sweats? **YES/NO**
    j) Unexplained weight loss? **YES/NO**
    k) Unexplained infections or swollen glands? **YES/NO**
    l) Chronic or recurrent diarrhea? **YES/NO**
    m) Persistent cough? **YES/NO**
    n) Hepatitis B or any sexually transmitted disease including genital sores or discharges? **YES/NO**

18. Have you ever had or been advised to have a blood test for AIDS or an AIDS related condition? **YES/NO**
19. Have you ever been refused as a blood donor? **YES/NO**
20. Have you received a blood transfusion within the last five years? **YES/NO**
21. Have you ever had a Life, Medical or Personal Accident insurance declined, terminated or subjected to special terms by any insurer? **YES/NO**

If your answer to any of the above questions is **"YES"** please supply full details including name and address of attending Doctor, date and exact nature of consultation or treatment, as may apply:_____
_____
_____

I declare that the answers to the above questions and the details supplied are true and complete and that I have not withheld any material information and I agree that such answers shall be the basis of the contract for assurance. I consent to the Company seeking information from any medical practitioner, hospital, clinic, insurance company or any other person who or which has any record or knowledge of my health.

Date _____ Applicant's Signature _____

Signature & Stamp of Financier_____