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 ……..…..……..…….ID/Passport No……

KRA Pin ……..……. Membership Number……. Payroll Number……..

Age…… Physical Address (Home/Estate/Street/House Number) ……..……...…….

County ……..Sub-County…….…..…… Location……..

P.O. Box……..… Code…… E-mail ……. Telephone (Private) ……..…...……

B. LOAN DETAILS (Please state the loan amount (See Note 10).

Amount in figures (Ksh.) ……Amount in words (Kshs): ……...……

……..…

Repayment period (in months) …… (Maximum 8 Months)- Put after amount in figures

Loan Application Amount (Ksh.):

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: FORGERY 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:…….……Business Capital/Equity(Ksh.):……

E. ALTERNATIVE CONTACT (should not be a spouse or guarantor(s)See Note 7)

Name:…….……Telephone No:…….

Email:……..Relationship: ……

F. TO BE COMPLETED BY ACCOUNTS DEPARTMENT (applicant not authorized to sign)

Gross Salary…….. Outstanding Company loans…….. Net Salary……...

Name…….. Signature…….

Designation…….. Official Stamp……

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…….. Designation……. Signature…….

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 Card or Passport and copy of KRA PIN Certificate if not previously provided.
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

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. SECURITY OFFERED

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……

J. GUARANTORS

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

Loanee's Name ……. Sign……..…… ID/Passport No…….. Loan Amount (Kshs)……..….. Date……

Guarantors Verification (Kentours Office): Name……. Signature…… Date……..

CIC GENERAL INSURANCE LTD.

CIC COOPCARE
PROPOSAL FORM

CIC GROUP

WRITE NAME AT THE BACK OF EACH PHOTOGRAPH ANDATTACH WITH A CLIP

(PLEASE, DO NOT USESTAPLE OR PIN)

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

Personal Particulars of The Applicant

Name of Insured Company _____

TITLE Mr. ☐ Mrs. ☐ Miss. ☐ Other ☐ PROPOSAL COMMENCEMENT DATE Day ☐☐ Month ☐☐ Year ☐☐☐☐

SURNAME ☐☐☐☐☐☐☐☐☐☐ OTHER NAMES ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ID/PASSPORT NUMBER ☐☐☐☐☐☐☐☐☐☐

GENDER ☐ MARITAL STATUS ☐☐☐☐☐☐ DATE OF BIRTH ☐☐ ☐☐ ☐☐☐☐ MOBILE NUMBER ☐☐☐☐☐☐☐☐☐☐ ALTERNATIVE PHONE NUMBER ☐☐☐☐☐☐☐☐☐☐

POSTAL ADRESS ☐☐☐☐☐☐ POSTAL CODE ☐☐☐☐☐ TOWN OF RESIDENCE ☐☐☐☐☐☐☐☐☐☐ EMAIL ADRESS (OFFICE) ☐☐☐☐☐☐☐☐☐☐

EMAIL ADRESS (PERSONAL) ☐☐☐☐☐☐☐☐☐☐ HEIGHT(CM) ☐☐☐ WEIGHT(KG) ☐☐☐ BLOOD GROUP AB O A B

SPECIFIC OCCUPATION/DESIGNATION ☐☐☐☐☐☐☐☐☐☐☐☐ DATE OF EMPLOYMENT ☐☐ ☐☐ ☐☐☐☐ STAFF PAYROLL No. ☐☐☐☐☐☐☐☐☐☐

KRA PIN NUMBER ☐☐☐☐☐☐☐☐☐☐ SACCO MEMBERSHIP No. ☐☐☐☐☐☐☐☐☐☐

Particulars of Dependants To Be Included On Cover

No.	Full Name or Dependant (Surname First)	Dependant type (Spouse/Child)	Gender (M/F)	Date of Birth	Blood Group	I.D No.	PIN No.

Health Questions (You Must Complete All Questions)

1. Has any of you or your above dependants been hospitalized in the last 3 years? Yes ☐ No ☐
2. Have any of you or your above dependants ever had an accident resulting in a permanent injury? Yes ☐ No ☐
3. Do any of you suffer from any disease that is recurrent in nature? Yes ☐ No ☐
4. Are any of you on regular medication? Yes ☐ No ☐
5. Do any of you have any kind of physical disability? Yes ☐ No ☐

Please state whether any of you proposed for inclusion on cover has ever been treated, received treatment or expects to receive treatment for any of the following conditions / illness:

6. Heart and Blood vessels disorders e.g. high blood pressure, heart disease, stroke, congenital (inborn) heart conditions, chest pains, arterial disease. Yes ☐ No ☐
7. Blood/ circulatory disorders e.g. Sickle cell anemia, Varicose, Thrombosis, Kidney, Liver, Hemophilia, leukemia or any other blood disorder. Yes ☐ No ☐
8. Respiratory disorders e.g. Bronchitis, Tuberculosis, Asthma, cigarette smoking disorder, any other respiratory related disorder. Yes ☐ No ☐
9. Neurological disorders e.g. Meningitis, stroke, brain or spinal cord disorder, epilepsy, any other neurological related disorder. Yes ☐ No ☐
10. Ear, Nose and Throat related problem e.g. throat surgery, sinuses. Yes ☐ No ☐
11. Eye disorders e.g. cataract, glaucoma, eye surgery, blindness. Yes ☐ No ☐
12. Gynecological or genitor-urinary disorders e.g. Pelvic Inflammatory disease, menstrual irregularities. Yes ☐ No ☐
13. Kidney disorders such as kidney failure, kidney stones, recurrent infections etc. Yes ☐ No ☐
14. Musculoskeletal disorders e.g. arthritis, back problems, joints, gout, etc. Yes ☐ No ☐
15. Endocrine diseases such as diabetes, thyroid disease, high cholesterol. Yes ☐ No ☐
16. Surgical such as appendectomy, tonsillectomy or any other surgical procedure. Yes ☐ No ☐
17. Other diseases/ disorders: cancer, alcohol/drug problem, hepatitis, ulcer, mental disorder, gall bladder disease, HIV infection. Yes ☐ No ☐

If you answered YES to any of the questions 1 to 17, kindly give more details in the table below.

No	Name of Applicant	Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	Current status

If the space is not adequate, fill in a separate plain paper and staple it to the form

18. For female applicants / spouses only:
    a) Have you / your spouse ever delivered a child by Caesarean operation? Yes ☐ No ☐

If yes please give member name: _____

b) Is any member currently pregnant? Yes ☐ No ☐
If yes please state number of weeks of pregnancy _____

19. Is any of you allergic to drugs? Yes ☐ No ☐

If yes give details _____

20. Have you been on medical insurance before? Yes ☐ No ☐

If yes give the name of the Insurer/HMO, expiry date and special exclusions: _____

I hereby apply to join the above medical scheme. I understand to the best of my knowledge and belief that all the answers given above are true, that I have not concealed or withheld any material information which the underwriter ought to know inorder to assess me or my family members for medical insurance. I hereby authorize the hospitals, medical or dental practitioners who have treated me or any of my dependants to disclose to CIC General Insurance Ltd. The records relating to such current or previous hospitalizations, medical treatment and to allow CIC to receive extracts from such records, and I undertake to assist in obtaining such information.
By signing this proposal form I hereby grant CIC General Insurance Limited (the Insurer) and all its contracted third-party processors authority to process my personal information/ data, for the purpose of performing the insurance contract as per my proposal herein. I am aware that I may withdraw my consent at any time by writing directly to the Insurer and that such a withdrawal may affect the ability of the insurer to provide the Insurance cover.

Signature of Principal Member: _____ Date: _____

Agency Name & Stamp: _____

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