

NATIONAL INSURANCE CORPORATION OF TANZANIA LIMITED



P.O. BOX 9264, DAR ES SALAAM

TEL: (022)2113823/29, FAX: (022)2113403, TELEX: 41146

GROUP MEDIGARE INSURANCE PROPOSAL FORM

(To be completed by employer)

Important:- Please note that all questions should be completed in full and answered correctly, making false statements or with holding any material information shall render the contract of this insurance null and void

- Insurance shall be inforce or effective after waiting period of 30 days of the date of premium payment.

Ques. 1. Full name of Proposer _____

Business or occupation _____

Postal Address _____

(a) Telephone No. _____

(b) Telex No. _____

(c) Telefax No. _____

Period of insurance From _____ To _____

Physical Address _____ Town _____

Ques. 2. PARTICULARS OF EMPLOYEES

(A) Please indicate number of employees in your employment

(B) Is the cover to apply to all employees? Yes No

(C) Please indicate number of employees to be covered in each age band provided below:-

AGE BAND	FEMALE	MALE	TOTAL
18 - 24			
25 - 29			
30 - 34			
35 - 39			
40 - 44			
45 - 49			
50 - 54			
55 - 59			
60 - 64			

Ques. 3. PARTICULARS OF DEPENDANTS

(A) Do you require this insurance to cover your employees family members? Yes No

(B) If the answer is 'Yes' please indicate number of dependants to be covered in each age band as per below:-

(i) Spouses

AGE BAND	FEMALE	MALE	TOTAL
18 - 24			
25 - 29			
30 - 34			
35 - 39			
40 - 44			
45 - 49			
50 - 54			
55 - 59			
60 - 64			

(ii) Children

AGE BAND (YEARS)	FEMALE	MALE	TOTAL
Below 18			
18 - 24			

Ques. 4. GROUP PROFILE

(a) Please indicate the total number of persons proposed for the scheme

(i) Number of employees.....

(ii) Number of spouses

(iii) Number of Children.....

Are your employees proposed for this insurance covered by other insurance?

..... Yes No.

If 'Yes' give particulars



Ques. 5. SCHEME ADMINISTRATION

(A) Please indicate if the scheme will be contributory or non-contributory. _____scheme.

(b) If the scheme is contributory, indicate the percentage distribution of cost.

Employer

Employee

(c) If the scheme is non contributory indicate who should bear the cost

Employer or employees? _____

(d) Do employees have the choice to join or not to join the scheme?

(e) Please indicate if the scheme will provide for	Yes	No
(i) Extension of benefits _____	<input type="checkbox"/>	<input type="checkbox"/>
ii) Profit sharing _____	Yes	No.
	<input type="checkbox"/>	<input type="checkbox"/>

Ques. 6. DETAILS OF INSURANCE REQUIRED

Medicare Insurance provides for medical expenses attributed to illness or bodily injury as a result of accident in the following form.

(a) Basic cover:- A compulsory cover i.e. Outpatient and Hospitalisation
 (b) Optional cover:- These are various options as shown below
 Please tick boxes provided against each option to indicate cover selected by you.

(i) Maternity care	Yes	No.
	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Optical care	Yes	No.
	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Dental Care	Yes	No.
	<input type="checkbox"/>	<input type="checkbox"/>
(v) Capital benefits	yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
(vi) Any other extension you may require?	Yes	No.
	<input type="checkbox"/>	<input type="checkbox"/>

If the answer is yes please give particulars.

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Ques. 7. SCHEDULE OF BENEFITS

Please indicate the amount of benefits required

- (a) Hospitalisation - not exceeding T.shs. 3,000,000/= or 5,000,000/= and Outpatient not exceeding T.shs.300,00/= per head under the scheme for any one year. Shs.
- (b) Maternity care -not exceeding T.shs. 500,000/= per insured person for any one period of insurance. Shs.....
- (c) Optical care not exceeding T.shs. 150,000/= per insured person for any one period of insurance. Shs.....
- (d) Dental care not exceeding T.shs. 150,000/= per insured person for any one period of insurance and T.shs.20,000/= per visit Shs.....
- (e) Accidental death not exceeding T.shs. 500,000/= Shs.....
- (f) Loss of Limb or Limbs of the insured person not exceeding T.shs, 375,000/= Shs.....
- (g) Loss of sight of one or both eyes of the insured person not exceeding T.shs. 300,000/= Shs.....
- (h) Loss of hearing of one ear or both ears of the insured person not exceeding T.shs. 250,000/= . Shs.....
- (i) Burial expenses not exceeding Tshs. 750,000/= for age above 18 yrs. below age 18yrs. not exceeding Tshs. 250,000/=

Ques. 8. INSURANCE AND MEDICAL COST BACK GROUND

- (a) Have you ever been insured under Medical Insurance Scheme? Yes No
- (b) (I) If the answer is “Yes” please give name (s) of the insurance company(ies) through which you have been insuring.

(ii) Please indicate Medical related claims paid and outstanding for the past three years.

YEAR	CLAIMS PAID	CLAIMS OUTSTANDING	TOTAL

(C) If the answer on (a) above is “No”, please indicate amount of Medical cost paid and outstanding for the past three years.

YEAR	MEDICAL COST PAID	MEDICAL COST OUTSTANDING	TOTAL MEDICAL COST

(d) Do you have any other insurance policies in respect of your properties ? Yes No

(e) If the answer is “Yes” please give details

No.	Type of policies	Sum assured Tshs.	Premium paid Tshs.	Insurer
1.
2.
3.
4.

Ques. 9. Out of the list of hospitals registered by the Corporation, please select Hospitals whereby your employee will be treated.

Hospital	Postal Address
_____	_____
_____	_____
_____	_____

Declaration

I the undersigned, warrant that the answers in this member form are true, correct and complete. I acknowledge that such answers are all material. It is agreed that this declaration and the information given in this proposal form shall be the basis of a contract entered between us and the corporation.

Date _____ Signature _____
 (Rubber stamp is required)