RETAIL MEDICAL POLICY

J CARE SENIOR APPLICATION FORM

The Jubilee Insurance Company of Tanzania Limited
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P.O. Box 20524, Dar Es Salaam
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medical@jubileetanzania.com
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P.O.Box 10456, Mwanza
Tel: +255 28 2500822 Fax: +255 28 2500238
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Arusha
2nd Floor, NSSF's Mafao House, Old Moshi Road
P.O. Box 1836, Arusha.
T : +255 27 2252131/ F : +255 27 2507341.
E : jicar@habari.co.tz

Zanzibar
Ground floor, ZSTC Building
P.O. Box 2344, Zanzibar
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Email: jicznz@jubileetanzania.com

DIRECTIONS:
Please read carefully and fill out the entire form.
1. *This form must be completely and legibly filled out in BLOCK letters.*
2. *Please attach a copy of ID or Passport, Birth certificate/ notification (for children below 18 years), passport size photograph of yourself and of each member of your family proposed for insurance.*

* *Terms and Conditions apply.*

Mbeya
NBC (1997) Ltd Building ,
Karume Avenue, Ground Floor
P.O. Box 2182, Mbeya.
T/F : +255 25 2503172
E : jicmby@jubileetanzania.com

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Dodoma
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P.O. Box 11027, Dodoma.
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E : jicdom@jubileetanzania.com

Morogoro
First Floor, Hood Property Building, Ngoto Street.
P.O. Box 190, Morogoro.
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Tegeta Branch
Kibo Commercial Complex
1st Floor, Plot No 483
Block ''E'' Tegeta
Bagamoyo Road, Dar es Salaam
T: +255 22 2926303
Email : jictgt@jubileetanzania.com

1. DETAILS OF APPLICANT

Surname ____________________ Title ____________________

First name ____________________ Other names ____________________

ID or Passport No ____________________ Gender ☐ Male ☐ Female

Date of birth D D M M Y Y Y Y Marital Status ____________________

Height (ft) __________ Weight (kg) __________

Name of employer (if applicable) ____________________

Occupation ____________________ Nationality ____________________

CONTACT INFORMATION

Postal address ____________________

Physical home address ____________________

Home telephone ____________________ Office telephone ____________________

Cell phone/ Mobile telephone ____________________ Email ____________________

PARTICULARS OF NEXT OF KIN

Name in Full ____________________

Relationship ____________________ ID or PP No. ____________________

Telephone No. ____________________ Postal Address ____________________

PARTICULARS OF BENEFICIARY OF PERSONAL ACCIDENT COVER AND/ OR LAST EXPENSE COVER (Optional)

Name in Full

Relationship | ID or PP No.

Telephone No. | Postal Address

2. DEPENDANT'S DETAILS
Please note children will be eligible for cover from age of 3 months upto 17 years.

Dependant 1

Surname | Title

First name | Other Names

ID or Passport No | Gender ☐ Male ☐ Female

DOB D D M M Y Y Y Y | Marital Status

Height (ft) | Weight (kg)

Relationship to Applicant | Occupation

Dependant 2

Surname | Title

First name | Other Names

ID or Passport No | Gender ☐ Male ☐ Female

DOB D D M M Y Y Y Y | Marital Status

Height (ft) | Weight (kg)

Relationship to Applicant | Occupation

Dependant 3

Surname | Title

First name | Other Names

ID or Passport No | Gender ☐ Male ☐ Female

DOB D D M M Y Y Y Y | Marital Status

Height (ft) | Weight (kg)

Relationship to Applicant | Occupation

Dependant 4

Surname | Title

First name | Other Names

ID or Passport No | Gender ☐Male ☐ Female

DOB D D M M Y Y Y Y | Marital Status

Height (ft) | Weight (kg)

Relationship to Applicant | Occupation

3. PLAN DETAILS

Please tick (√) the plan chosen or required and the riders

Plan	Classy	Royal	Executive	Advanced	Premier
Inpatient	150,000,000	100,000,000	80,000,000	50,000,000	20,000,000
Outpatient	3,000,000	2,500,000	2,000,000	1,500,000	1,200,000
Dental	800,000	600,000	600,000	400,000	200,000
Optical	800,000	600,000	600,000	400,000	200,000
Last Expense	2,000,000	1,500,000	1,500,000	1,000,000	1,000,000

Premium Computation

	Premiums (in Tshs)								
	Inpatient	Outpatient	Maternity	Last expense	Personal Accident	Evacuation	Dental	Optical	Totals
Main Member									
Spouse									
Child I									
Child II									
Child III									
Child IV									
Total Premiums									
Total Amount									

4. DETAILS OF PREVIOUS MEMBERSHIP

Name of Scheme/Plan - Principal Applicant

______________________________ From: dd/mm/yy To: dd/mm/yy

Name of Scheme/plan – Spouse

______________________________ From: dd/mm/yy To: dd/mm/yy

Have you or any of your dependants ever been declined, loaded, or had exclusions applied to them by a medical scheme? Yes/No
If 'yes' please provide details ______________________________

____

Have you or any of your dependants lodged a claim in the last one year? Yes/No
If 'yes' please provide details ______________________________

5. CONFIDENTIAL MEDICAL HISTORY

State whether you or any of your dependants have ever been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including but not limited to:

Applicants are numbered as per section 2. Please indicate Yes or NO in the applicant's box below. Note the principal applicant is No. 1.							
	Question	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
1.	Blood disorders. e.g. anemia, bleeding disorders, leukemia						
2.	Cancer, growths or tumors whether benign or malignant						
3.	Cardiovascular (heart and blood vessels) disorders e.g. high blood pressure, varicose veins, palpitations, deep vein thrombosis						
4.	Ear, nose and throat disorders e.g. hearing/speech impairment, ear infections, sinus problems, nasal/throat surgery, tonsils, adenoids, previous nasal injuries, upper airway infections, epistaxis						
5.	Endocrine disorders e.g. diabetes, high cholesterol , thyroid abnormalities						
6.	Eye related disorders e.g. blindness, glaucoma, eye surgery, , cataracts, lens implants, refractive and laser surgery						
7.	Genito-urinary system e.g. Pelvic inflammatory disease prostate problem, abnormalities of the penis, scrotum. Reproductive system, blood in the urine, kidney stones, kidney failure, bladder problems, Dialysis,						
8.	Gastro-intestinal disorders e.g. recurrent indigestion, heartburn, ulcers, hernia, piles, fissures. Have you ever had any endoscopic study of the oesophagus, stomach or colon?						
9a.	Gynecological and obstetrical disorders e.g. Fibroids, ectopic pregnancy, caesarian section, Menstrual irregularities. Abnormal pap smear, receiving hormone treatment. Uterine bleeding, Laparoscopic surgery, Dilatation and curettage, miscarriages, pregnancy related problems.						
10.	Musculo-skeletal disorders e.g. arthritis, Back problems, gout, osteoporosis. All joint problems and fractures						
11.	Neurological disorders e.g. epilepsy, Stroke. Brain or spinal cord disorders, Headache, migraine, Paralysis, meningitis						
12.	Psychological disorders e.g. alcohol or drug dependency, anxiety disorder, insomnia, depression, stress, attention deficit disorder, post traumatic stress, attempted suicide,						
13.	Respiratory disorders e.g. asthma, rhinitis, chronic bronchitis, cigarette smoking related disorders, tuberculosis, persistent cough, allergies, chronic obstruction pulmonary disease, shortness of breath.						
14.	Skin disorders e.g. eczema, melanoma, skin cancer, burns, scars, keloids, warts						
15.	State whether you or any of your dependants have received medical advice or treatment for any tropical disease e.g. leprosy, sleeping sickness, elephantiasis, bilharzia, yellow fever						
16.	Have you or any of your dependants ever sought counseling or treatment in connection with sexual transmitted infection e.g. gonorrhoea, syphilis, herpes simplex, Chlamydia						
17.	Have you or any of your dependants ever sought counseling or treatment in connection with HIV or AIDS infections or tested positive for HIV or AIDS?						
18.	Do you or any of your dependants have any hereditary disorders, birth defects or congenital conditions?						
19.	Do you or any of your dependants have incomplete dental treatment plan, dental implants, orthodontic treatment, dentures, and wisdom teeth problems or do you or any of your dependants currently receive, or expect to receive dental treatment in the next 12 months?						
20.	Investigations and/or specialized treatment: In and out of hospital a) Are you or any of your dependants currently undergoing or expect to undergo investigations for any medical condition and / or symptoms not yet diagnosed? b) Are you or any of your dependants currently receiving, or expect to receive specialized treatment (i.e. chemotherapy, radiotherapy, bone marrow transplant, mechanical ventilation, oxygen therapy, dialysis, psychotherapy or counseling?						
21a. 21b	Are you or any of your dependants on any medication (please indicate in the table provided below) Do you or any of your dependants expect chronic medication to be prescribed in the next 12 months?						

If you answered YES (number 21 a & b) please supply details below

Applicant	Prescribed Medication	Diagnosis	Date Started/ To Be Started

If you answered YES to any of the questions above, please supply full details below

Q.NO.	Applicant	Date	Diagnosis	Treatment	Consulting Doctor	Physical address/ Telephone Number

(If the space provided is insufficient, please attach additional information to this application.)

6. SURGERY AND HOSPITAL ADMISSIONS

Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past, and /or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future?

Applicant	Surgical Procedure/ Hospital Admission	Date	Diagnosis

(If the space provided is insufficient, please attach additional information to this application.)

N.B: Any misrepresentation or non-disclosure of material or factual information will render all benefits granted by the scheme null and void. In addition, any payment made due to such actions will be recovered from the member by the scheme.

7. General Exclusions

1. Expenses incurred as a result of a Member's participation in:
(a) Naval, military or air force service or operations;
(b) Hazardous sports including but not limited to Winter sports, water sports mountaineering, hunting, polo, racing on horseback, rugby, league football, motorcycling or motor racing on machines of greater than 125 c.c.;
(c) Riding or driving in any kind of race;
(d) Air travel except as a fare-paying passenger in any aircraft licensed for passenger carrying. Cover shall not in any event apply to an Member whilst operating, learning to operate or serving as a Member of a crew of any aircraft or to travel in any aircraft being used for sky-diving, racing, testing or exploration.

2. Expenses directly or indirectly incurred as a result of:
(a) War ("declared or undeclared"), riot, strike and civil commotion;
(b) Intentional self-injury, suicide or attempted suicide (whether sane or insane), venereal disease, Member's own criminal act, intoxication, the use of drugs not prescribed by a physician or injury sustained whilst in a state of insanity, alcoholism or costs resulting from dependency on or abuse of drugs or other addictive substance;
(c) Nervous breakdown, general debility, psychoneurosis, general "overhaul"
(d) Vaccination, or any treatment undertaken or carried out as a preventative measure;
(e) Treatment by chiropractors, acupuncturists and herbalists, stays and/or maintenance or treatment received in health hydros, nature cure clinics or similar establishments or private beds registered within a nursing home, sanatoria, convalescent and/or rest homes or 'cures' attached to such establishments;
(f) Pregnancy, childbirth, maternity benefits, abortion, miscarriage, ante-or-postnatal care, caesarean operation.

(g) Family planning and fertility treatment e.g. costs of treatment related to infertility and impotence, hormonal imbalance, hormone replacement therapy (HRT);
(h) Cosmetic or beauty treatment and/or surgery;
(i) Massage
(j) Birth defects, Congenital illness, conditions and illnesses related to genetic disorders;
(k) *Psychiatric illness, mental disorders and/or insanity expenses will be covered up to the applicable sub limit subject to twelve months waiting period.
(l) Any claim for expenses relating to any contingency arising whilst the Member is outside the territorial limits of Tanzania, but this limitation shall not apply to any Member temporarily abroad and requiring emergency treatment for an illness or injury that occurs during the period of travel provided that such period does not exceed six weeks in any one visit. Travel and accommodation costs are not covered.
(m) Any claim for expenses related to an accident or illness which may have occurred prior to the effective date or illness occurring within Sixty (30) days of the effective date or to any illness where it was within the knowledge of a Member that he was suffering from it at the effective date.
(n) Any claim for expenses occasioned by or through or in consequence, directly or indirectly caused by acts of God (natural causes)
(o) Treatment of obesity and slimming preparations
(p) Epidemics or unknown diseases
(r) Any experiment, treatment and drugs not scientifically recognized or not proven to be effective based on established medical practice.
(s) Costs of treatment for, or related to, Menopause, andropause, ageing, puberty and pre-menstrual tension syndrome
(t) *All expenses associated with HIV/AIDS and related conditions (subject to twelve months waiting period)
(u) *Pre-existing and Chronic conditions (subject to twelve months waiting period and full declaration on the application at policy inception)
(v) * Cancer treatment (subject to twenty four months waiting period)
(aa) * Treatment of Haemorrhoids, Fibroids, Hernia, Adenoidectomy (subject to twelve months waiting period)
(bb) Organ transplant (subject to twelve months waiting period)
(cc) Any treatment arising from an accident or event because the member or dependent was under the influence of alcohol or drugs, unless prescribed and taken according to the instructions of a medical practitioner
(dd) Medical expense directly or indirectly resulting from or in connection with any act of terrorism (“declared or undeclared”), regardless of any other cause contributing concurrently or in any other sequence to the medical expense
(ee) All expenses in respect of illnesses/conditions that were subject to waiting periods when the member and dependant joined the scheme

* Upon expiry of the waiting period (s) as indicated above, members will be required to enrol and adhere to Jubilee's chronic disease management program. These conditions must be declared at the time of application for a member who qualify for the benefit and subject to Jubilee’s written acceptance . Any newly diagnosed must be notified in writing immediately to jubilee for you to qualify for the benefit by Jubilee’s acceptance.

3. Charges recoverable under any workmen’s injury benefit act or Government health Service Scheme of compensation including NHIF or any other medical plan.

8. DECLARATION

General

1. I, the undersigned member:

1.1. Hereby apply for myself and my dependants to be registered on The Jubilee Insurance Co of Tanzania Ltd, Medical Scheme ("the Scheme") and have read, understood and agree to abide by the Rules of the Scheme.

1.2. Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and, should there be any change in the state of health or illness suffered by myself or any of my dependants from the date of signing this application form and the date of acceptance of the risk by the Scheme, notification of such change will be provided to the Scheme in writing with full details of condition/ailment;

1.3. Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non
disclosure of any information material to the assessment of this application shall render any contracts to which this appliction relates null and void and all premiums paid shall be forfeited;

1.4. Understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary including the results of such medical examinations and tests that they may require me or my dependants to undertake;

1.5. Consent to the Scheme addressing any requests for information, tests or examinations directly to any dependant of mine over the age of 18, with same legal consequences as if the request had been addressed to me in my capacity as a member;

1.6. Acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any due premium is not paid on the due date; and

1.7. undertake to inform the Scheme within 30 days should the situation change,

Authority

2. Accepting that I am curtailing my and my dependants' right to privacy but in order to facilitate the assessment of the risks and the consideration of any claim, I irrevocably authorize;

2.1. The Scheme to obtain from any person, whom I hereby so authorize and direct to give, any information which the Scheme deems necessary,

2.2. I further authorize and instruct the Scheme and any hospital concerned to give away information relating to myself and my
dependants to the Medical Case Managers appointed by the Scheme for purpose of ensuring that the members of the Scheme receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources,

2.3. I understand and accept that the above authorization constitute a partial waiver of my and my dependants' right to privacy.

3 I declare that:

3.1. My dependants(s) is/are residing with me,

3.2. I am liable for his/her family care,

3.3. The dependant(s) is/are my immediate family (Must be a blood relative or legally adopted),

3.4. I undertake to repay the Scheme any amount by which claims paid out exceed benefits covered.

Signature of Member …………………………………………… Date …………………………………………….

Signature of Spouse ……………………………………………. Date …………………………………………….

9. INTERMEDIARY/BROKER DETAILS

Full name of Intermediary/Broker ____

Telephone Contacts ____

Intermediary/Broker Declaration

I hereby declare that I explained the benefits of this application and that the applicant is aware of the membership terms and conditions of Jubilee Insurance Company of Tanzania Limited.

Signature of Intermediary/Broker ………………………………. Date ……………………………………………

OFFICIAL USE ONLY

10. POLICY COMMENCEMENT DATE

Commencement Date: Day________ Month___________ Year_________

Subject always to Declaration section of this application form, the commencement date of this Policy will be the date on which this application is accepted in writing by us. Please note the commencement date can be no more than 30 days from the date of completion of this application. Under no circumstances will Policies be backdated

Note: Cover is conditional upon full payment of premium and acceptance of your application that is only confirmed when an acceptance letter is issued to you)