CIC GROUP

THECO-OPERATIVE INSURANCE COMPANY OF KENYA LIMITED
CIC PLAZA MARA ROAD P.O BOX 5985-00200
TEL (020)2823000, 0722-209602-5,0733-618117,FAX.2823331/3 NAIROBI

Email: cic@cic.co.ke **website** www.cic.co.ke

CIC PERSONAL ACCIDENT INSURANCE

(for individuals and families)

PROPORSAL FORM

AGENCY/BROKER: _____

1. Name of the proposer. _____
2. Pin No._____
3. Gender (Male/Female). _____
4. Date of Birth: _____
5. P.O Box: _____CODE_____Town_____
6. Telephone Number: _____Mobile Number_____
7. Period From_____To_____

The policy will provide monetary payments in the event of bodily injured sustained by the injured. It covers injury caused by violent, accidental, external and visible means subject to the option selected by the injured

COVER IS AVAILABLE AS FOLLOWS

a) Death
b) Permanent total disability
c) Temporary total disability
d) Medical Expenses
e) Funeral expenses
f) Professional trauma counselling
g) Physiotherapy expenses

COVERS AVAILLABLE FOR CHILDREN ONLY

a) Dental expenses
b) Artificial appliances

CLAIMS PROCEDURES

1. Notification to the insurance company should be done as soon as reasonably possible
2. The following documents should be submitted to the insurance company
    - Police abstract in the case of road accident or assault,
    - Physician examination reports
    - Original medical receipts in case medical expenses are incurred
    - Death certificate
    - Burial permit

Please indicate here below your selected benefits – See overleaf for options to choose from

	NAME			
Name	1.Self	2.	3	4
Date of Birth				
Plan				
Annual premium Ksh				

Please answer the following questions

1. Has any of the persons to be insured suffered any accident (s) previously? _____

If yes, please give details including extent of

injuries.....

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2. Does any of the persons to be insured suffer from any physical defect or infirmity? _____

If yes, please give details including extent of

injuries.....

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BENEFICIARY (IES)(OPTIONAL)

Name **TEL/CONTACT**

1._____ _____

2._____ _____

Declaration

I do hereby declare that the above answers and statements are true, and that I have withheld no material information regarding this proposal.

Date _____**Signature of proposer** _____

WE KEEP OUR WORD

CIC PERSONAL ACCIDENT INSURANCE

BENEFITS SCHEDULE

	III	IV	V	VI	VII	VIII	IX
Death	500,000	800,000	1,000,000	2,000,000	5,000,000	8,000,000	10,000,000
Permanent Total Disability	500,000	800,000	1,000,000	2,000,000	5,000,000	8,000,000	10,000,000
Temporary Total Disability	5,000	8,000	10,000	15,000	30,000	40,000	50,000
Medical expenses	70,000	100,000	150,000	200,000	500,000	800,000	1,000,000
Annual premium per person	1,748	2,652	3,556	5,565	13,099	20,130	25,153
Funeral expenses	50,000	60,000	70,000	80,000	90,000	100,000	150,000
Annual premium per person including funeral	1,773	2,682	3,591	5,605	13,144	20,180	25,228

expenses cover							

OTHER BENEFITS AT AN ADDITIONAL PREMIUM

Benefit	Limit	Annual premium per person
Counseling	20,000	201
Physiotherapy	20,000	201

Rates applicable for clerical and administrative (non-manual) accupations