Jubilee
INSURANCE

J-CARE MEDICAL POLICY

MEMBERSHIP APPLICATION FORM

JUBILEE HEALTH INSURANCE LIMITED
Head Office:
Jubilee Insurance House, Wabera Street,
P.O. Box 6694 - 00100 GPO, Nairobi, Kenya
Tel: +254 20 328 1000
Call Centre: +254 709 949 000
Email: talk2ushealth@jubileekenya.com
www.jubileeinsurance.com

DIRECTIONS:
*Please read carefully and fill out the entire form in **BLOCK LETTERS**.*
1. *Birth certificate/notification (for children below 18 years).*
2. *Please attach a copy of your PIN Card, ID/Passport*
3. *You are required to attach passport size colour photographs for each member.*
4. *Kindly complete all questions in full. Incomplete application forms cannot be processed.*

** Terms and Conditions apply.*

1. DETAILS OF MAIN APPLICANT

*All names should be captured as shown in ID/Passport and Birth Certificate for child dependants.

Surname: | Title:
Other Names: | PIN No.:
ID No.: | Gender: ☐ Male ☐ Female
Marital Status: | NHIF No.:
Date of Birth: | Employer Name: *If Applicable*
Occupation: | Nationality:

CONTACT INFORMATION

Postal Address: | Home Address:
Mobile No.: | Office Phone: | Email:

PARTICULARS OF NEXT OF KIN

Name in Full:
Relationship: | ID No.:
Mobile No.: | Postal Address:

PARTICULARS OF BENEFICIARY OF PERSONAL ACCIDENT COVER AND/OR LAST EXPENSE COVER

Name in Full:
Relationship: | ID or PP No.:
Mobile No.: | Postal Address:

2. DEPENDANTS DETAILS

To be completed if member's family is applying for Health Insurance.

NO.	NAMES IN FULL	DATE OF BIRTH (DD/MM/YYYY)	ID CARD NO./BIRTH CERTIFICATE NO./BIRTH NOTIFICATION NO.	BLOOD GROUP	RELATIONSHIP TO MEMBER
1					
2					
3					
4					

5					
6					
7					
8					

3. PLAN DETAILS

Please tick (✓) the plan chosen and the riders *(Last expense and Personal Accident is free for the Principal Applicant).*

BENEFIT	CLASSIC		PREMIER		ADVANCED		EXECUTIVE		ROYAL	
Inpatient	500,000		1,000,000		2,000,000		3,000,000		5,000,000	
Outpatient	50,000		50,000		80,000		100,000		150,000	
Maternity	80,000		100,000		120,000		120,000		150,000	
Personal Accident	500,000		500,000		500,000		500,000		500,000	
Optical	5,000		10,000		20,000		30,000		40,000	
Dental	5,000		10,000		20,000		30,000		40,000	
Last Expense	50,000		50,000		75,000		100,000		100,000	

PREMIUM COMPUTATIONS (Premiums in KES)

	INPATIENT	OUTPATIENT	MATERNITY	LAST EXPENSE	PERSONAL ACCIDENT	DENTAL & OPTICAL	TOTAL
Main Member							
Spouse							
Child I							
Child II							
Child III							
Child IV							
Child V							
Total Premiums							
Insurance Training Levy (0.2%)							
PCF Levy (0.25%)							
Stamp Duty							40
Total Amount							

Commencement of cover is subject to issuance of an acceptance letter and receipt of full annual premiums by Jubilee Health Insurance. Premiums should be paid directly to Jubilee Health Insurance by the following means:-

1. **Cheque to Jubilee Health Insurance Ltd**
2. **MPESA payment via Jubilee Health Insurance Paybill NO. 7195247**
3. **Direct Debit to Jubilee Health Insurance bank account at Diamond Trust Bank**

We shall not be liable for any premiums paid to other parties and not received by Jubilee Health Insurance.

4. DETAILS OF ANY PREVIOUS MEDICAL

Name of the Scheme/Plan - Principal Applicant:

From: *dd/mm/yyyy* To: *dd/mm/yyyy*

Name of the Scheme/Plan - Spouse:

From: *dd/mm/yyyy* To: *dd/mm/yyyy*

Have you or any of your dependants ever been declined, loaded, or had exclusions applied on 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

Please state if any one included in this application has ever been treated or is currently receiving treatment or expect to receive treatment or has experienced symptoms of any known or suspected medical condition. In completing the questions please ensure that each question is answered fully and accurately.

Applicants are numbered as per section 2. Answer YES or NO in each box below. Note the main applicant is No. 1						
Question	**No. 1**	**No. 2**	**No. 3**	**No. 4**	**No. 5**	**No. 6**
1.Do you or any of your family proposed for this insurance already hold Life, Personal Accident or Medical Insurance policies?						
If yes please provide name of insurer and policy number						
2. Are you or any member of your family proposed for this insurance currently under any type of medical treatment?						
3. Have you or any of your family proposed for this insurance suffered from any medical/health complaint which may necessitate a surgical operation or for which you reasonably anticipate the necessity of treatment?						
4. Have you or any member of your family proposed for this insurance suffered from:-						
a. Blood disorder, sickle cell anemia, cancer, growth or tumors whether benign or malignant?						
b.Cardiovascular (Heart and blood vessel) and respiratory related disorders, hypertension, deep vein thrombosis, respiratory disorders, asthma, tuberculosis, chronic obstruction pulmonary disease?						
c.Ear, nose, throat disorders, tonsils, adenoids, hearing or speech impairment, eye related disorders, glaucoma?						
d.Genito-urinary system disorders or abnormalities of the male or female reproductive system, kidney stones or kidney failure?						
e.Gastro - intestinal disorders, hernia, ulcer, piles						
f.Gynecological and obstetrical related disorders, fibroids, menstrual irregularities, abnormal pap smear.						
g.If currently pregnant please advise expected delivery date.						
h.Musculo-skeletal related disorders e.g. gout, osteoporosis, joint problems and fractures						
i.Neurological related disorders, epilepsy, stroke, brain disorders, paralysis						
j.Psychological related disorders, drug and/or alcohol dependency, anxiety, depression, stress						
k.Skin disorders, eczema, sexually transmitted diseases, herpes, gonorrhea and HIV or AIDS and related conditions or tropical diseases such as leprosy, yellow fever, bilharzia						
l.Congenital, hereditary disorders or birth defects						
5. Have you or any of your family proposed for this insurance suffered from a chronic/long term medical debtal condition or is there any known disability, abnormality or recurrent illness or injury?						
6. Are you or any member of your family proposed for insurance now under observation or taking treatment or education for any disease or disorder?						
Please state the name and address of your medical doctor/physician or hospital.						

Note : If the answer is YES to any question above please provide full details below (If the space provided is insufficient kindly attach additional information to this application).

NAME AND RELATIONSHIP TO THE APPLICANT	RELEVANT QUESTION	MEDICAL CONDITION	TREATMENT AND CONSULTATIONS RECEIVED(WITH DATE)	NAME THE TREATING DOCTOR OR HOSPITAL AND THEIR TELEPHONE NUMBER OR ADDRESS	NEEDS FOR FUTURE TREATMENT OR CONSULTATION

N.B: Any misrepresentation or non-disclosure of material or factual information will render all benefits granted by Jubilee Health Insurance null and void. In addition, any claims payment made due to such actions will be recoverable from the policy holder.

6. EXCLUSIONS (These are some of the exclusions. For more details please refer to the policy document available on request)

1. Treatment for pre-existing, chronic conditions, congenital, psychiatric conditions,organ transplant, HIV/AIDS and related conditions, Haemorrhoids, Fibroids and other gynaecological illness and treatment, Hernias, Thyroidectomy, Tonsillectomy, and Adenoidectomy (within the first year).
2. Treatment of Cancer (within the first 2 years).
3. Sexually transmitted diseases except HIV/AIDS (HIV/AIDS subject to 1 year waiting period).
4. Peri-Menopause, Menopause, andropause, hormone replacement therapy, age and puberty related treatment.
5. Pregnancy, child birth, maternity benefits, maternity related complications, antenatal or post natal care, caesarean operation except where purchased and subject to twelve months waiting period.
6. Genetic disorders and related conditions or genetic testing.
7. Cosmetic or plastic surgery unless necessitated by an accidental injury that occurs while the insured is covered under this contract or beauty treatments, massage or stays in sanatoria, old age homes, places of rest, etc.
8. Medical check up, general health examinations, prophylactic treatment, vaccinations except for KEPI vaccinations where the outpatient benefit has been purchased.
9. Transportation other than a licensed ambulance, as provided for under the inpatient coverage of this contract.
10. Hearing test or cost of hearing aids unless resulting form accidental injury.
11. Nutritional food supplements or replacements and vitamins whether prescribed by a physician or not.
12. Injury or illness resulting from naval, military or air force operations, insurrection, war, civil commotion or an act of terrorism, whether declared or undeclared or as a result of participation in riot and/or strikes.
13. Alternative treatment such as herbal, acupuncture treatment, chiropractors etc.
14. Expense resulting from the insured participating in extreme/hazardous sports and activities or riding or driving in any kind of race.
15. Pain Management, Epidemics and pandemics.
16. Dental treatment including teeth extractions, fillings, teeth scaling, etc. unless the dental cover has been purchased.
17. Optical treatment relating to correction of eyesight e.g. eye glasses and contact lenses unless the optical cover has been purchased.
18. Intentional self-injury while sane or insane, suicide or attempted suicide.
19. Expenses recoverable under any other insurance such as NHIF, Workmen's Compensation, Personal Accident among others.
20. Treatment required as a result of non compliance, failure and refusal to comply with medical advice.
21. Reimbursement claims only applicable once the outpatient credit limit has been reached.
22. Contraceptive services and supplies, family planning, fertility treatment e.g. costs of treatment related to infertility, impotence, any injury, illness or disease specified as an exclusion and complications caused by a condition that is excluded.
23. Services primarily for weight reduction of treatment of obesity and slimming operations or any care which involves weight reduction as a main method of treatment.
24. Treatment for consumption of alcohol, drugs, intoxication, dependancy on or abuse of alcohol, drugs or any other substance abuse, complications, injury or illness arising directly or indirectly thereof.

7. DECLARATION

General

I, the undersigned member:

1.1. Hereby apply for myself and my dependants to be registered on Jubilee Health Insurance Ltd, Medical policy and have read, understood and agree to abide by the Rules of the policy;

1.2. Warrant that the contents of this application and any change in the state of health or illness suffered by myself or any are true, correct and complete, 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 or by the insurer, notification of such change will be provided to the insurer 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 application relates null and void and all premiums paid shall be forfeited;

1.4. Understand and accept that no benefit will be payable by the policy 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. Acknowledge and accept that the insurer reserves the right to cancel membership of the policy if any due premium is not paid on the due date; and

1.6. Undertake to inform the insurer within 30 days should the situation stated above change.

Authority

2.1 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;

2.2 The insurer to obtain from any person, whom I hereby so authorize and direct to give, any information which the insurer deems necessary;

2.3 I further authorize and instruct the insurer and any hospital concerned to give away information relating to myself and my dependants to the insurer for the purpose of ensuring that members of the policy receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources;

2.4 I understand and accept that the above authorization constitutes a partial waiver of my and my dependants' right to privacy; and

2.5 I do hereby authorize the insurer to send the policy document electronically to the email address provided in this application form.

I declare that:

3.1 My dependant(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),

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

Signature of Member:..... Date:*dd/mm/yyyy*.....

8. INTERMEDIARY/BROKER DETAILS

Full Name of Intermediary: .....

Trading as:..... Tel:.....

PIN No.:..... Email:.....

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 Health Insurance Limited.

Signature of Intermediary:..... Date:*dd/mm/yyyy*.....

Unit Manager's Names (where applicable):.....

BDM's Name (where applicable):.....