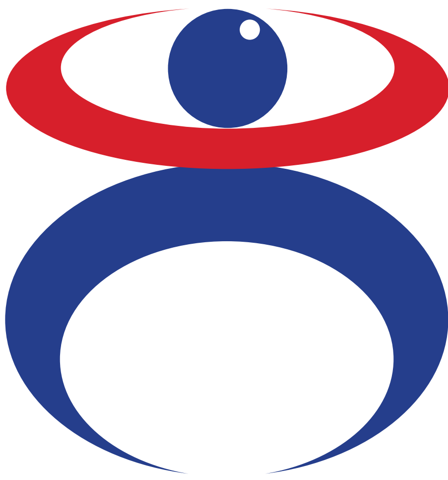
No.

FOR OFFICIAL USE ONLY

Group Reference Number	Date of Commencement	Date of Expiry
	D D M M Y Y Y Y	D D M M Y Y Y Y



RESOLUTION INSURANCE

Group Schemes Application Form

Please ensure that the Member Application Form is completed in respect of each applying member.

A. GROUP DETAILS (Please give current & accurate details for us to update you continuously & consistently)

Name of Group

Telephone Number — Code / Number

Additional Telephone No.

Fax Number

PIN Number

E-mail Address

Postal Address — Number / Postal Code / Town

Physical Address (Building)

Floor / Street / Road / Town

Describe the nature of business

Notes

CONTACT PERSON (Key liaison between Group applying and Resolution Insurance Company Limited)

Name

Designation

E-mail Address

Telephone Number — Code / Number

Mobile Number — Code / Number

B. NOTES

- A formal medical service contract must be signed between the group applying and Resolution Insurance Company Limitedd within 2 months from start date
- Complete membership application forms and photos must be forwarded for **each** applicant before start date
- Resolution Insurance Limited accepts new members from the age of 1 month to 64 years
- Applicants over 50 years of age are required to undergo a medical examination at specified clinics at their own cost
- Dependants between the ages of 18 and 25 years must produce proof of full time student status

C. DETAILS OF PREVIOUS MEDICAL SCHEME

Please provide details of your group's previous medical scheme membership

1. Name of Scheme/Plan

From: D D M M Y Y Y Y To: D D M M Y Y Y Y

2. Has your group ever been declined, loaded, or had exclusions applied to them by a medical scheme? YES NO

If 'yes' please provide details (A separate report can be attached to this application) ...

D. NUMBER OF MEMBERS & DEPENDANTS TO BE COVERED

Plan Name	Number of Staff	Number of Dependants
Inpatient		
Premier Plus		
Premier		
Executive		
Superior		
Advantage		
Hakika		
Corporate Plans		
Outpatient		
Plan 150		
Plan 100		
Plan 75		
Plan 50		
Plan 35		

Plan Name	Limit	Number of Staff	Number of Dependants
Auxillary Services			
Dental			
Optical			
Maternity			
Other			

Please note: A selection for outpatient cover MUST include the inpatient cover. However, a choice of inpatient services only is available.

Total premium for plans selected Kshs.

Payment Mode: Visa EFT IPF RTGS

I / We agree that if cheques are sent by Post Office Mail or courier I am/ We are liable for the consequence of a late payment, or non-receipt of payment by Resolution Insurance Company Limited.

Name	Name
Designation	Designation
Signature	Signature
Date	Date

The above persons must be authorized officials of the group.

F. DECLARATION

1. As a participating group we hearby apply for membership for our group members to the Resolution Insurance Company Limited, Medical Scheme.
2. On our employees' behalf, we accept:
   2.1 The benefits provided for in terms of the Medical Service Contract.
   2.2 The Medical Service Contract together with any amendments from time to time.
3. We warrant the correctness of the statements and information contained in this application and acknowledge that the correctness thereof and of all other documents submitted now or in the future by any office members or intermediary or on behalf of the employer shall constitute a condition precedent to the payment of the benefits provided for in terms of the Medical Service Contract.
4. We consent to our employees and their listed dependants participating in the contracts to which this proposal relates being called upon to submit to such medical examinations and tests as Resolution Insurance Company Limited deems necessary during the currency of the said contracts and of Resolution Insurance Company Limited addressing such requests directly to our employees or their dependants, with the same legal consequences as if such requests had been addressed to us.
5. We acknowledge and accept that Resolution Insurance Company Limited reserves the right to cancel membership if any contribution is not paid on due date.
6. We understand that Resolution Insurance Company Limited assumes no liability for any employee until such time as notice of acceptance of the risk is given by Resolution Insurance Company Limited and payments of the first premium has been received.
7. We undertake to give Resolution Insurance Company Limited immediate notice should any changes material to the assessment of this application prior to the date upon which Resolution Insurance Company Limited grants written acceptance. This will enable Resolution Insurance Company Limited to reconsider the terms of acceptance.
8. It will be the employers' duty to procure the consent in writing of all the members, of full disclosure to Resolution Insurance Company Limited, of all medical information in the possession of the Employer and of the member, whether or not it deems that information relevant or not, and whether or not that information has been expressly requested by Resolution Insurance Company Limited.

AUTHORIZED SIGNATORY(IES)

Name	Name
Designation	Designation
Signature	Signature
Date	Date

N.B. Any misrepresentation or non-disclosure of materials or factual information will render all benefits granted by the Scheme null and void. In addition any payment made due to such actions will be recovered from the member by the Scheme.

OFFICIAL STAMP

F. AGENT/BROKER DETAILS

Full name of contact at Agency /Brokerage

Name of Agency/Brokerage

Telephone Number — Code — Number

Postal Address — Number — Postal Code — Town

Email

Agent/Broker Declaration

I hereby declare that I explained the benefits of this application and that the Corporate Group contact person is aware of the membership terms and conditions of Resolution Insurance Company Limited.

Signature of Agent/Broker .... **Dated this** ____DD____ **Day of** ______MM______ **20**___YY___

RESOLUTION INSURANCE

RESOLUTION INSURANCE COMPANY LIMITED

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