Long Form Health Certificate for Juveniles

(To be used for all policies on insured's under 16 years of age)

LIBERTY
In it with you

ADVICE INSURE INVEST
Regulated by the Insurance Regulatory Authority

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Policy Number _____ Agency Code Number _____

APPLICATION FOR

Change in ☐ Plan ☐ Amount ☐ ADB ☐ AX ☐ Reinstatement

Addition of ☐ Child's Protection Agreement (CPA) ☐ Other (specify) _____

A. QUESTIONS WITH RESPECT TO CHILD

Full name of child _____

Date of birth _____ - _____ - _____
Day Month Year

1. Address of child _____

Town _____ Code _____

2. How much insurance is now in force on child? (Company & Amount) _____

_____

3. Has any company ever refused insurance on child?if yes give details ☐ Yes ☐ No

_____

4. Is any other application for insurance on child now pending or contemplated? ☐ Yes ☐ No

if yes give details

_____

5. **Child's family record**

	IF LIVING			IF DEAD	
	Age	**State of health**	**Ins. carried**	**Age**	**Cause of death**
Father					
Mother					
Brothers					
Sisters					

6. Have any of child's parents, brothers or sisters ever had tuberculosis, insanity,cancer, diabetes or syphillis? ☐ Yes ☐ No

if yes give details

_____

7. Has anyone in child's home had any contagious disease in the past three months? ☐ Yes ☐ No

if yes give details

_____

8. Has child any deformity, lameness, loss of limb, rupture, impairment of sight, speech or hearing ☐ Yes ☐ No

if yes give details

_____

9. Has child ever had any illness, accident or operation, or is any operation comtemplated? ☐ Yes ☐ No

(If yes give full details with name and address of attending physician?

10. Is Child now under observation or taking treatment or medication for any disease or disorder? ☐ Yes ☐ No

if yes give details

11. Do you intend to seek medical advice, treatment or to have any medical tests performed in respect to the child? ☐ Yes ☐ No

if yes give details

12. AIDS (Acquired Immune Deficiency Syndrome) Questions:

a. Have you received medical advice or treatment in connection with AIDS or an AIDS-related condition or a sexually transmitted disease? ☐ Yes ☐ No

b. Have you been told you had AIDS or an AIDS-related complex? ☐ Yes ☐ No

c. Have you had or been told you had a positive blood test for antibodies to the AIDS virus (Human Immune Deficiency virus)? ☐ Yes ☐ No

d. Do you have any of the following which are unexplained : fatigue, Weight Loss, Diarrhoea, enlarged Lymph nodes or unusual skin lesions? ☐ Yes ☐ No

(If yes to any questions give full details)

13. What is child's exact height? ☐ feet ☐ inches

What is child's exact weight ? (in ordinary clothes) ☐ lbs or kilos

14. Is child in good health to the best of your knowledge? ☐ Yes ☐ No

if no give details

B. QUESTIONS WITH RESPECT TO APPLICANT DETAILS

1. Full name of applicant

Gender ☐ Female ☐ Male Date of birth ☐ Day – ☐ Month – ☐ Year

2. Place of birth

3. Residence address

Town Code

4. Occupation:

Telephone number Email

5. Send premium notices to ☐ Residence ☐ Business

6. What payment have you made with this

C. QUESTIONS WITH RESPECT TO APPLICANT IF CHILD'S PROTECTION AGREEMENT IS REQUESTED

1. How much insurance is in force on your life and in what companies?

2. Has any application for life, accident or health insurance or reinstatement of any such insurance on your life ever been declined, postponed or rated? ☐ Yes ☐ No

if yes give details

3 a. Have you during the past 3 years taken any aerial flights other than as passenger on commercial airlines, or do you contemplate any such flights? ☐ Yes ☐ No

b. Have you EVER flown as a pilot or student pilot? ☐ Yes ☐ No

(If answer to either question is "yes" aviation supplement is required)

4. Have you ever had or been told you had Pleurisy, tuberculosis, heart trouble, syphillis or any ulcer or tumor on any part of the body? ☐ Yes ☐ No

if yes give details

5. Have you ever had or been told you had high blood pressure, albumin or sugar in the urine? ☐ Yes ☐ No

if yes give details

6. Do you now or have you ever had any deformity, spinal curvature lameless, loss of limb, rupture, impairment of sight, speech or hearing? ☐ Yes ☐ No

if yes give details

7. **Applicant's family record**

	IF LIVING			IF DEAD	
	Age	**State of health**	**Ins. carried**	**Age**	**Cause of death**
Father					
Mother					
Brothers					
Sisters					

8 a. Have you been associated during the past two years with anyone having tuberculosis? ☐ Yes ☐ No

if yes give details

b. Have your parents, or any of your brothers or sisters ever had tuberculosis, insanity, cancer or diabetes? ☐ Yes ☐ No

if yes give details

9. Have you ever had any illness or operation, or is any operation contemplated? ☐ Yes ☐ No

(If yes give details with name and address of attending physician?

10. Are you now under observation or taking treatment or medication for any disease or disorder? ☐ Yes ☐ No

if yes give details

11. Do you intend to seek medical advice, treatment or have any medical tests performed? ☐ Yes ☐ No

if yes give details

12. **AIDS (Acquired Immune Deficiency Syndrome) Questions:**

a. Have you received medical advice or treatment in connection with AIDS or an AIDS-related condition or a sexually transmitted disease? ☐ Yes ☐ No

b. Have you been told you had AIDS or an AIDS-related complex? ☐ Yes ☐ No

c. Have you had or been told you had a positive blood test for antibodies to the AIDS virus (Human Immune Deficiency virus)? ☐ Yes ☐ No

d. Do you have any of the following which are unexplained : fatigue, Weight Loss, Diarrhoea, enlarged Lymph nodes or unusual skin lesions? ☐ Yes ☐ No

If yes to any questions give full details

13. What is the applicant's exact height? ☐

What is the applicant's exact weight? (in ordinary clothes) ☐

14. Is the applicant in good health to the best of your knowledge? ☐ Yes ☐ No

If no give details

I HEREBY DECLARE, on behalf of myself and of any person who shall have or claim any interest in said policy, that each of the above answers is full, complete and true, and agree that they shall be taken as the exclusive basis of the reinstatement, change or issue of the insurance to which this application relates, and that such reinstatement, change or issue shall not be considered as effected by reason of any cash paid or settlement made in payment of or on account of the amount now due until this application shall be duly approved at the head office of the Company, or that the receipt, retention, deposit or cashing of any such payment or settlement by the Company or its agent shall not constitute a waiver, forfeiture, or otherwise affect this condition. Notwithstanding any provision to the contrary in the said policy I further agree that the policy, if reinstated or modified in such manner as to increase the risk, shall become contestable but shall be incontestable after it has been in force during the lifetime of the insured for two years from the date of this application, except for non payment of premium. I further agree that my acceptance of any policy issued on this application shall be a ratification of any correction in or addition to this application made in the space provided for head office endorsements.

I have paid _____on account of charge for reinstatement, change or issue of insurance under Policy No_____ in accordance with the provisions of the conditional receipt bearing the number of this application

Dated at _____this_____ day of _____

Applicant Signature _____

PART 2A CHILD'S MEDICAL EXAMINATION

(To be completed by authorized Medical Examiner when required under Company's rules)

1. Does child's appearance indicate good health and normal mental and physical development? ☐ Yes ☐ No
2. Is child deaf, dumb, blind, maimed or deformed in any way? ☐ Yes ☐ No
3. Do you find evidence of disease of the respiratory organs, heart or blood vessels? ☐ Yes ☐ No
4. Do you find evidence of disease of the stomach or abdominal organs? ☐ Yes ☐ No
5. Exact height ☐ feet ☐ inches (in shoes) Did you measure? ☐ Yes ☐ No

   Accurate weight ☐ lbs. (ordinary clothes) Did you weigh? ☐ Yes ☐ No
6. **Pulse per minute**

Rate at rest	Number of any	
	Intermissions	**irregularities**

7 a. **Urinalysis**

If child has attained age five		
Specific gravity	**Sugar**	**Albumin**

b. Are you satisfied that specimen is authentic? ☐ Yes ☐ No

8. Do you find any signs, symptoms or history which may relate to AIDS or an AIDS-related complex? ☐ Yes ☐ No
9. In your opinion, is there anything detrimental to the risk other recorded above? ☐ Yes ☐ No

REMARKS

Medical Examiner _____ Date ☐ Day – ☐ Month – ☐ Year

PART 2B APPLICANT'S MEDICAL EXAMINATION IF CHILD'S PROTECTION AGREEMENT IS REQUESTED

(To be completed by authorized Medical Examiner when required under Company's rules)

1. Do you find evidence of past or present disease of lungs or pleurae? ☐ Yes ☐ No
2. Do you find evidence of past or present disease of heart or blood vessels? ☐ Yes ☐ No
3. **Pulse per minute**

Rate at rest	Number of any	
	Intermissions	**irregularities**

4. **Blood Pressure**

Systolic	5th Phase	
	4th Phase	**irregularities**

5. Do you find evidence of past or present disease of the stomach or abdominal organs? ☐ Yes ☐ No
6. Exact height ☐ feet ☐ inches (in shoes) Did you measure? ☐ Yes ☐ No

   Accurate weight ☐ lbs. (ordinary clothes) Did you weigh? ☐ Yes ☐ No
7. Do you find evidence of a hernia? ☐ Yes ☐ No

If so, state kind and if securely retained by truss

8. Is there any deformity, impairment of sight or hearing or loss of any part of any member? ☐ Yes ☐ No

9. Are the reflexes normal? (Test pupils, knee jerks and for Romberg's sign) ☐ Yes ☐ No

10. a. **Urinalysis**

If child has attained age five		
Specific gravity	**Sugar**	**Albumin**

b. Are you satisfied that specimen is authentic? ☐ Yes ☐ No

11. Do you find any signs, symptoms or history which may relate to AIDS or an AIDS-related complex? ☐ Yes ☐ No

12. In your opinion, is there anything detrimental to the risk other than recorded above? ☐ Yes ☐ No

REMARKS

CONSENT & DECLARATION

I/We consent to Liberty Life Assurance Kenya Limited:

(i) Collecting, using, disclosing and/or processing and/or storing my/our personal data for purposes that are relevant to my policy and as permitted by law;

(ii) Collecting and sharing my personal data in accordance with the privacy statement on its website (https://www.liberty.co.ke/);

(iii) Transferring my/our personal data to their reinsurers and affiliated companies for the purposes of insurance and as permitted by law;

(iv) And/or its contracted Third parties contacting me via email/phone-call/SMS/post in regard to insurance products and/or services.

I/We hereby declare the truth and correctness of the above statements and agree that this Declaration shall be held to be promissory and the basis of the contract between me/ us and Liberty Life Assurance Kenya Limited.

I/We hereby declare the truth and correctness of all the statements and particulars entered in this request and that I have not withheld any material information, and that my/our answers herein are in my/our full knowledge and have been written by me/us or with my/our full authority.

Medical Examiner _____ Date ☐☐ - ☐☐ - ☐☐☐☐
Day *Month* *Year*

INSTRUCTIONS TO AGENT

- Part I, Section A (Child) and B (Applicant) - must always be completed by the Agent.
- Part I, Section C (Applicant) - To be completed by Agent whenever CPA, DPR or EPR are to be added or reinstated.
- Part II, Section A (Child) - To be completed by Medical Examiner at no expense to the Company when (1) Policy is being changed to a lower premium plan for the same amount of protection and amount of policy exceeds the non medical limits; (2) Amount of protection is being increased to an amount exceeding the non medical limits; (if amount in (1) and (2) is over Ksh. 500,000 use Form C-3 instead) (3) Reinstatement is requested and premium is collected later than three months from the due date provided policy was originally issued on a medical basis; and (4) Upon request from the Head Office of the Company.
- Part II, Section B (Applicant) - To be completed by Medical Examiner at no expense to the Company when (1) Addition of Child's Protection Agreement is requested if the amount of the Policy exceeds the non medical limits; (if amount is over Kshs. 500,000 use Form C-3 instead) (2) Reinstatement of Child's Protection Agreement is requested and premium is collected later than three months from the due date provided policy was originally issued on a medical basis; and (3) Upon request from the Head Office of the Company.

CONDITIONAL RECEIPT

Received of_____. the sum of _____on account of charge for reinstatement, change or issue of insurance under Policy

No_____, issued by the Liberty Life Assurance Limited upon the life of _____reinstatement, change or

issue shall not take the effect until application therefor, dated the _____ day of _____ Shall be duly approved at the head office. The receipt, retention, deposit, or cashing, or other use by the Company or its agent of said sum shall not in any manner affect this condition. If the Company declines such application, the consideration received will be returned on surrender of this receipt

_____
Agent or Cashier

NOTICE

This is a temporary receipt only. If the reinstatement or change requested is approved, a regular receipt signed by an executive officer of the Company and countersigned by the Agency Cashier will be given to you.

If you do not hear from the Company in relation to the insurance within sixty days, notify the Company at its Head Office, P.O. Box 30364 - 00100 Nairobi, Kenya.