

# NATIONAL INSURANCE CORPORATION OF TANZANIA LIMITED



P.O. BOX 9264, DAR ES SALAAM

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## INDIVIDUAL MEDICARE PROPOSAL FORM

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

1. Full name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Postal address \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Nationality \_\_\_\_\_

2. Please indicate particulars of your dependants you are proposing for Medicare Insurance Scheme.

FULL NAME	OCCUPATION	RELATIONSHIP TO YOU (Wife, Husband, Son, Daughter)	DATE OF BIRTH		
			DAY	MONTH	YEAR

3. Do you and all of your dependants now enjoy good health?  
 If not, please give details.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. 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 covers:- These are various options as shown

Please tick boxes provided against each option to indicate cover selected by you.

- (i) Maternity care ..... Yes    No
- (ii) Optical care ..... Yes    No
- (iii) Dental care ..... Yes    No
- (iv) Capital benefits ..... Yes    No
- (v) Any other extension you may require..... Yes    No

If the answer is yes please give particulars.

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5. Please indicate the amount of benefits required.
- (a) Hospitalisation not exceeding T. Shs. 3,000,000/= Per insured person in case of individual policy. Shs.....
  - (b) Outpatient services not exceeding Tshs.600,000/= Per policy holder per period of insured. Shs.....
  - (c) Maternity care(not exceeding Shs. 500,000 per insured person for any one period of insurance. Shs.....
  - (d) Optical care(not exceeding T.shs.150,000/=) ..... Shs.....  
Per insured person for any one period of insurance.
  - (e) Dental care(not exceeding T.Shs. 150,000/=) ..... Shs.....  
For any one period of insurance and Shs.20,000/= Per visit)
  - (f) Accidental death(not exceeding Shs.500,000 Shs. ....
  - (g) Loss of sight of limb or Limbs of the insured Person. (not exceeding T.shs. 375,000/=) Shs.....
  - (h) Loss of sight of one or both eyes of the ..... Shs.....  
Insured person(not exceeding T.shs.300,000/=)
  - (i) Loss of hearing of one ear or both ears ..... Shs.....  
of the insured person (not exceeding T.shs. 250,000/=)
  - (j) Burial expenses not exceeding T.shs. 750,000/= for age above 18  
Below 18 not exceeding T.shs. 250,000/=

6. Do you wish to participate in a profit sharing programme? Yes  No.

7. Please answer yes or No for each given following questions,(i) to (viii):-Please underline the ailment

NAME	CATEGORY (Self, Wife, Son)	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)	(viii)

8. Have you or any of your dependants suffering, or been told suffering from :-

- (i) Infertility or impotence
- (ii) Any urinary complication, kidney dialysis?
- (iii) Any sexual transmitted disease, HIV/AIDS genital disorder?
- (iv) Any heart disease or heart disorder Hypentations?
- (v) Mental illness or disease and psychiatric disorder
- (vi) Any tumor, cancer an eye or ear disorder

(vii) Any diabetes or Sugar in urine

(viii) Have you or any of your dependants ever been hospitalised for last two years?

B: If you have replied "Yes" in any of the questions in 7A, please give more particulars in the format given below.

NAME	HOSPITAL ADDRESS	NAME OF DOCTORS	MEDICAL CONDITION	DURATION OF TREATMENT	PRESENT STATE OF HEALTH

Note:

Medical insurance is designed to cover as many services a person might require, however the following illnesses treatments and services are not covered i.e.

Drug abuse, Self inflicted injuries, cosmetic surgery, Gender reassignment (sex change), preventive treatment, mobility aids, experimental treatment, experimental drugs (for example genome project or genetherapy) organ transplant, war risk, injuries arising from dangerous hobbies (hazardous pursuits) such as during birth control devices and pills, circumcision unless for medical reasons, insured member above required age pre-existing and chronic conditions, services or treatment in any home spa; hydro-clinic, sanatorium or long term care facility, routine medical examination, routine medical examination or check-ups, vaccinations for employment or travel, nuclear risks, self poisoning prostheses and corrective devices.

Also excluded are;

Incase of Dental Services: Cost of replacement, repairs of old dentures, bridges and plates  
and

Incase of optical services: cost of replacement or repair of eye glasses or eye testing, provision of eye glasses or contact lenses, resulting from the deterioration of eye sight .

**Declaration**

I the undersigned, warrant that the answers in this member form are true, correct and complete 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. I hereby authorise the Hospital / medical or dental practioners who have treated me or any of my dependants to disclose to NIC ' S Doctor or representative the records relating to such current or previous hospitalisation / medical treatment and to allow the representative to receive extracts from such records and undertake to assist in obtaining such information.

Date \_\_\_\_\_

Signature of the proposer \_\_\_\_\_

NB: Hospital selected: –

- 1. ....
- 2. ....
- 3. ....