

**ANAYA POST-RETIREMENT HEALTHCARE FUND APPLICATION FORM**

- Please complete this application form in black ink.
- Kindly fill the form in BLOCK capitals.
- This form must be completed after reading through the product brochure.

**Please note:** We cannot process your application if it is incomplete, incorrect or the correct documents have not been attached.

**SECTION 1: CHOOSING YOUR OPTION**

Please select one Benefit Option only.

PLATINUM     GOLD     SILVER     BRONZE

**SECTION 2: INTERMEDIARY DETAILS**

Name of Broker/agent

Broker code

Telephone

Cell phone

Email



This section to be completed by the broker or agent if applicable.

- 1 I declare that I am an accredited healthcare broker contracted to Enwealth Financial Services Limited as a financial advisor and that I am licensed by the Insurance Regulatory Authority (IRA).
- 2 I acknowledge that the applicant has appointed me as his / her financial advisor and that he/she is entitled to cancel my services at any time. I confirm that the applicant was provided with my personal details, physical and postal address and telephone number.
- 3 I acknowledge that there has been no material misrepresentation of any fact by me and that in the event of material misconduct or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation or conduct.
- 4 I declare that the applicant is familiar with the information requested in the application form and all the relevant information was provided by the applicant. The advice and assistance given to the applicant was impartial and in the best interest of the applicant.

Signature of Broker/ Agent: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_



**SECTION 3: DETAILS OF PRINCIPAL MEMBER**

Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Title	<input type="text"/>	Surname	<input type="text"/>
Other Names	<input type="text"/>		
Nationality	<input type="text"/>	ID/PP No.	<input type="text"/>
NSSF No.	<input type="text"/>	NHIF No.	<input type="text"/>
KRA PIN	<input type="text"/>	D.O.B	<input type="text"/>
Marital Status	<input type="text"/>	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
Cell Phone	<input type="text"/>	Other	<input type="text"/>
Telephone	<input type="text"/>		
Email:	<input type="text"/>		
Postal Address:	<input type="text"/>	Code	<input type="text"/>
Physical Address	<input type="text"/>		

*(Please Complete Section 4 if the Contribution is through your employer)*

**SECTION 4: EMPLOYER INFORMATION**

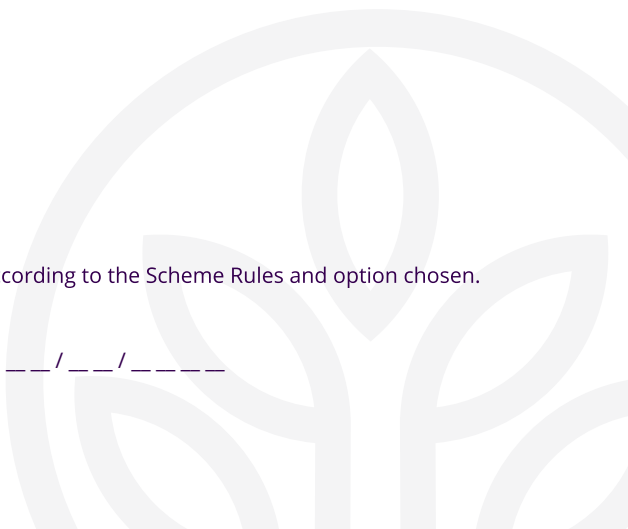
Name of employer	<input type="text"/>
Name of company representative	<input type="text"/>
Job title of company rep	<input type="text"/>
Representative: Telephone	<input type="text"/>
Email	<input type="text"/>
Fund's pay point code	<input type="text"/>



We confirm that the applicant is employed by us. Contributions are being deducted according to the Scheme Rules and option chosen.

Signature of employer representative: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_



## SECTION 5: DETAILS OF NEXT OF KIN

I hereby nominate the following as beneficiaries under this product in the event of my demise prior to retirement and any benefits accrued thereafter.

Next of Kin				
Name	Address	ID No	% Share	Relationship

## SECTION 6: DETAILS OF GUARDIAN

*(Please provide the details of guardian if the nominee is less than 18 years)*

Guardian Details		
Guardian Name	Guardian ID No	Relationship

### REQUIRED DOCUMENTS

Kindly provide the following documents together with duly filled application form;

- Copy of National ID/Passport
- Copy of Pin Certificate
- Clear and Colored Passport photos

## SECTION 7: PROTECTION OF YOUR INFORMATION

- 1 We will keep your information confidential. The fund administrator and the underwriter have data security measures in place to do this. Personal information refers to information that identifies you or relates specifically to you or your dependants, such as an identity number, name or email address
- 2 We have data security measures in place to protect your personal information. This may include access control to restrict the disclosure of personal information to only authorized individuals, confidentiality agreements with service providers and staff members.
- 3 We will only use your information for the following purposes:
  - Fraud prevention and detection
  - Statistical analysis
  - Audit and record-keeping purposes
  - Compliance with legal and regulatory requirements
  - Verifying your identity
  - Any other legally permissible for the mutual benefit of the fund.
- 4 We may share your information with the service providers for the purpose of processing it and rendering services to you.
- 5 You may access the personal information we hold and request us to correct any errors or delete it.

In partnership with:



**APOLLO ASSET  
MANAGEMENT**

and





## SECTION 8: ACKNOWLEDGEMENT AN DECLARATION

- 1 I, the undersigned, apply to be admitted as a member of the fund. If accepted, I agree to abide by the rules of the Fund. I know that the rules are available on [www.enwealth.co.ke](http://www.enwealth.co.ke) and will be provided to me upon my request to the fund administrator.
- 2 I declare that any false information in this application form or the non-disclosure of any material information will result in my membership being declared null and void.
- 3 I accept that the fund administrator has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation or fraudulent behavior.
- 4 If any of my or my circumstances changes after the date of signing of this application or the acceptance of my membership, I will promptly notify the fund administrator of the changes.
- 5 I instruct and allow my employer to deduct and pay over amounts (that may become owing or due on my behalf) to the fund from time to time to fund my benefits.
- 6 I agree that should the fund administrator incur any legal costs or expenses to recover any contributions owed by me or any other amount due by me to the fund for any reason; I shall be responsible for such costs and expenses on the attorney / Administrator's scale.
- 7 I authorize the fund administrator to disclose information to the fund and its contracted service providers and partners.
- 8 I agree to provide the fund administrator with any medical or historical information and grant the fund administrator's access to medical information reasonably specific ailment, disease, disorder, condition or disability. required relating to a
- 9 I understand that Healthcare underwriting terms shall apply which may include premium and vary from time to time.
- 10 I allow fund administrator to take all reasonable steps to verify information provided by me in this application form and agree to submit proof of identification to the fund on demand.
- 11 I declare that the information provided in this document is true, consistent and accurate and if accepted will form the basis of my agreement with the fund administrator.
- 12 I acknowledge that I have read and understood the content of this application form. I confirm that the content of this application form and the implications thereof have been read and explained to me.

Contribution Commencement Date: \_\_\_/\_\_\_/\_\_\_\_\_

Signature of Principal Member: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_\_

In partnership with:



**APOLLO ASSET  
MANAGEMENT**

and

