

KENTOURS REGULATED NON-WDT SACCO SOCIETY LTD

1st Floor Commodore Office Suites, Kindaruma Road, Kilimani, Nairobi.
P.O. Box 79333 - 00200 Nairobi. Telephone: 0709 309 000. Cell: 0722 968 596, 0733 667 596.
Website: www.kentours.co.ke. E-mail: info@kentours.co.ke.

CIC COOPCARE LOAN APPLICATION AND PROPOSAL FORM

Office R/No	Date received in office	
A. PERSONAL DETAILS		
Full Name	LD/Passport No(A	Attach Copy)
KRA Pin(Att	tach Copy) Membership Number Payroll Numb	er
Age Physical Address (Home/Estate/Stre	reet/House Number)	
CountySub-Count	tyLocation	
P.O. Box	nil	
B. <u>LOAN DETAILS</u> (Please state the loan ar	mount (See Note 10).	
	Amount in words (Kshs):	
	Maximum 8 Months)- Put after amount in figures	
Total Coopcare Premium		
Administration fee	100.00	
Excise duty 20% of Administration fees	20.00	
Total Loan Amount		
C. EMPLOYMENT DETAILS		
Employer:		
Physical Address / Station:	Office Telephone:	
Your Designation:	Department:	
Member's Signature	Date	
N/B: F0	ORGERY IS A CRIMINAL OFFENCE	

D. BUSINESS DETAILS (FOR NON-EMPLOYED MEMBERS)
Name of Business:
Nature of business: Expected monthly income:
Physical Address: Postal Address:
Telephone Number:
E. <u>ALTERNATIVE CONTACT</u> (should not be a spouse or guarantor(s)See Note 7)
Name:
Email:
F. TO BE COMPLETED BY ACCOUNTS DEPARTMENT (applicant not authorized to sign)
Gross Salary Outstanding Company loans
NameSignature
Designation
Date
G. TO BE COMPLETED BY PERSONNEL DEPARTMENT
I certify that the company has no objection to this loan application and further agrees to effect the requirements of
the loan agreement in favour of KENTOURS SACCO SOCIETY LTD
If there is any objection, please specify
Name
Date Official Stamp

NOTES:

- 1. This Form is for CIC Coopcare Loan only. The approved amount will be paid by Kentours Sacco to CIC General Insurance Ltd.
- 2. The Form must be filled in full. Attach a coloured passport-size photograph (do not use staple or pin), copy of ID or Passport and copy of KRA PIN certificate.
- 3. The payslip must be current and signed/stamped by the employer. For individual member (not in employment), one must provide 3 months certified bank statement (management may request for additional information).
- **4.** A new member is eligible for the loan after 6 months.
- 5. The interest rate is 1% per month, calculated on reducing balance basis and charged on the 20th of every month.
- **6.** Cancellations/alterations/incompleteness can cause delay in processing of the loan application.
- 7. An alternative contact is a person through whom the loanee can be reached besides his/her spouse or guarantor(s).
- 8. The insurance scheme only covers dependants who are members of the nuclear family i.e., one spouse and children. At the point of joining the scheme, the principal member and the spouse must not be over 70 years of age. Eligibility age for children is 37 weeks to 18 years. Children above 18 years up to 25 years are covered subject to proof of full dependence on the parents. There is no age limit for children with disabilities.
- **9.** The loan applied should not exceed three and half (3.5) times deposits.
- **10.** The loan amount will depend on the number of people to be insured and the preferred benefits per tables A, B and C below, subject to a maximum of Ksh. 50,000.
- 11. A detailed write-up on the product is available on Kentours Sacco website (www.kentours.co.ke)

PREMIUM RATES

Table A All benefits

	All benefits (Inpatient, Outpatient, Maternity, Dental, Optical and Last Expense)								
Plan	Member Only	Tick	Member Plus upto 6 Dependants	Tick	Premium per Additional Dependant(s) above 6				
Option 1	7,500		26,700		3,600				
Option 2	8,500		31,600		4,100				
Option 3	9,500		36,000		4,600				

Number of additional dependant(s)

Table B Inpatient Only

Table D	inpatient Omy							
Inpatient only (Inpatient, Maternity and Last Expense)								
Plan	Member Only	Tick	Member Plus up to 6 Dependants	Tick	Premium per Additional Dependant(s) above 6			
Option 1	2,500		7,300		1,100			
Option 2	3,200		10,800		1,400			
Option 3	3,800		12,700		1,700			

Number of additional dependant(s)

BENEFITS

Table C Benefits

Plan	Inpatient	Outpatient	Maternity	Dental	Optical	Last Expense	Accommodation (Net of NHIF)	Tick
Option	Family	Family	Family	Family	Family	Family	Bed Type	
Option 1	100,000	30,000	15,000	5,000	5,000	50,000	Ward Bed	
Option 2	200,000	40,000	20,000	5,000	5,000	50,000	Ward Bed	
Option 3	300,000	50,000	25,000	7,500	7,500	50,000	Ward Bed	

H. <u>SECURITY OFFERED</u>

Authority to Deduct My Salary, Hold My Deposits, Terminal Benefits and Dispose My Assets

I hereby authorize the Society to deduct my salary to pay the amount of loan granted to me on monthly basis under the terms which the loan is given until it is cleared in full. Should I leave employment before completion of repayment, or default to pay, I hereby authorize the loan balance to be deducted from my deposits in the society, my terminal benefits, attaching any other property that I have given towards the loan, demand savings and attaching guarantors. Also, should I leave the current employment, I authorize recovery of any outstanding loan from future employment.

I. LOANEE'S DECLARATIONS

- a. In connection with the application and/or maintaining a credit facility with Kentours Sacco, I authorize the Sacco to carry out credit checks with or obtain my credit information from, a credit reference bureau. In the event of account going into default, I consent to my name, transaction and default details being forwarded to a credit reference bureau for listing. I acknowledge that this information may be used by banking institutions and other credit grantors in assessing application for credit by name, associated companies, and supplementary account holders and for occasional debt tracing, fraud prevention purposes and/or for any other lawful purposes.
- b. In support of my loan application, I declare that the above information is true to the best of my knowledge. I understand that if any of the information I have provided proves to be false, it will lead to the automatic decline of my application. If it is found out that any information I have provided proves to be false after disbursement, the Sacco has the right recall the loan.

c. Consent to Process, Store and Share Personal Data

I hereby consent to the collection, processing, storage and sharing of the personal data that I have provided for the purpose of maintaining my Sacco membership. I understand that this data may be made available to the Sacco's partner organizations or individuals for lawful purposes. I shall indemnify the Sacco against any loss or injury arising out of any claim as a result of processing, storing and sharing of such data.

Loanee's Name	.Signature	ID No	Loan Amount ((Kshs))	Date
Bounce of turne	. 515114141 6	1122 1 (6) 111111111111111111111111111111111	Louis simount ((,	Dave

J. <u>GUARANTORS</u>

i) Repayment Guarantee

We, the undersigned guarantors hereby accept jointly and severally liability for the repayment of the loan in the event of the loanee's default. We understand the amount may be recovered by an offset against our deposits in the society or by attachment of our salaries or properties and that we shall be liable for the defaulted loans to the tune of the amount guaranteed.

- ii) We understand and accept that the Credit & Risk Management or Administration & Finance committee may approve a lesser amount of loan than applied for, if the member does not qualify for the amount applied.
- iii) Guarantors are **strongly advised** to read all the information provided in this form by the applicant and terms and conditions contained herein, so as to understand the full implications of signing this part.

	GUARANTOR NAME	EMPLOYER	ID NO.	PHONE	M/NO.		OUNT GUARANTEED	DATE	SIGNATURE
	(Must be a Member)			NO.		FIGURES	WORDS		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									

Loanee's N	ame	Sign	ID/Passport No	Loan Amount (Kshs)	Date
		C	1	, ,	
a		O.CC \ N	a:		D .
Guarantors '	Verification (Kent	ours Office): Nam	e Signature	·	Date

CIC GENERAL INSURANCE LTD.



Name of Insured Company



Please complete in block letters. Attach one recent colour passport photograph for each proposed insured, write the name and sign on the back of each.

(PLE. S

WRITE NAME AT THE BACK
OF EACH PHOTOGRAPH AND
ATTACH WITH A CLIP

(PLEASE, DO NOT USE STAPLE OR PIN)

Persona	l Particul	lars of T	he Ap	plicant

			_			Day Month	Year
TITLE	Mr. Mrs. Miss. Other		PROPO	DSAL COMMENC	EMENT DATE		
SURN	AME OTHER NAMES					ID/PASSPORT NU	MBER
GEND	ER MARITAL STATUS DATE OF BIF	RTH	МОВ	ILE NUMBER		ALTERNATIVE PHO	ONE NUMBER
POSTA	AL ADRESS POSTAL CODE	TOWN OF RESIDENC	E	EMAIL	ADRESS (OFFIC	CE)	
EMAIL	ADRESS (PERSONAL)	HEIGHT(CM)		WEIGH	T(KG)	BLO	OOD GROUP
						Α	AB O A B
SPECI	FIC OCCUPATION/DESIGNATION	DATE OF EMPLOYME	ENT		STAFF PA	YROLL No.	
	articulars of Dependants To Be			ERSHIP No.			
No.	Full Name or Dependant (Surname First)	Dependant type (Spouse/Child)	Gender (M/F)	Date of Birth	Blood Group	I.D No.	PIN No.

Г	Health Questions (You Must C	omplete All Que	stions)		
1.	Has any of you or your above dependant	s been hospitalized in	the last 3 years?		Yes No
2.	Have any of you or your above dependar	nts ever had an acciden	it resulting in a per	manent injury?	Yes No
3.	Do any of you suffer from any disease th	at is recurrent in natur	e?		Yes No
4.	Are any of you on regular medication?				Yes No
5.	Do any of you have any kind of physical o	lisability?			Yes No
Ple or e	ase state whether any of you propose expects to receive treatment for any o	d for inclusion on cove f the following condi	er has ever been t tions / illness:	reated, received treatment	
6.	Heart and Blood vessels disorders e.g. hi conditions, chest pains, arterial disease.	gh blood pressure, hea	art disease, stroke,	congenital (inborn) heart	Yes No
7.	Yes No				
	Respiratory disorders e.g. Bronchitis, Tul related disorder.	perculosis, Asthma, cig	arette smoking dis	order, any other respiratory	Yes No
9.	Neurological disorders e.g. Meningitis, s related disorder.	troke, brain or spinal c	ord disorder, epile	osy, any other neurological	Yes No
10.	Ear, Nose and Throat related problem e.	g. throat surgery, sinu	ses.		Yes No
11.	Eye disorders e.g. cataract, glaucoma, ey	e surgery, blindness.			Yes No
12.	Gynecological or genitor-urinary disorde	ers e.g. Pelvic Inflamma	atory disease, mens	trual irregularities.	Yes No
13.	Kidney disorders such as kidney failure,	kidney stones, recurre	nt infections etc.		Yes No
14.	Musculoskeletal disorders e.g. arthritis,	back problems, joints,	gout, etc.		Yes No
15.	Endocrine diseases such as diabetes, thy	roid disease, high chol	esterol.		Yes No
16.	Surgical such as appendectomy, tonsille	ctomy or any other sur	gical procedure.		Yes No
17.	Other diseases/ disorders: cancer, alcoh disease, HIV infection.	ol/drug problem, hepa	titis, ulcer, mental	disorder, gall bladder	Yes No
IF v	ou answered YES to any of the questio	os 1 to 17 kindly sive	moso dotails in t	ha babla balaw	
и у	od allswered TL3 to ally of the question	ons 1 to 17, kindly give	inore decaits in the	ne table below.	
No	Name of Applicant	Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	Current status
					Current status
					Current status
					Current status
					Current status
No		Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	Current status
No If to	Name of Applicant	Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	Current status Yes No
No If to 18.	Name of Applicant he space is not adequate, fill in a separ	Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	
If the state of th	Name of Applicant he space is not adequate, fill in a separ For female applicants / spouses only: a) Have you / your spouse ever delivered	Ailment/ Disorder Tate plain paper and s a child by Caesarean o	Date Diagnosed taple it to the fore	Doctor & Contact Address	
If the state of th	Name of Applicant he space is not adequate, fill in a separ For female applicants / spouses only: a) Have you / your spouse ever delivered res please give member name: b) Is any member currently pregnant?	Ailment/ Disorder Tate plain paper and s a child by Caesarean o	Date Diagnosed taple it to the fore	Doctor & Contact Address	Yes No
If the state of th	Name of Applicant he space is not adequate, fill in a separ For female applicants / spouses only: a) Have you / your spouse ever delivered res please give member name: b) Is any member currently pregnant? If yes please state number of weeks of p Is any of you allergic to drugs?	Ailment/ Disorder Tate plain paper and s a child by Caesarean o	Date Diagnosed taple it to the fore	Doctor & Contact Address	Yes No Yes No
16 to 19. If your 19.	Name of Applicant he space is not adequate, fill in a separ For female applicants / spouses only: a) Have you / your spouse ever delivered res please give member name: b) Is any member currently pregnant? If yes please state number of weeks of p Is any of you allergic to drugs?	Ailment/ Disorder Tate plain paper and s a child by Caesarean corregnancy	Date Diagnosed taple it to the fore	Doctor & Contact Address	Yes No Yes No
If to 18. If you 20.	Name of Applicant he space is not adequate, fill in a separe For female applicants / spouses only: a) Have you / your spouse ever delivered the splease give member name: b) Is any member currently pregnant? If yes please state number of weeks of p Is any of you allergic to drugs? es give details	Ailment/ Disorder Tate plain paper and s a child by Caesarean coregnancy	Date Diagnosed taple it to the fore	Doctor & Contact Address	Yes No Yes No
If the second se	Name of Applicant he space is not adequate, fill in a separ For female applicants / spouses only: a) Have you / your spouse ever delivered res please give member name: b) Is any member currently pregnant? If yes please state number of weeks of p Is any of you allergic to drugs? es give details Have you been on medical insurance bel es give the name of the Insurer/HMO, ex reby apply to join the above medical scheme. I cealed or withheld any material information v eby authorize the hospitals, medical or dental ords relating to such current or previous hospit bitaining such information. igning this proposal form I hereby grant CIC C sonal information/ data, for the purpose of per e by writing directly to the Insurer and that such	Ailment/ Disorder Tate plain paper and s a child by Caesarean corregnancy Fore? piry date and special e understand to the best of which the underwriter ou practitioners who have t alizations, medical treatm iseneral Insurance Limited forming the insurance cor th a withdrawal may affec	peration? xclusions: my knowledge and b ght to know inorder reated me or any of rent and to allow CIC to (the Insurer) and all intract as per my proposit the ability of the insurer in the solution of the contract of of the	elief that all the answers given above to assess me or my family member my dependants to disclose to CIC Coreceive extracts from such record ts contracted third-party processor is al herein. I am aware that I may wurer to provide the Insurance cover	Yes No Yes No Yes No Yes No Yes No Yes No Indicate the service of
If the second se	Name of Applicant he space is not adequate, fill in a separ For female applicants / spouses only: a) Have you / your spouse ever delivered res please give member name: b) Is any member currently pregnant? If yes please state number of weeks of p Is any of you allergic to drugs? es give details Have you been on medical insurance bel es give the name of the Insurer/HMO, ex reby apply to join the above medical scheme. I cealed or withheld any material information v eby authorize the hospitals, medical or dental ords relating to such current or previous hospit bitaining such information. igning this proposal form I hereby grant CIC C sonal information/ data, for the purpose of per e by writing directly to the Insurer and that such	Ailment/ Disorder Tate plain paper and s a child by Caesarean conception of the best of which the underwriter ou practitioners who have the alizations, medical treatmost in the insurance conception of the property of the	peration? xclusions: my knowledge and b ght to know inorder reated me or any of rent and to allow CIC to (the Insurer) and all intract as per my proposit the ability of the insurer in the solution of the contract of of the	Doctor & Contact Address The lief that all the answers given above to assess me or my family member my dependants to disclose to CIC Correceive extracts from such record tts contracted third-party processor is all herein. I am aware that I may we	Yes No Yes No Yes No Yes No Yes No Yes No Indicate the service of

Note: Kindly indicate the National I.D number for your spouse and each child above 18 years of age. (Please attach copies)

CIC GENERAL INSURANCE LTD.

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