Jubilee
INSURANCE

RETAIL MEDICAL POLICY

MEDICAL INSURANCE
MEMBERSHIP APPLICATION FORM

Head Office:
Jubilee Insurance House, Wabera Street,
P.O. Box 30376 - 00100 GPO, Nairobi, Kenya
Tel: +254 020 328 1000
Fax: +254 020 328 1150
Email: jic@jubileekenya.com
www.jubileeinsurance.com

Mombasa Office:
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P.O. Box 90220 - 80100, Mombasa, Kenya
Tel: +254 020 222 4286 / 231 4019 / 231 6760
Fax: +254 020 231 6796
Email: mombasa@jubileekenya.com

Kisumu Office:
Jubilee Insurance House, Oginga Odinga Road,
P.O. Box 378 - 40100, Kisumu, Kenya
Tel: +254 020 202 0836 / 202 0845
Fax: +254 020 202 0532
Email: kisumu@jubileekenya.com

DIRECTIONS:
PLEASE ANSWER ALL QUESTIONS IN BLOCK LETTERS.

Please attach a copy of your PIN Card, ID/Passport, Birth certificate/ notification (for children below 18 years). You are required to attach passport size colour photographs for each member on the photosheet page provided.

Kindly complete all questions in full. Incomplete application forms cannot be processed.

1. DETAILS OF MAIN APPLICANT

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

Surname _____ Title _____

First name _____ Other names _____

ID or Passport No. _____ Gender ☐ Male ☐ Female

PIN No. _____ NHIF No. _____

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 _____

Mobile phone _____ 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

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 the age of 1 month upto17 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 | 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 | 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 | Height (ft) | Weight (kg)

Relationship to Applicant | Occupation

Dependant 5

Surname | Title

First name | Other Names

ID or Passport No | Gender ☐Male ☐ Female

DOB D D M M Y Y Y Y | Height (ft) | Weight (kg)

Relationship to Applicant | Occupation

3. PLAN DETAILS

Inpatient is a core benefit. Dental and Optical options are available only with Outpatient plans.
Please tick (√) the plan chosen or required and the riders

Plan Limit (Kshs)	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 Computation

	Premiums (in Kshs)							
	Inpatient	Outpatient	Maternity	Last ex-pense	Personal Accident	Evacuation	Dental & Optical	Totals
Main Member								
Spouse								
Child I								
Child II								
Child III								
Child IV								
Child V								
Total Premiums								
Insurance Training Levy (0.2%)								
Policyholder Compensation Fund Levy (0.25%)								
Stamp Duty								40.00
Total Amount								

Commencement of cover will be subject to issuance of an acceptance letter and receipt of full premium by Jubilee Insurance. All premiums must be paid to Jubilee Insurance directly. We shall not be liable for any premiums made to other parties and not received by Jubilee Insurance.

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 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

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 main 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. 9b.	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. Pregnant, if positive, provide expected date of delivery ***(dd/mm/yy)***						
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?						
21.	Are you or any of your dependants on any medication (please indicate in the table provided below)						

If you answered YES (number 21) 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 Jubilee Insurance null and void. In addition, any claims payment made due to such actions will be recoverable from the policy holder.

7. GENERAL EXCLUSIONS

A. Expenses incurred as a result of a Member's participation in:

1. Naval, military or air force service, paramilitary, police and police reserve service or operations;
2. Expenses arising directly or indirectly as a result of participation in and not limited to professional sport or any especially hazardous pursuits such as motor cycling or motor racing machines of greater than 125 cc, polo, racing on horse-back, rugby, league footfall, Winter sports, yachting, sky-diving, hang-gliding, parachute jumping, bungee jumping, hunting, aqualung diving, boxing, wrestling or unarmed combat, water ski-jumping, mountaineering necessitating the use of ropes or guides
3. Riding or driving in any kind of race;
4. Air travel except as a fare-paying passenger in any aircraft licensed for passenger carrying. Cover shall not in any event apply to a 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.

B. Expenses directly or indirectly incurred as a result of:

1. War invasion ("declared or undeclared"), riot, strike and civil commotion, act of foreign enemy, hostilities or warlike operations, civil war, mutiny, insurrection, revolution, military or popular rising, military or usurped power, martial law or state of siege or any events or causes which determine the proclamation or maintenance or martial law or state of siege, confiscation, seizure, nationalization or destruction of or damage to the property by order of Government (de jury or de facto) or Land Authority or any process of Law.
2. Medical expenses 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 expenses.
3. Costs directly or indirectly resulting from the release of weapon(s) of mass destruction, whether such involves an explosive sequence(s) or not.
4. Treatment directly or indirectly arising from or required as a result of chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel, asbestosis or any related condition. Nuclear fission, ionising or non-ionising radiation or contamination by radioactivity from nuclear fuel or waste. For the purpose of this exclusion, combustion shall include any self- sustained process of nuclear fission.
5. Intentional self-injury, suicide or attempted suicide (whether sane or insane) or any bodily injury or illness wilfully self-inflicted or due to negligent or reckless behavior or as a result of result of committing or helping to commit a criminal act, except in an attempt to save a human life.

6. Venereal disease or any other sexually transmitted diseases or any related condition or complications thereof except for HIV/AIDS subject to the applicable waiting period
7. Treatment for dependency on or abuse of alcohol, drugs, any substance abuse or any other addictive conditions of any kind and complications, injury or illness arising directly or indirectly from such abuse or addiction;
8. Vaccinations or any treatment undertaken or carried out as a preventative measure including complications thereof but not limited to check-ups, scans of any nature or any other form of disease and illness prevention including but not limited to preventative medications and supplements. Only the Kenya Expanded Program on Immunization (KEPI) is covered for children below 1.5 years where the maternity benefit is purchased. This shall be covered within the Outpatient limit and subject to the applicable waiting period of the maternity benefit.
9. Treatment by chiropractors, acupuncturists, herbalists and other alternative treatments. Stays and/or maintenance or treatment received in health hydro's, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or a hospital where the hospital has effectively become the insured person's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.
10. Pregnancy, childbirth, maternity benefits, abortion, miscarriage, ante-or-postnatal care, caesarean operation. This exclusion does not apply where maternity cover option has been purchased subject to twelve months waiting period (12) the benefit shall exclude any treatment and expenses related to surrogacy.
11. Foetal Surgery
12. Family planning and fertility treatment any form of assisted conception and complications e.g. costs of treatment related to infertility and impotence, hormonal imbalance, hormone replacement therapy (HRT). Investigations, diagnostics and treatment of impotence, sexual dysfunction or any consequence thereof, treatment for sterilization or fertilisation, vasectomy or other sexually related conditions or gender reassignment and related consequence.
13. Costs of treatment for, related to, Peri-Menopause, Menopause, Andropause, ageing, puberty and pre-menstrual tension syndrome.
14. Cosmetic or beauty treatment and/or surgery, obesity, removal of fat or other surplus tissue from any part of the body, whether or not for medical or psychological purposes, and any associated treatment costs consequent of such treatment. This shall include breast reduction or enlargement. The only exception is reconstructive surgery resulting from an accident.
15. Treatment of, related to, or caused by weight loss/gain, obesity, eating disorders or weight problems of any kind. This includes but is not limited to the treatment of conditions such as anorexia nervosa, bulimia, bariatric, and any treatment required for any condition caused as a result of these conditions.
16. Normal eye tests, non-medical/natural degenerative eye defects, including but not limited to Myopia, Presbyopia and Astigmatism and any corrective surgery for non- medical/natural degenerative sight defects, except where the benefit is purchased.
17. Routine or restorative dental treatment, whether or not performed by a medical practitioner or dental practitioner or specialist or an oral and maxillofacial surgeon, except where the benefit is purchased.
18. Hearing tests or cost of hearing aids. This shall include treatment for, or arising from, but not limited to deafness caused by an illness, accident, congenital abnormality or ageing.
19. Massage and hydrotherapy
20. Pre-existing and chronic conditions subject to twelve months waiting period and full declaration on the application at policy inception.
21. All expenses associated with HIV/AIDS and related conditions subject to twelve months waiting period and full declaration on the application at policy inception.
22. Congenital illness and conditions related to genetic disorders, and/or chromosomal disorders and hereditary conditions subject to twelve months waiting period and full declaration on the application at policy inception.
23. Cancer treatment subject to twenty four months waiting period and full declaration on the application at policy inception.
24. Treatment of Haemorrhoids, Fibroids, Hernia, Adenoidectomy, Hysterectomy and Thyroidectomy subject to twelve months waiting period.
25. Occupational /Speech Therapy. Treatment for speech disorders, including stammering, learning difficulties, hyperactivity, attention deficit disorder, speech therapy and, developmental, social or behavioural problems unless caused by an accident
26. Psychiatric illness, mental disorders and/or insanity expenses subject to twelve months waiting period. These conditions that are excluded shall include but are not limited to treatment for conditions such as, conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behavior, obsessive-compulsive disorder, attachment disorder, adjustments disorders, as well as all treatments that encourage positive social-emotional relationships, such as communication therapies, floor time and family therapy.
27. Costs for any illness, diseases or injuries arising from ear or body piercing and tattooing
28. Pain management
29. Claims arising or related or associated with Epidemics/Pandemics or unknown diseases.
30. Any claim for expenses relating to any contingency arising whilst the Member is outside the territorial limits of Kenya, 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 trip. Travel and accommodation costs are not covered.
31. Any claim for expenses related to an accident or illness which may have occurred prior to the effective date or illness occurring within Thirty (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.
32. Costs related to locating a replacement organ removal of a donor organ from the donor, removal of an organ from you for the purposes of transplantation into another person, purchase of a donor organ or transportation, any resulting complications and all associated administration costs. Eligible organ transplant is subject to twelve months waiting period.
33. Cost of providing, maintaining or fitting an external prosthesis or appliance or other equipment, medical or otherwise except for wheelchairs (inpatient) , walking frames and crutches following treatment resulting from an accident.
34. Medical aids including but not limited to glucometers, blood pressure machines, and oxygen concentrators.
35. Bodily injury or disease and/or illness arising out of non-adherence to medical advice given by a registered medical practitioner. This shall include treatment required as a result of failure to seek or follow medical advice or travel against medical advise
36. Evacuation or travel costs not specifically authorised in writing by Jubilee Insurance prior to travelling.
37. All expenses in respect of illness/conditions that were subject to waiting periods when the member and dependent joined the policy and purchased the benefit.
38. Experimental treatment and drugs not scientifically recognised or not proven to be effective based on established medical practice.
39. Charges recoverable under any Workmen's Injury Benefits Act, Personal Accident policies or Government Health Services Schemes 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 Kenya 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 other documents which may be required in support thereof 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 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 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. 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 Insurer to obtain from any person, whom I hereby so authorize and direct to give, any information which the insurer deems necessary,

2.2. 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 the members of the policy 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 constitutes 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),

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

Signature of Member _____ Date _____

Signature of Spouse _____ Date _____

9. POLICY ACCEPTANCE

Jubilee Insurance hereby confirms that upon receipt of full premium the following documents will be issued within 30 days. The policy holder should contact Jubilee Insurance if the same is not received. The documents that will make up the policy membership pack will include a Welcome letter, photocards for each member, the provider panel and policy document.

10. INTERMEDIARY DETAILS

Full name of Intermediary _____

Trading as _____ Tel _____

PIN No. _____ Email _____

Intermediary 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 Kenya Limited.

Signature of Intermediary _____ Date _____

Unit Managers Name (where applicable) _____

BDM's Name (where applicable) _____

PHOTO SHEET

Date:

MAIN MEMBER PHOTOGRAPH

1ST DEPENDANT PHOTOGRAPH

MAIN MEMBER:
NAME (As per ID/Passport):_____
PIN No.: _____
DOB: _____
ID/PASSPORT No.: _____

DEPENDENT 1
NAME (As per ID/Passport): _____
RELATIONSHIP: _____
DOB: _____
ID/PASSPORT No.: _____

2ND DEPENDANT PHOTOGRAPH

3RD DEPENDANT PHOTOGRAPH

DEPENDENT 2
NAME (As per ID/Passport):_____
RELATIONSHIP: _____
DOB: _____
ID/PASSPORT No.: _____

DEPENDENT 3
NAME (As per ID/Passport): _____
RELATIONSHIP: _____
DOB: _____
ID/PASSPORT No.: _____

4TH DEPENDANT PHOTOGRAPH

5TH DEPENDANT PHOTOGRAPH

DEPENDENT 4
NAME (As per ID/Passport):_____
RELATIONSHIP: _____
DOB: _____
ID/PASSPORT No.: _____

DEPENDENT 5
NAME (As per ID/Passport): _____
RELATIONSHIP: _____
DOB: _____
ID/PASSPORT No.: _____

OFFICIAL USE ONLY

11. 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.