QUEST
VITALITY MEDICAL SCHEME

Zambuko Trust
MICROFINANCE
Transforming Lives.

Passport PHOTO

LOAN APPLICATION FORM

Applicant Surname		First Name	
Physica Address (Residence)		Ownership of property: Tick	Owned / Rented
ID Number		Gender	
Date of Birth	D D M M Y Y Y Y		
Telephone No.		Church Affiliation	
Marital Status		Spouse's Full Name (if married)	
Spouse's Mobile #		Spouse's Occupation & Employer	
No. of Children			
Total Number of Dependants		Dependants at School	
Number of Adults Depandants			
Next of Kin 1		Relationship	
Tel No.		Address	
Next of Kin 1		Relationship	

Amount required:$_____ Address _____ Own Capital Available:$_____

What do you want to use the loan for ?		Repayment Installmer Easily affordable	
Do you have another loan or have you borrowed elsewhere before?	YES NO	If yes please state previous lender and balance remaining	
Current Source of Income for Family			
Education Details		Business skills	
Have you received any Business-related training?			

Work Experience

Employer's Name & Physical Address	Tel #	Post Held	Years of Employed	Reasons for Leaving
1				
2				
3				

Please give names of 2 Referess
(By giving the names, you are giving Zambuko Trust the permission to contact them)

Name	Mobile Number	Physical Address
1		
2		

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Personal Assets Pledged as Security for Loan (list and Value items & Serial numbers):
(Note: Assets must be worth x 2 amount of loan, and cannot be disposed of before loan is paid off. if granted)

Asset Description	Serial Number	Market Value
A		
B		
C		
D		
E		
F		

Package Selection | Please Indicate The Package you wish to join

QUEST ACCESS ☐ QUEST PREMIUM ☐ QUEST PREMIUM PLUS ☐

QUEST EXCELLENCE ☐ QUEST STANDARD ☐ QUEST STUDENT ☐ OTHER

SENIOR PLAN ☐ DAY TO DAY ☐ HOSPITAL BENEFITS ☐ COMBINED BENEFITS ☐

Registration Or Addition Of Dependents Spouse/Child/New-born/Adult dependent

Adult rates apply to any dependent who is 18 years and older. Child rates apply to full time students aged between 18-25 years provided proof is attached to the application form for the current academic studies. Acceptance of the dependents will be in accordance with the rules of the Scheme..

First Name	Surname	Date Of Birth							Relationship	Gender		I.D Number	Contact Number
		D	D	M	M	Y	Y	Y	Y	M	F		
										M	F		
										M	F		
										M	F		
										M	F		
										M	F		
										M	F		

I hereby instruct Quest Vitality Scheme to deposit claim refunds using the information provided below and authorize the Scheme to reverse any erroneous transactions and/or rectify any electronic fund transfer errors without prior notice.

MEDICAL HISTORY

Please note: It is compulsory to answer each question. Failure to disclose medical conditions could limit and/or exclude you or your dependents from receiving certain benefits or result in termination of your membership.

1 Any Chronic illnesses. Cardio and Vascular conditions, Obstructive lung diseases, Diabetes, High or Low blood pressure, Raised Cholesterol Asthma, Depression, Anxiety, Systematic lupus erythematosus, Epilepsy, Thyroid disorders? If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Tre a t m e n t	Name Of Medication	Attending GP/Specialist

2 Digestive system or Stomach disorders? Liver failure, Gall bladder or pancreas, Stomach or duodenal ulcer, Hiatus hernia, Crohn's disease, Irritable bowel syndrome, Rectal bleeding, Hepatitis. If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Tre a t m e n t	Name Of Medication	Attending GP/Specialist

3 Muscle, Bone, Dental, Orthodontic condition, Skin or nerve illness or disorders. Acne, Eczema or psoriasis, Multiple sclerosis, Back injury/neck or joint problems or replacements, Arthritis, Prosthetic limbs, Gout, Stroke, Blackouts, Migraine, Alzheimer's etc. If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Tre a t m e n t	Name Of Medication	Attending GP/Specialist

4 Urinary tract, genital /Gynaecological disorders? e.g. UTI, Kidney stones, Kidney Failure, Prostatitis, Ovarian cysts, Fibroids, etc., If yes please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Tre a t m e n t	Name Of Medication	Attending GP/Specialist

5 Ear, Nose, Throat or Eye disorders? Defective vision, Cataracts, Glaucoma, Blindness, Retinitis, wear spectacles or contact lenses, Hearing loss, Ear discharge, Allergies, recurrent Tonsillitis, etc. If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Tre a t m e n t	Name Of Medication	Attending GP/Specialist

6 Are you or any of your dependents pregnant? If yes, please provide details Y N

Name Of Beneficiary	Expected Date Of Delivery	Attending Doctor

7 Have you or any of your dependents had surgery in the past 12 months, or are you planning to have surgical procedure in the next 12 months? Or any other condition not stated above? If yes, please provide details Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Tre a t m e n t	Name Of Medication	Attending GP/Specialist

I affirm that the information entered above is accurate, and I hereby tender my non-refundable application fee of $_____

Customer Signature: _____ Date: _____

FOR OFFICIAL USE ONLY

Has the application been screened for pre-assessment (reference checks)? _____

Business Development Officer: _____ Date: _____

Reviewed by Branch Supervisor: _____ Date: _____