Assemble INSURANCE
Your Future is Protected

CORPORATE EMPLOYEE PROPOSAL FORM

TO BE COMPLETED BY INDIVIDUAL STAFF AND ATTACH TWO RECENT PASSPORT SIZE PHOTOS WITH NAMES WRITTEN AT THE BACK PER EACH MEMBER

NAME OF COMPANY

MEMBER DETAILS

SURNAME | FIRST NAMES

DATE OF BIRTH | D D M M Y Y Y Y | MARITAL STATUS | MARRIED / SINGLE / WIDOWED

OCCUPATION

EMPLOYEE ID | HEIGHT | WEIGHT

ALLERGIES

NATIONAL ID NO./PASSPORT | POSTAL ADDRESS

PHYSICAL ADDRESS | EMAIL

TELEPHONE NO. OFF. | RES.

MOBILE

	ENTER BELOW DETAILS OF THE SPOUSE (01) WHERE APPLICABLE AND ALL DEPENDANTS TO BE INCLUDED IN THE CORPORATE APPLICATION FOR MEMBERSHIP IN AGE ORDER.															
	SURNAME	FIRSTNAME	F/M	DATE OF BIRTH								AGE	ALLERGIES	HEIGHT/WEIGHT	CATEGORY (SPOUSE/CHILD)	TELEPHONE	EMAIL ADDRESS
				D	D	M	M	Y	Y	Y	Y						
1																	
2																	
3																	
4																	
5																	
6																	

MEDICAL DECLARATION

NOTE: FOR MEMBERSHIP TO BE CONSIDERED THIS DECLARATION MUST BE COMPLETED IN FULL AND ALL QUESTIONS ANSWERD. IF THE ANSWER IS YES TO ANY OF THE QUESTIONS WHICH FOLLOW PLEASE PROVIDE DETAILS BELOW. ALL QUESTIONS MUST BE ANSWERED TRUTHFULLY AND IN FULL. N/A IS NOT ACCEPTABLE AND ANY ALTERATIONS MUST BE COUNTER SIGNED BY THE MEMBER

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS? Please answer YES or NO
(ask your Doctor for assistance if needed)

QUESTION		00	01	02	03	04	05	06
a)	Cardiovascular							
	High Blood Pressure							
	Heart Disease							
b)	Respiratory							
	Arthritis							
	Tuberculosis							
c)	Endocrine							
	Thyroid Disease							
	Diabetes							
d)	Neurological							
	Paralysis							
	Epilepsy							
e)	Muskulo Skeletal							
	Arthritis							
	Gout							
	Slipped Disk							
f)	Blood disorder							
	Sickle Cell Anemia							
	Leukemia							
	AIDS/HIV							
g)	Genito - Urinary							
	Pelvic inflammatory Disease (Female)							
	Enlargement of the Prostate (Male)							
h)	Gastro-intestinal							
	Duodenal or Stomach Ulcers							
	Liver Disease							

QUESTION		00	01	02	03	04	05	06
i)	SURGICAL OPERATIONS							
j)	OTHER MEDICAL CONDITIONS OR DISABILITIES (not specifically covered above)							
k)	Has any member been hospitalized within the last 3 years?							
l)	Is any member on any regular prescribed medication? If YES give details and type of medication							
m)	Is any member a member of any Rescue or Medical Insurance Organization? If Yes, give details							
n)	Has any Female member had a pap smear (screening test for cervical cancer) in the last year? Female only							
o)	Has any Male member had a PSA (Screening test for Prostrate cancer) done? Male only							
p)	Other than those declared above, does any member have any particular health concerns you would wish to inform Assemble about?							
00								
01								
02								
03								
04								
05								
06								

MEDICAL EXAMINATION IS REQUIRED AT AGE OF 50 YEARS AND ABOVE.
The application will not be accepted if you do not undergo medical examination.

This is signed declaration that information is true and that Assemble has the express authority to access any medical information from any source as required from time to time.

I hereby consent to and authorize Assemble to disclose to my employer any and all information, reports, records and details relating to me including such medical or other information that would otherwise be confidential for purposes of the administration of the medical scheme

Name & Signature Principal Member: .....Date: .....

ASSEMBLE CARD PHOTO SHEET

PLEASE STICK PHOTOS WITH GLUE ONTO SPACE PROVIDED, DO NOT STAPLE PHOTOS

NAME.....	NAME.....	NAME.....
DATE OF BIRTH.....	DATE OF BIRTH.....	DATE OF BIRTH.....
MEMBER SINCE.....	MEMBER SINCE.....	MEMBER SINCE.....
MEMBERSHIP NO.....	MEMBERSHIP NO.....	MEMBERSHIP NO.....
NAME.....	NAME.....	NAME.....
DATE OF BIRTH.....	DATE OF BIRTH.....	DATE OF BIRTH.....
MEMBER SINCE.....	MEMBER SINCE.....	MEMBER SINCE.....
MEMBERSHIP NO.....	MEMBERSHIP NO.....	MEMBERSHIP NO.....

FOR OFFICIAL USE (UNDERWRITING COMMENTS

AGENT : INSURED FROM : INSURED TO:

	UNDERWRITING DECISION	POLICY TYPE	STANDARD PREMIUM	CHARGED PREMIUM
00				
01				
02				
03				
04				
05				
06				
	TOTAL PREMIUM(TZS/USD)			

UNDERWRITING OFFICER: SIGNATURE: DATE :