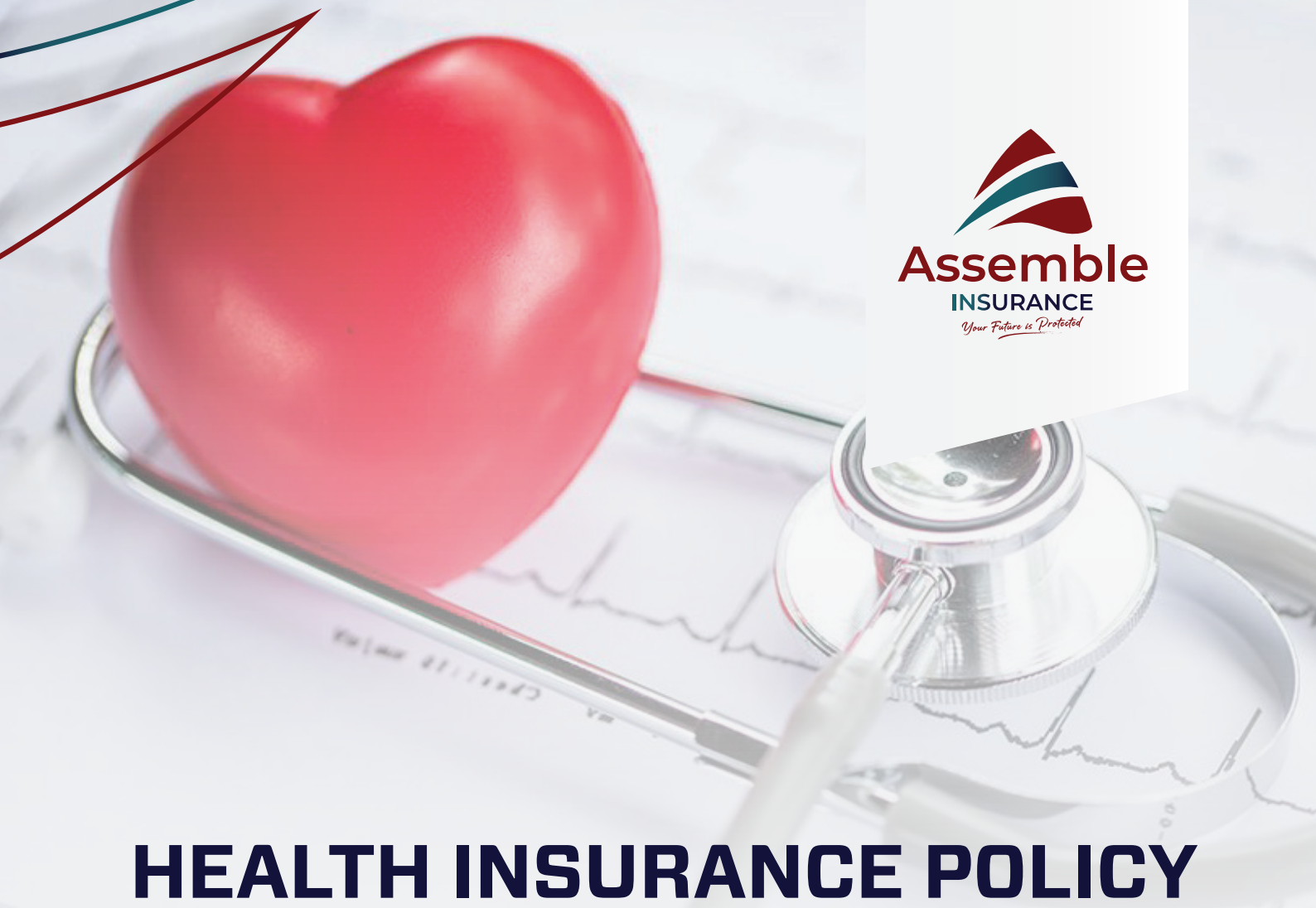

Assemble
INSURANCE
Your Future is Protected

HEALTH INSURANCE POLICY CORPORATE CLIENT

POLICY CONDITIONS

1.0 Standard terms and conditions

This Agreement, together with your signed Proposal Forms, and Certificate of Insurance make up the Contract between you and us. You are completed, signed and dated Proposal Forms are an integral and crucial part of your Agreement with us and the Cover we provide. The terms of this Agreement apply to you and all the members as stated on the Schedule of Insured Persons on your Certificate of Insurance only if you have an employer-employee relationship with the principal members listed in the Schedule of Insured Persons.
Words written in bold type have specific meaning within the context of this Agreement. Such words are either defined within the text of this Agreement, or in the Definitions section for the Agreement.

1.1 Completing your proposal form and Member application forms

When you apply for cover under this Policy you must ensure that your proposal form and your member application form have been honestly, fully and accurately completed, and that you and the principal member have made full disclosures of all the facts relating to your health and to the health of all your registered dependants.

1.2 Age limit

No new member may join any Assemble Scheme after age of Sixty-Five (65) years of age. However Assemble reserves the right to waive the age limits.

1.3 Commencement of your cover

Cover shall commence from the date of entry as stated on your **Certificate of Insurance**. We will not commence cover until we have accepted your proposal form (duly completed and signed by you) and we have received payment of your **full premiums**.

Your premium for each new period of cover will depend on the number of adult and children members you have on your schedule of insured persons at the start of the new period of cover and their plan type. Future renewal premiums are subject to change.

2.0 The cover provided

This Policy covers the costs of recognized medical treatments incurred by the members listed on your Schedule of Insured Persons. It also covers the costs of emergency treatment incurred while a member is temporary outside the territorial scope. We will also pay for the costs of referral for treatment overseas provided the treatment is not available in Tanzania. The provision of these services will be guided by the appropriate conditions in this policy and Benefit Schedule of your selected plan.

2.1 Waiting periods

There shall be no waiting period to access any benefit applied to members under this coverage, unless specified otherwise in the quotations.

2.2 Benefits of the health plans

The Schedule of Benefits table attached here to sets out the benefits provided by each health plan you have chosen for you and your registered dependant members. Please ensure that these members familiarize themselves with the benefits of their health plan. We will only pay for the benefits stated in this benefit schedule. If the member incurs cost for benefits not covered by their health plan, they will have to pay these cost themselves. The maximum amounts we pay for certain benefits are limited as per benefit schedule. If the member incurs cost in excess of the limits stated in this benefits schedule, they will have to pay for the exceeded amount, in case with approval of HR office, Assemble will pay the exceeded amount, the client will have to refund the exceeded amount with inclusive of 15% admin fee.

2.3 Service Providers panel

The service provider panel attached provides a listing of our accredited medical service providers within Tanzania. The Panel can change from time to time and changes will be communicated to you throug established communication channels.

3.0 Paying your premiums

Pursuant to section 137 of the Insurance Act (2009), section 35 of the Insurance Regulations (2009) and the amended insurance regulations (2017); An Insurance Policy will become invalid retroactive to the date of inception if full premium is not paid to the insurer for insurance cover effected at the instruction of the insured.

3.1 Premium on inception of cover

You must pay full premium amount due to us at the beginning of each Policy period, this payment for all the members on your Schedule of Insured Persons falls due before your cover commence.
We must receive your premiums on or before the due dates and in the nominated currency for your Policy. If the full premium due is not received by us on the due date all your members would not be eligible for receiving services which are otherwise available under the Policy till such time the premium is paid up. We would also have the right to cancel the Policy with effect from the due date.

3.2 Addition or cessation of members

If you wish to add new members with dependants you must submit a member application form completed by the new member applying for membership. If you wish to add new dependant of an existing member then you need to complete the new additional dependant application form. All registered child dependants must be on the same plan as one of the parent members. Any additional members must be included and any members that are ceasing cover must be excluded. The premium payment must be for all new members.

Premium due on additions during the month has to be paid monthly and the amount payable would be the pro rata premium applicable for additional members for the period they would be on cover till the expiry of the Policy period.

If you wish to delete a dependent member, you should send us a duly completed Dependent Deletion Form along with the original Insurance card of such dependent. We will delete the concerned dependents effective from the date of receipt of such application.

You must ensure that the insurance cards are returned to us immediately along with the application for deletion of dependents. You will be held responsible for payment if the members along with their dependants continue to avail of services at our accredited providers even after their exit from the scheme in the event of non-return of the insurance cards to us. We will send the invoice to you for the payment of any claims incurred by the terminated members and / or the dependent members.

3.3 Members changing health plans

If you or any registered dependent, wish to transfer to an Assemble Health plan with fewer benefits, you must tell us in writing and we may consider the change from your next renewal date. If a principal member with any registered dependants, wishes to transfer to an Assemble health plan with a wider range of benefits, they must tell us in writing, complete a new member application form and make a full declaration of any changes in their state of health since their date of entry. If accepted, we will make the change from your next renewal date. We may apply waiting periods if their state of health has changed since your date of entry or we may refuse to increase their cover at our sole discretion. Any increase in cover will be subject to us having received payment of the appropriate additional premium from you. No dependent shall be allowed to have a superior cover than the principal member.

3.4 Changes in premium rate

Once you are covered under our health plan you may continue to renew your cover annually. We shall determine your renewal premium at the time of renewal, rates of premium payable for adult or child members may vary from the previous policy rates, after consultation and agreement between Assemble and you we will rise an invoice. Reasonable advanced notice of amendments will be provided by us and in all circumstance at least 30 days prior to the date upon which the new premium will apply. Upon renewal of your policy all benefits may be subjected to changes.
All renewal premiums shall be based on claims experience from the past insurance period and will also take into account any loadings due to medical inflation.

3.4 Your renewal Invoice

We will send you a renewal invoice which will indicate the total premium due and schedule of Insured Persons under your scheme.

However, Assemble Insurance at our sole discretion may accept or reject any renewal.

4.0 Registered child dependants

Any registered dependent child can continue to be covered under their health plan at the appropriate child rate for as long as they are unmarried and less than eighteen (18) years old at each subsequent renewal date. When a registered dependent child marries, or reaches the age of eighteen (18) years at their renewal date they are no longer eligible to be covered as a child on the health plan.
A dependent child of eighteen (18) years or above and in full time studies may be allowed to be included in the cover as dependent until he/she reaches twenty-four (24) years of age provided that, evidence of being in full time studies is provided, the appropriate premium rate is charged based on the age of that dependent member and there is no break in their insurance period of cover. This member will not be entitled to access maternity benefit. Maternity benefits is the benefit for Main Member or Spouse.

5.0 Making and Settling of Claims

5.1 Local and Reginal Claims

All medical services have to be accessed at Assemble accredited service providers within East Africa. A member has to use Assemble medical insurance card whenever he / she seeks medical care. After receiving medical services from the accredited healthcare provider, member has to check the claim form if it represents the given services, then sign the claim form. Member has rights of explanation from the service provider in case of any concern or misunderstanding or ambiguity about the bill/service, member may escalate the matter/concern to Assemble for further actions.
Upon receipt of the claim form from the healthcare provider, we will vet it and payment shall be made directly to the healthcare provider.

5.2 In Patient Emergency Treatment while outside of East Africa

Member with an international health plan, traveling outside East Africa must notify Assemble prior to departure. Assemble will provide a travel letter for up to 45 days to cover for any inpatient emergency treatment/procedure while abroad.

4.2 Renewal Premiums

Your premium for each new period of cover will depend on the number of adult and children members you have on your schedule of insured persons at the start of the new period of cover and their plan type. Future renewal premiums are subject to revision and change.

4.3 Your renewal notification letter

We will send you a renewal notification letter which will indicate the total premium due and schedule of Insured Persons under your scheme. This letter will be sent to you prior to your renewal date. However, Assemble Insurance at our sole discretion may accept or reject any renewal. All renewal premiums shall be based on claims experience from the past insurance period and will also take into account any loadings due to medical inflation.

5. Making and Settling of Claims

5.1 Local and Reginal Claims

All medical services have to be accessed at Assemble accredited service providers within East Africa. A member has to use Assemble medical insurance card whenever he / she seeks medical care. After receiving medical services from the accredited healthcare provider, member has to check the claim form if it represents the given services, then sign the claim form. Member has rights of explanation from the service provider in case of any concern or misunderstanding or ambiguity about the bill/service, member may escalate the matter/concern to Assemble for further actions.

Upon receipt of the claim form from the healthcare provider, we will vet it and payment shall be made directly to the healthcare provider.

5.2 In Patient Emergency Treatment while outside of East Africa

Member with an international health plan, traveling outside East Africa must notify Assemble prior to departure. Assemble will provide a travel letter for up to 45 days to cover for any inpatient emergency treatment/procedure while abroad. In case of an inpatient medical emergency, member shall be required to report the case via WhatsApp number indicated on the travel letter to Assemble Insurance within 48 hours from time of accessing such service.

In case of an inpatient medical emergency, member shall be required to report the case via WhatsApp number indicated on the travel letter to Assemble Insurance within 48 hours from time of accessing such service. The member will be required to settle the bill for the medical treatment or service by himself/herself, then submit that bill/invoice to us for reimbursement at a reasonable and customary charge.
The cover will be up to the total value limited by the stated maximum sum applicable to the relevant Health Plan. The Company will not provide any outpatient, scheduled or non-Emergency hospital services outside the territorial scope. For North America the company will only meet fifty percent (50%) of the hospitalisation cost or where benefit limit is reached fifty percent (50%) of the benefit limit as per benefit schedule.

5.3 International/Regional Medical Referral and follow ups

In cases of international referral, member will have to submit a referral letter from tertiary level Hospital specialist indicating that, such treatment/service is not available within Tanzania. The letter must be accompanied by the medical report describing his/her current medical status for our review. Assemble will have sole desecration to decide on whether or not to approve an international referral requests. The referral will also consider the health plan of the member and the benefit balance. Before approving an International referral, Assemble may request for further information/documents from the member as it may be reasonably necessary.
If the referral request is approved, Assemble insurance will pay for a return Economy Class Ticket and accommodation while abroad. In case a referred member is a child or has a medical condition which does not allow him/her to travel alone, Assemble may authorize/provide a medical personnel to travel with the patient.
We do not pay for international/referral follow up visits, however upon submission of a comprehensive medical report from the treating hospital/doctor, Assemble may allow one immediate follow up visit only.

5.4 Reimbursement

ASSEMBLE shall only make cash reimbursement for medical services which were pre-authorized by ASSEMBLE or for medical emergency services or where there is no medical service provider accredited by ASSEMBLE

5.4.1 Submitting a Reimbursement Claim - Local Reimbursement Claims

If you or your registered dependent wishes to make a claim it must be submitted to us:
On a recognized Assemble Reimbursement claim form. This form shall show the patient's name, date of birth, address, membership number and signature, the details of tariff code, diagnosis and Treatment given and fees charged thereof and the healthcare provider's signature, together with an original Electronic Fiscal Devices (EFD) receipts.
On a bonafide original invoice. This invoice shall show the patient's name, address, the membership number and signature of the member. It must also provide sufficient details of treatment, service or supply to enable us to determine the amount payable to the member or healthcare provider.

5.4.2 Submitting a Reimbursement Claim - Foreign Reimbursement Claims

If the member has received inpatient medical emergency treatment or services while outside of East Africa, the member will be required to settle the bill for the medical treatment or service by himself/herself, then submit that bill/invoice to us for reimbursement at a reasonable and customary charge.
Invoices in such instances must show sufficient details to allow us to assess them and reimburse the member or pay the provider what is considered a reasonable and customary charge for the inpatient medical emergence treatment or service given, provided prior notification and authorization had been given to/by us for the travel, admission and treatment.
The information required for such claims to be approved and paid shall be: duly filled ASSEMBLE Reimbursement claim form, ASSEMBLE Travel Letter given prior travel, ASSEMBLE authorization for the services, proof of travel, full medical report for the procedure/treatment and original copies of the invoice/receipts. In addition the member's name and membership number must appear on the invoice for it to be acceptable as a claim.

5.5 Important points to remember when claiming

Claims shall be considered only if received by us within ninety (90) days after the date of service. The onus of ascertaining whether or not we have made payment for the medical treatment incurred shall rest with the member.

It shall be the duty of member to restrict medical expenses wherever possible to the reasonable limits, such as he/she would accept and sign the bill as if the payment will be from his/her own account/pocket. It shall be incumbent upon members to ensure that all claims are bona fide and they shall not connive and/or be party to any device or practice which may be prejudicial to us.
Only you or your registered dependent has the right to claim for incurred medical expenses from us.
Claims for medical treatment incurred in Tanzania shall be acceptable for assessment and payment, if the healthcare provider giving the treatment or service is currently registered with the relevant statutory body in Tanzania and who is a practitioner or Centre that is on our associated providers list.
Claims from self-referrals and non-adherence to the policy terms and conditions shall render your claim invalid. All members shall consider details of the nature of an illness or their treatment to be confidential on any claim lodged with us. All payable reimbursement claims will be subjected to a 10% co-payment deduction.

6.0 Benefits requiring pre-authorization

The following benefits falling under your Schedule of Benefits are available to your members only on pre-authorization from us if the same is accessed from our associated and accredited providers:-

6.1 All benefits listed under the heading of inpatient Benefits irrespective of whether the services is accessed after admission into the health care provider as inpatient or not.

6.2 All dental benefits.

6.3 All correction of eye sight benefits.

6.4 Other services such as but not limited to same day medical procedures, MRI & CT Scan

7.0 Members who are covered by another insurance plan

If any member listed on your Schedule of Insured Persons has any other insurance cover or right to compensation for the cost of treatment, for benefits the member has claimed from us, you must tell us in writing as soon as possible.

If the member does have other insurance cover or right to compensation, we will only pay our share of the cost of treatment up to the benefit limit applicable.

7.1 Claims for an illness or injury caused by a third party

If one of the members listed on your Schedule of Insured Persons is claiming for an illness or injury that was caused by some other person or organization (a third party) you must let us know in writing straight away, or indicate to us on the claim form. We will then pay benefit in accordance with the terms of this agreement provided you take all the reasonable steps we ask to recover from the person at fault (such as through the third party's insurance company) the cost of the treatment paid by us, plus interest, at our own expense. If you are able to recover the cost of any treatment for which we have paid, you must repay that amount, plus any interest, to us. If such repayment is not made we have the right to recover the expenses from you.

8.0 Our right to cancel your plan if we are misled

We can cancel the health plan of any member on the Schedule of Insured Persons who has misled us or been in breach of this Agreement, given us incorrect, incomplete or misleading information, failed to provide any reasonable information which we have asked for, conspired with a third party to obtain benefit from this plan, or submitted a claim which is in any respect fraudulent or unfounded. In any of these circumstances we have the right to cancel the member's cover from their date of entry and recover from you any benefit we have paid in relation to such claim.

9.0 Rescues and evacuations

The Company shall, on being notified of an Emergency that requires Rescue, arrange for a Company approved air or ground to undertake the Rescue of the Member.
The following terms and conditions shall apply:

- **a)** Whenever it deems necessary, the Company shall endeavor to ensure that a qualified doctor and/or nurse are on board the air or ground ambulance undertaking the Rescue.
- **b)** Depending on the severity of the injury or illness a Member may be flown either as a passenger on a commercial airline or on a chartered aircraft.

The Company will base the decision on the medical and logistical circumstances of the case.

c) The aircraft captain undertaking an air rescue shall have sole discretion to decide how evacuation shall be undertaken. The Company will not be liable for injury or loss suffered by a Member as a result of this decision.

d) The Company shall endeavor to transport an ill or injured Member directly to a destination to enable him to receive medical attention at a suitable hospital. If for any reason beyond the control of the Company or if in the opinion of a doctor or the aircraft captain the condition of the ill or injured person is such that it is necessary to terminate the flight or depart from the flight schedule or change the airfield of destination, the Company and the Member shall be deemed to have authorized such termination, departure or change as the case may be without thereby incurring any liability.

e) The Company shall not be liable for any injury or loss suffered by a Member if the Rescue or hospitalization is delayed, hindered or prevented by any circumstances whatsoever beyond its control including but not limited to acts of war, civil commotion or strife, lock-outs, stoppages or restraint of labour from whatever cause whether partial or general, government interference or restrictions, fire, flood, acts of God, compliance with international, national or local civil aviation regulations or any other regulations having the force of law, adverse weather conditions or the immobilization of aircraft or ground ambulance for any reason whatsoever, or breakdown in or failure of communications for any reason.

f) The Company shall not be liable for any injury or loss sustained by a Member in the course of undertaking a Rescue save as provided by the Carriage by Air Act or the relevant Carriage by Air legislation in the local jurisdiction.

g) The Company will only undertake a Rescue or provide medical services if a Member is seriously injured or ill, and requires immediate hospitalization. The Company may charge back and recover from a Member the full cost of a Rescue or hospitalization in circumstances where the Company would not have judged such Rescue or hospitalization necessary had it been correctly appraised of the medical condition of the Member prior to such Rescue or hospitalization, or if in its opinion the Accident, injury or illness giving rise to such Rescue or hospitalization could have been prevented or its-

consequences mitigated by the Member taking due and rea sonable precautions which he failed to do. Whether or not a particular medical case falls into any particular category will depend upon the circumstances of the case.

h) The Company will facilitate the provision of Reasonable and Customary care, and other medical services and treatment when transporting the Member to hospital .The costs of all these services together will be limited by the annual limit applicable to the relevant benefit. The Company has the right to decide who shall provide the appropriate service.

i) The Company will only provide evacuation to a Member who is entitled to such service and who is so ill or injured that his life is in immediate danger and who cannot obtain adequate medical treatment in the geographical region where the Emergency arises. The Company will decide on the necessity for such Evacuation in consultation with the treating Medical Advisor. The Company will pay for any one parent or guardian of the Insured Member who is under eighteen years of age to accompany him.

j) The Company reserves the right to seek the advice of its own medical advisor whose opinion will be binding upon all parties to the contract.

k) The Company's maximum liability shall not exceed the annual limit stated in the Schedule.

10.0 Cancellation of the cover under the health plans

10.1 Cancellation of cover under corporate client

If you decide to cancel the health plans for all the members listed on your Schedule of Insured Persons you must tell us in writing and we will cancel your cover from the beginning of the month after receipt of your instructions (not before; you cannot backdate the cancellation of any membership), or from a date in the future as advised by you. Provided no claims have been submitted in respect to the current period of cover, we will refund the prorated premium for remaining period that is from the date of notice of cancelation to the expiring date of the corporate (for all members who have not utilize their benefit).

If a member has submitted any claim, no premium refund is due. Credit note will be generated after Ninety (90) days from cancellation date, to provide time for submission of claims form from service providers if any.
We may cancel your Policy by sending 30 (thirty) days' notice by registered letter to you at your last known address and in such event you shall be entitled to the return of any premiums paid corresponding proportionately to the unexpired period of cover.
10.2 Cancellation of cover under member who has left the company.
You may terminate membership of any member in your plan by filling and Stamp Membership Cessation form. We will refund the prorated premium for remaining period that is from the date of notice of cancellation to the date of corporate expiring date for a member who has left your organization by issuing a credit note to your organization provided no claims have been submitted in respect to the current period of cover of such member. Credit note will be generated after Ninety (90) days from cancellation date, to provide time for submission of claims form from service providers if any.

11.0 Costs we do not cover

There are some costs and expenses that are not covered by the health plans. Please ensure that the principal members and their registered dependant read and understand this section as we will not pay for expenses arising from:

11.1 Addictive conditions/disorders and alcohol, drug and solvent abuse

We do not pay for any treatment required for or arising from any addictive condition or disorder, or misuse and/or abuse of drugs or alcohol, or substance or solvent abuse, even if it is related to prescribe drugs.

11.2 Bone marrow transplants

We do not pay for bone marrow transplants or any other organ transplants unless specially authorized in advance.

11.3 Contamination

We do not pay for the treatment of any conditions arising directly or indirectly from contamination caused from nuclear fission, ionizing radiation or by radioactivity from nuclear fuel or waste.

11.4 Cosmetic Surgery

We do not pay for operations or treatments which are not medically essential, including operations or treatments of a cosmetic nature whether or not such operations or treatments have been advised on treatment grounds.
We will, however, pay for a surgical operation to restore your appearance after an accident, or after surgery for breast cancer, provided the accident and/or breast surgery occurred after the member's date of entry and provided the original treatment for the accident or breast cancer surgery was paid for by us.

11.5 Criminal Activity

We do not pay for any treatment arising from or related to injuries sustained whilst engaging in a criminal or unlawful acts such as but not limited to suicide and abortion.

11.6 Experimental drugs and treatments

We do not pay for any treatment which in our reasonable opinion is experimental, or has not been proved to be effective based on established medical practice.

11.7 Foetal Surgery

We do not pay for surgery undertaken on a child whilst it is in its mother's womb except on emergency cases.

11.8 Health hydro's and sauna baths

We do not pay for the use of health hydro's, sauna baths, exercise centres or any similar establishments or private beds registered as nursing homes attached to such establishments or a hospital where the hospital has effectively become the member's home or permanent abode.

11.9 Infertility

We do not pay for investigation and treatment for infertility and all other related procedures once determined is infertility.

11.10 Menopausal treatment

We do not cover the cost of medication/procedure to treat the symptoms of menopause.

11.11 Professional sports and wilful exposure to needless danger

We do not pay for treatment required as a result of a member being engaged in any professional sporting activity, or any sport or activity reasonably considered by us, at our discretion, as being of a dangerous nature without limiting the generality thereof including but not limited to parachuting, gliding, paragliding, parascending, white-water rafting, canoeing, underwater diving involving the use of any artificial apparatus, unless the member holds an open water diving certificate and is diving with another certified diver or the member is diving with a certified instructor, both no deeper than 30 meters below the surface, hand gliding, or bungee jumping; or any occupation reasonably considered by us, at our discretion, as being of a dangerous nature, without limiting the generality thereof, including, but not limited to mining, construction and security unless previously disclosed and accepted by us.

11.12 Routine and periodic health examinations and vaccinations

We do not pay for any medical examinations or routine health checks, vaccination or preventative treatment of any kind unless indicated on your schedule of Benefits.

11.13 Search and rescue

We do not pay for search and rescue operations if a member is lost in a remote area.

11.14 Self-inflicted injuries

We do not pay for the treatment of self-inflicted injuries.

11.15 Travel documents and companion costs

In case of international referral, we do not pay for any costs relating to obtaining any traveling documents including but not limited to Passports and visa.

We also do not cover for the cost of airfares, hotel accommodation, food or any other cost for referred member's companion or relative of a member who is caring for the member whilst in hospital or being evacuated or under medical confinement of any kind, except for an international referral and the referred member is a child or has a medical condition which does not allow him/her to travel alone, Assemble may authorize/provide a medical personnel to travel with the patient.

11.16 Treatment prior to date of entry

We do not pay for any treatment that was given before a member's date of entry or after cancellation of membership or during any period for which we haven't received premiums.

11.17 Treatment that is not covered under the benefit schedule

We do not pay for any treatment that is not covered under the benefit schedule of the Assemble health plan of the member.

11.18 Treatment of any person who is not registered

We do not pay for any treatment that is not covered under the benefit schedule of the Assemble health plan of the member. We will not cover any treatment for a previous undeclared chronic condition.

11.16 Treatment prior to date of entry

We do not pay for any treatment that was given before a member's date of entry or after cancellation of membership or during any period for which we haven't received premiums.

11.17 Treatment that is not covered under the benefit schedule

We do not pay for any treatment that is not covered under the benefit schedule of the Assemble health plan of the member. We will not cover any treatment for a previous undeclared chronic condition.

11.18 Treatment of any person who is not registered

We do not pay for any treatment incurred by non-registered dependants of a member or any other person who is not listed on your schedule of insured persons.

11.19 Treatment by a relative

We do not pay for any treatment administered by family, or relatives of a member whether qualified or not.

11.20 Vitamins, Tonics, Minerals and other food supplements

We do not pay for any vitamins, tonics, minerals, and other food supplements etc. except for under five (5) years children, pregnant women and where the same is dispensed on a medical necessity to prevent side effect of a drug that is also dispensed along with such vitamins, tonics, minerals and other food supplements.

11.21 Homeopathy, Chiropractor and herbal medicines

We do not pay for any treatment of homeopathy, chiropractor and herbal medicines.

11.22 War Risk

We do not pay for treatment of any conditions arising directly or indirectly from or as a consequence of riot, strike or civil commotion, civil war, rebellion, revolution, insurrection or military or usurped power, any declared or undeclared war or the like, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) and acts of terrorism committed by a person or persons acting on behalf of or in connection with any organization.

11.23 Act of God

In the event where Assemble is unable to perform its obligations under the terms of this Agreement, despite having taken reasonable precautions, because of acts of God or other causes reasonably beyond our control, we shall not be liable for any damages resulting from such failure to perform or otherwise from such causes.

11.24 Pandemics/epidemic/unknown disease

Costs which are directly or indirectly related to a (possible) outbreak of an epidemic or pandemic, as declared and defined by the Government or World Health Organization (WHO), this is including: preventive and/or restrictive measures taken by the authorities,

such as travel restrictions and/or bans and keeping the insured, his/her family members and/or travelling companions quarantined, the cost of medical examinations and/or medical treatment of the insured by or on behalf of public authorities.

11.25 Transportation other than licensed ambulance authorized by Assemble

Assemble Insurance will not cover for any transport costs incurred by member other than services given by licensed ambulance and which was pre-authorized by Assemble

11.26 Self-international/regional referral

We will not cover costs which will be resulting from a member referring his/herself to a facility Outside of Tanzania without our pre authorization.

11.27 Outpatient and Maternity treatment while abroad

Maternity Benefit and Outpatient Benefit including Dental and Optical benefits are covered when visiting local accredited facilities only.

11.28 Re-imbursement not prior authorized by Assemble

This is an act of using health facility which has not been accredited by Assemble without Assemble pre-authorization and for non-emergency case.

12.0 Maternity Benefit (If applicable and covered under your policy)

a. Routine antenatal visits and laboratory tests.

b. Early and late ultrasound scans

c. Elective/Emergency caesarean section (C/S)

d. Normal delivery

e. Post-partum follow up clinics

f. Routine medication to correct anaemia

12.1 Benefits under term/ mature babies and preterm/ Premature Babies

Post-natal follow ups are limited to four weeks and in case of any complication arising during labor or delivery or after delivery the new born child will be covered up to Congenital Benefit of the mother. Thereafter the new born baby should be insured or Assemble will not be responsible for the hospital cost.

12.2 Benefits not covered under Maternity

a. Surgical correction of sex organs abnormalities and differentiation.
b. Induced abortion not medically indicated
c. Voluntary termination of pregnancy

13.0 Definitions of Key Terminologies

This section explains what we mean by certain words and phrases in this agreement. Words written in bold both here and in this agreement are particularly important as they have specific meaning.

Act of God an accident or event resulting from natural causes, without human intervention or agency, and one that could not have been prevented by reasonable foresight or care

Adult means all principal members and his/her spouse on the schedule of insured persons.

Accident means a sudden, unexpected, specific event which occurs at an identifiable time and place.

Agreement means the contents of this Policy read in conjunction with your completed and signed proposal form, members' Application forms and your Certificate of Insurance. Together these make up your contract with us.

Annual means a period of twelve calendar months from the first day of the month of the date of entry of the member.

ASSEMBLE means ASSEMBLE Insurance Tanzania Limited.

Benefit schedule means the particular benefits provided by the health plans you have bought for the principal members and their registered dependents who appear on your Schedule of Insured Persons. It states the type of expenses we cover and the maximum amount we pay for each particular benefit during your period of cover, subject always to the terms, conditions and exclusions of this agreement.

Checkups means doing medical examinations and / or investigations which are not related on any medical diagnosis.

Certificate of Insurance means the confirmation of insurance cover issued by us. Your certificate of insurance confirms the health plans you have bought, premium paid and period of the cover. It also includes list of Insured Persons. If there are any changes to the details on your Certificate of Insurance we will issue you with a new Certificate of Insurance confirming the changes.

Cosmetic Surgery/Procedure are surgeries or procedures with the intention of improving the appearance of a body, this includes but not limited to dental alignment, bridging, crowning and cleaning.

Child means a principal member's own son or daughter, step-son or step-daughter, or any legal minor dependent of the principal member. The child is under 18 (eighteen) years of age.

Chronic condition means a medical condition that requires continuous treatment for four months or more and appears on the chronic registration list.

Date of entry means the date on which cover for each of the members listed in your Schedule of Insured Persons commenced.

Emergency means a situation in which a member requires immediate hospitalization and treatment to prevent a medical condition that arises from an accident, injury or sudden illness from threatening the life or long-term health of the member.

Evacuation services mean the transportation of a member to a nearest hospital within Tanzania from the place of distress where adequate services are not available to stabilize the patient in the event of an emergency and life threatening medical conditions of the member.

Endorsements is a document by which we make amendments to the agreement, the certificate of insurance, the Benefit Schedule, the schedule of waiting period, the schedule of insured persons and any other such attachment to the certificate of insurance.

Healthcare provider means a person or place recognized by us to provide medical health services, this include:

- **a)** A registered medical practitioner, including general practitioner, physician, specialist, surgeon, anesthetist, pathologist or radiologist;
- **b)** A registered nurse;
- **c)** A registered pharmacist and pharmacy;
- **d)** A registered physiotherapist;
- **e)** A registered dentist;
- **f)** A registered optician;
- **g)** A private or other hospital;
- **h)** A supplier of internal prostheses.

Infertility means primary or secondary inability to bear children. This can be either due to congenital or acquired causes

Life threatening condition means a critical medical condition, covered by a member's plan, which in the opinion of specialist healthcare provider constitutes a life threatening situation which requires immediate inpatient treatment.

Member means either a principal member or registered dependent who appears on your Schedule of Insured Persons and for whom you pay us a premium to be covered by one of the health plans.

Member application form means the application form that anyone, wishing to be covered by an Assemble health plan, must complete honestly, fully and accurately about themselves and any of their dependents.

New Born baby (full term/mature babies) means any baby born between 38th week and 42th week.

New Born baby (pre-term/premature) means any baby born before 38th Week.

Parent accommodation means the necessary accommodation for a parent who is accompanying a child (under 18 years) during a rescue or evacuation or international referral.

Period of cover is a period of one year from the Commencement Date for which the premium has been received and accepted. The period of cover will continue, subject to the terms and conditions of this agreement, provided we receive your premiums on or before the due date. If a premium is not received by us on or before its due date, your period of cover will end from the day before the unpaid premium's due date.

Post hospitalization means a period of 90 days after a member has been hospitalized in which the medical services, related to the conditions for which the member was hospitalized, are covered.

Pregnancy (Normal) means pregnancy from the day of conception to the day of spontaneous delivery (SDV) or Caesarean Section (SV)

Pregnancy (Abnormal) means pregnancy with complications such as but not limited to early bleeding (ante partum),abortions (threatened inevitable/spontaneous) leakage of amniotic fluid(ammonites), intrauterine fetal death (IUFD), pregnancy induced hypertension, ectopicpre glance, excessive liquor/inadequate liquor (polyhydramnios/ oligohydramnios), abnormal lies (breech/transverse/oblique), intrauterine congenital malformations (neural tube defects/ hydrocephalus/ spina bifida/ encephalic/ anencephalies/ conjoined twins/ orthopaedian.

Premium means the amount you are required to pay us annually for yourself and your registered dependents listed on your Schedule of Insured Persons.

Premium due date means the date on which your premium payment falls due.

Pre-existing conditions means medical problems, and or chronic ailments one had when they obtained their health insurance cover or at the time they enrolled in their health insurance coverage.

Principal member means anyone who has completed a member application form and has been accepted by us to be covered under an Assemble health plan.

Proposal form means the application form you have completed and signed on behalf of yourself and your registered dependents for whom cover is requested.

Psychiatric treatment means any necessary hospitalization of a member for a psychiatric disorder.

Reasonable and customary means the costs that ASSEMBLE Insurance shall reimburse a member on the basis of the general cost of similar medical services obtainable within ASSEMBLE and it's accredited Medical Facilities.

Registered dependent means a legally recognized spouse or legal child of a principal member who has been accepted by us and for whom premiums have been received by us from you.

Renewal Date is shown on your Certificate of Insurance and will normally be the beginning of each period of cover.

Rescue means the transportation of a member who has suffered a serious medical emergency, within Tanzania, from area of emergency to the nearest health facility where stabilization and management of the condition can be provided.

Schedule of Insured Persons means members either a principal members or registered dependent who is covered under your Certificate of Insurance and for whom you pay us premium to be covered under Assemble health plan.

Self-Referral is an act of referring oneself to an international/Regional health facility Outside of Tanzanian without pre authorization of Assemble Insurance.

They, their, them and themselves means any member listed on your Schedule of Insured Persons.

Us, we, our means Assemble Insurance Tanzania Limited.

You, your means any individual that holds a policy with us for themselves and their dependents who are members of an ASSEMBLE health plan.

Waiting period means that a period of time for which a member is required to wait to be entitled to full benefit for a particular condition.

14. Expiry of Membership

In the event of the expiry, termination of the Policy/contract or a membership withdrawal the Employer/Insured shall be responsible for the collection and surrendering of the Assemble identity cards to Assemble.
The Employer/Insured shall bear full responsibility in case of usage of the card after the expiry, termination or withdrawal of the membership.

15. Interpretation of the Agreement

This Agreement shall only be read in conjunction with the Certificate of Insurance and all attachments as listed therein. The contents of the Certificate of Insurance and its attachment shall supersede the contents of this Agreement wherever there is conflict between the two. Hand written matters will always have to be signed and stamped by the authorized signatory to the Certificate of Insurance.

16. Arbitration and jurisdiction

All differences arising out of this Policy shall be referred to the decision of an arbitrator to be appointed, in writing, by the parties in difference or, if they cannot agree upon a single arbitrator to the decision of two arbitrators, one to be appointed in writing by each of the parties within one calendar month after having been required to do so by either of the parties or in case the arbitrators do not agree of an umpire appointed in writing by the arbitrators before entering upon the reference. The umpire shall sit with the arbitrators and preside at their meetings and the making of an award shall be a condition precedent to any right of action against us. If we disclaim liability to you for any claim hereunder and such claim shall not within six months from the date of such disclaimer have been referred to arbitration under the provisions herein contained then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.
Any legal proceedings instituted in connection with this Policy shall be brought before the relevant arbitration legislation in the United Republic of Tanzania.

PERSONAL DATA PROTECTION POLICY

1.0 Preamble

Assemble Insurance Tanzania Limited is committed to protecting the personal data of clients, employees, partners, and the public. We recognize privacy as a fundamental right, and this policy affirms our responsibilities under Tanzania's Personal Data Protection Act, 2022, including robust procedures for security, transparency, lawful processing, and accountability. This policy applies across all insurance services (health and general) and employment practices.

2.0 Overview Of The Policy

Definitions

Personal Data: Any information relating to an identified or identifiable individual.
Data Subject: An individual whose personal data is collected.
Processing: Any operation performed on personal data (e.g. storage, use, transfer).
Sensitive Data: Data relating to health, biometric, criminal, or financial records.
Processing: Any operation performed on personal data including collection, storage, retrieval, use, disclosure, and deletion.
PDPC: Personal Data Protection Commission of Tanzania.
DPO (Data Protection Officer): A person officially appointed to oversee how an organization handles personal data.
A Data Protection Impact Assessment (DPIA): A structured process used to identify and minimize risks to personal data before starting any project or activity that involves sensitive or large-scale data processing.

3.0 Introduction

In an increasingly digital and interconnected environment, data protection is both a legal and ethical responsibility. Assemble Insurance is dedicated to implementing robust controls for secure, transparent, and responsible use of personal data.

4.0 Purpose

To establish clear rules and procedures for handling personal data in compliance with PDPA, and to foster trust among clients, employees, and partners through transparent practices.

5.0 Scope

This policy applies to:

- All employees, officers, intermediaries, and contractors of Assemble
- Insurance Tanzania Limited;
- All third parties and service providers who process personal data on behalf of Assemble Insurance Tanzania Limited;
- All personal data collected from clients, policyholders (and their dependents), prospective policyholders(and their dependents), beneficiaries, employees, partners, vendors, and other stakeholders, visitors to the company premises.

6.0 Policy Statements

6.1 Principles of Personal Data Protection

Assemble adheres to the following core principles:

- **Lawfulness:** Only collect data with legal justification.
- **Fairness & Transparency:** Inform people why and how their data is used.
- **Purpose Limitation:** Don't use data for unrelated purposes.
- **Minimization:** Collect only what's necessary.
- **Accuracy:** Keep data up to date.
- **Storage Limitation:** Don't keep data longer than needed.
- **Security:** Protect data from unauthorized access.
- **Respect for Rights:** Honor requests for access, correction, or deletion.

6.2 Data Collection and Use

Types Collected:

- Identification details: (e.g. NIDA, passport, license, gender, nationality, marital status, Contact details, occupation/nature of business,).

- Health and medical records: For medical insurance application.
- Asset and claim details.
- Employment, payroll, and HR records.
- Surveillance footage via CCTV.
- Cookies and tracking data (web platforms).

Methods:
- Policy application forms.
- Claim submissions.
- Recruitment systems.
- Surveillance tools and company portals.

Legal Basis:
- Consent.
- Contractual necessity.
- Legal obligation.
- Legitimate interest (e.g. fraud prevention).

6.3 Data Subject Rights
Data subjects may:
- Access their personal data.
- Request correction or deletion.
- Withdraw consent at any time.
- Object to certain processing.
- Lodge a complaint with PDPC.

6.4 Processing Sensitive and/or Genetic/Biometric Data
Sensitive data is processed only when:
- Explicit consent is obtained.
- Required by law for insurance, employment, or security.
- Necessary for fraud investigation or claim validation.

Data is encrypted and access restricted to authorized personnel.

6.5 Consent Management
Consent is:
- Obtained during onboarding, application, or service engagement.
- Recorded securely.
- Revocable upon request (unless required by law).

6.6 Data Security and Storage

We maintain:

- Access controls and user authentication.
- Data encryption at rest and in transit.
- Firewall and intrusion detection systems.
- Secure servers for digital and physical storage.
- CCTV monitoring for physical site protection.

6.7 Complaints Handling

Complaints related to data misuse are handled via:

- Written submission to DPO.
- Internal investigation within 14 working days.
- Escalation to PDPC if unresolved.

6.8 Roles and Responsibilities of the DPO

The DPO is appointed independently to

- Oversee data protection practices.
- Advise on DPIAs and policy reviews.
- Serve as point of contact for PDPC and data subjects.

6.9 Employee Training and Awareness

All staff receive:

- Annual training on PDPA compliance.
- Onboarding guidance on data responsibilities.
- Refresher modules during system changes.

6.10 Data Retention and Disposal

- We retain your personal data only for as long as necessary to fulfill the purposes outlined in our Privacy Policy, or as required by applicable laws and regulations.

- Once the retention period expires, we securely delete or anonymize your data to ensure it is no longer identifiable or accessible.

- The retention periods for each category of data subjects and their respective personal data may vary based on the specific circumstances and legal requirements. Here are some general guidelines regarding data retention:

Retention Schedule by Data Category

Data Type	Retention Period	Rationale
Client personal data (non-biometric)	10 years after policy expiry	Regulatory audits, fraud investigations.
Biometric data (clients & employees)	1 year after contract ends	Minimize risk; ensure lawful processing.
Claims records	10 years	Legal defense, fraud detection, actuarial review.
Financial transactions	10 years	Tax and audit compliance.
Employee records	5 years after termination	Labor law compliance, internal investigations.
Consent forms	Duration of processing + 2 years	Proof of lawful basis for processing.
Health data	10 years	Medical underwriting, dispute resolution.
System logs (access /authentication)	1 year	Security audits, breach investigations

Review and Disposal:

- Annual Review: Data inventories shall be reviewed annually to identify records eligible for disposal.
- Secure Disposal: Data shall be destroyed using secure methods—e.g., digital shredding, physical document incineration.
- Documentation: Disposal actions must be logged for audit purposes.

Exceptions

- Data may be retained longer if required by law, litigation, or regulatory inquiry.
- Anonymized data may be retained indefinitely for statistical or research purposes.

6.11 Personal Data Breach Notification

In case of a breach:

- The DPO assesses severity within 72 hours
- A report is submitted to PDPC
- Affected individuals are notified with mitigation steps

6.12 Privacy Notes

Data subjects are informed via:

- Policy documentation
- Website banners and alerts
- Consent forms at point of collection

6.13 Data Protection Impact Assessment (DPIA)

DPIAs are conducted for:

- New IT systems
- Outsourced data processing
- Surveillance expansion or automation

6.14 Transborder Flow of Personal Data

When transferring data abroad, we ensure:

- Contracts with data protection clauses
- PDPC approval for sensitive transfers
- Use of encrypted channels

6.15 Sharing Personal Data

We share data only with:

- Regulators (e.g. TIRA, TRA, NSSSF)
- Reinsurers, claims assessors
- Consultants (e.g. Appointed Actuary)
  External Auditors
- Vendors under confidentiality agreements
- Each disclosure is logged and justified.

6.16 Disclosure to Law Enforcement

Disclosures are made:

- Upon receipt of valid legal orders
- With documentation of scope and necessity
- Limited to relevant data fields only

6.17 Use of CCTV and Locator Technologies

CCTV: Deployed at offices for safety and incident tracking
Recordings are retained by the legal retention schedule.

6.18 Data Protection by Design and by Default

We apply privacy measures at design stage including:

- Minimization of data fields
- Opt-in defaults for marketing
- Mandatory DPIAs for system upgrades

7.0 IMPLEMENTATION, MONITORING & EVALUATION

The DPO oversees policy implementation, supported by periodic audits, internal compliance reviews, and reporting to senior management. Feedback mechanisms, breach logs, and employee surveys help evaluate adherence and improve controls.

ACKNOWLEDGEMENT BY THE INSURED

We acknowledge to have read the Policy Document and understand the contents therein.

Signature and Stamp: _____Date:_____

Company Representative

Assemble
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Your Future is Protected

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