fortitudesacco
WE LISTEN WE CARE

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DEPENDANTS NOMINATION FORM

PERSONAL DETAILS (PRINCIPAL MEMBER)

NAME OF THE SACCO_____

NAME OF THE PRINCIPAL MEMBER_____ID. NO_____

MOBILE NO:_____EMAIL_____DATE_____

KRA PIN:_____GENDER: MALE ☐ FEMALE ☐

MANDATORY DOCUMENTS: PRINCIPAL MEMBER'S COPY OF ID AND KRA PIN & SPOUSE COPY OF ID

DEPENDANTS TO BE INSURED DETAILS

NO	DEPENDANT NAME	RELATIONSHIP	DOB(DD/MM/YYYY)	IDENTIFICATION NO/ BIRTH CERTIFICATE NO/ BIRTH NOTIFICATION NO
1				
2				
3				
4				
5				
6				
7				
8				
9				

MEDICAL DECLARATION BY APPLICANT

Have you or any of your dependants been previously diagnosed with any of the below conditions? (Answer to the best of your knowledge)

a) Cancer
b) Diabetes
c) Hypertension
d) Stroke
e) Major organ failure
f) Heart disease/Angina
g) HIV related illness

YES ☐ NO ☐

If you have answered YES to the above question, kindly provide details of the affected individual(s)

NAME	RELATIONSHIP	IDENTIFICATION NO/BIRTH CERTIFICATE NO.

TERMS AND CONDITIONS

1. Cover applies to principal member, one spouse, 4 biological children, biological parents and parents inlaw. Cover may be extended to adopted children subject to proof of legal adoption.
2. The policy pays six (6) claims per year
3. Cover commences once the premium is paid in full. Premium for any extra dependent and for any parents should be paid up front. Premiums may be reviewed annually at the discretion of the underwriter
4. There is a waiting period of 2 months from the date of commencement of the policy and subject to payment of full premium. In case of natural death within the waiting period no benefit is payable. There is no waiting period for accidental death.
5. Maximum age at entry is 80 years next birthday for parents, and 70 years for main member and spouse. There is no cover expiry age.
6. Maximum age entry for children 14day – 18yrs (upto 24years proof of schooling)
7. Multiple covers allowed up to Kshs. 1,000,000 and capped at Kshs. 500,000 for deaths arising from the above pre-existing conditions.

Authorization

I_____of Payroll/Staff No_____and Id.No_____hereby authorize Fortitude Sacco to make deductions of Ksh 250 (Two hundred and fifty only) from my salary towards payment of insurance cover of my dependents with effect from the month of _____Year_____

DECLARATION

I_____declare that I have read and understood the terms and conditions set out in this policy. I confirm that I have answered the above medical questions truthfully and consent to provision of information regarding my health and the health of my dependents and any parents covered, past or present to the Underwriter as may be required. I also confirm that the statements and particulars on this form are not misstated, and I have not withheld any material facts. I agree that this application together with any other information supplied shall form the basis of the insurance contract effected hereon.

Customer Name: _____

Customer Signature: _____Date: _____