Assemble
INSURANCE

Tanzania Head Office
Mlimani City Office Park, Building No.6,
1st Floor, Sam Nujoma Road Ubungo,
Dar es Salaam, Tanzania

P.O Box 9600, Dar Es Salam
Tel: +255 22 2411500 | +255 22 2411501
Fax: +255 22 2781472 | +255 22 2781204

Email: info@assemble.co.tz

INDIVIDUAL MEMBERSHIP
APPLICATION FORM

PLEASE COMPLETE IN FULL (IN BLOCK LETTERS) AND ATTACH THE FOLLOWING DOCUMENTS:

1. Recent passport-size photograph (taken within the last 6 months)
2. Copy of valid ID (National ID or Passport)
3. Birth certificate(s) for all children listed on the application
4. Marriage certificate (Applying for family coverage)

IMPORTANT:
Please note that failure to complete all information on all sides will delay the processing of your membership. All questions must be answered truthfully. N/A is not acceptable. Any alterations to any answer must be counter signed by the policy holder.

1	PERSONAL DETAILS TO BE COMPLETED BY POLICY HOLDER (Please Print)			
	SURNAME		FIRST NAMES	
	DESIGNATION		ID/PASSPORT NO:	
	POSTAL ADDRESS			
	PHYSICAL ADDRESS		EMAIL	
	MOBILE NO		TIN NO.	
	INTERMEDIARY NAME (IF ANY)			

2	ENTER BELOW DETAILS OF THE POLICY HOLDER (00), SPOUSE (01) WHERE APPLICABLE AND ALL DEPENDANTS TO BE INCLUDED IN THE APPLICTION FOR MEMBERSHIP IN AGE ORDER													
		SURNAME	FIRST NAME	GENDER	DATE OF BIRTH								CATEGORY	CARD TYPE	PREMIUM
					D	D	M	M	Y	Y	Y	Y			
	00												POLICY HOLDER		
	01												SPOUSE		
	02												DEPENDANT		
	03												DEPENDANT		
	04												DEPENDANT		
	05												DEPENDANT		
	06												DEPENDANT		
														TOTAL (TSHS.)	

3	Has anyone here ever had medical insurance, or currently has one	YES ☐	NO ☐
	If YES give details: INSURER	POLICY NO:	

4	Please provide the following particulars:							
		SURNAME	FIRST NAME	BLOOD GROUP	ALLERGIES	HEIGHT (M/CM)	WEIGHT (KGS)	OTHERS
	00							
	01							
	02							
	03							
	04							
	05							
	06							

5	Have you ever had any of the following medical conditions? (Ask your doctor for assistance if needed.)							
	NOTE: IF THE ANSWER IS YES TO ANY QUESTION BELOW, PLEASE PROVIDE FULL DETAILS BELOW EXCEPT IN UNCOMPLICATED CASES I.E. APPENDICECTOMY, TONSILLECTOMY, ADENOIDECTOMY, CAESARIAN SECTION AND CHOLECYSOSTOMY							
	QUESTIONS	00	01	02	03	04	05	06
(a)	CARDIOVASCULAR							
	High Blood Pressure							
	Heart Disease							
(b)	RESPIRATORY							
	Asthma							
	Tuberculosis							
(c)	ENDOCRINE							
	Thyroid Disease							
	Diabetes							
(d)	NEUROLOGICAL							
	Paralysis							
	Paralysis							
(e)	BLOOD DISORDERS							
	Sickle Cell Anemia							
	Leukemia							
	AIDS/HIV							
(f)	MUSCULOSKELETAL							
	Arthritis							
	Gout							
	Slipped Disc							

	QUESTIONS		00	01	02	03	04	05	06
	(g)	GENITO-URINARY							
		Pelvic Inflammatory (Female)							
		Fibroids (Female)							
		Enlargement of the Prostrate (Male							
	(h)	GASTRO-INSTETINALL							
		Duodenal or Stomach Ulcers							
		Liver Disease							
	(i)	SURGICAL OPERATIONS							
	(j)	OTHER MEDICAL CONDITIONS OR DISABILITIES (Not specifically covered above)							
	(k)	HOSPITALISED (within the last 3 years							
	(l)	CANCER , TUMORS OR GROWTH							
	(m)	ARE YOU PREGNANT? (Female)							
	(n)	ON REGULAR PRESCRIBED MEDICATION							

	00	
	01	
	02	
	03	
	04	
	05	
	06	

6 FAMILY DOCTORS INFORMATION

DOCTOR'S NAME: TEL NO.

CLINIC PHYSICAL ADDRESS

HE/SHE TREATES (NAME)

PHYSICAL ADDRESS EMAIL

7 PARTICULARS OF NEXT OF KIN/BENEFICIARY OF FUNERAL BENEFITS IF PROVIDED UNDER THE BENEFITS

IF CHILD GIVE DETAILS OF GUARDIAN

NEXT OF KIN (FULL NAME)

RELATIONSHIP PASSPORT/ID NO.

ADDRESS TELEPHONE

8 ANTI-MONEY LAUNDERING CHECK

What is the Source of Funds for Premium Payment (Please tick as applicable)

☐ Salary ☐ Business Income ☐ Investment Returns ☐ Gift/Inheritance ☐ Other

If Other, please specify here

Are you or any of the family member listed in this application form a Politically Exposed Person (Please tick as applicable)

☐ YES ☐ NO

If Yes, please write the name here:

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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		
UNDERWRITING OFFICER	SIGNATURE:	DATE:
OTHER COMMENTS		
DESGINATION	SIGNATURE:	DATE:

DECLARATION

IMPORTANT: The following in conjunction with the scheme rules or membership constitute the contract with Assemble insurance, sign below, unless anything is not clear in which case kindly seek further advice from assemble insurance. note that all reference to the singular includes, the case of dependents, all those under 18 years. the policy holder must sign the declaration on his/her own behalf and on behalf of all other dependents under 18 years.

1. I declare that all those persons named in the application form are members of my immediate family for whose membership I am responsible.

2. I am applying for the Service Combination of Assemble Insurance membership as marked on the first page.

3. My country of residence is within the territory as declared in this application form and I will notify Assemble Insurance if it ceases to be so.

4. I have declared all material facts whether or not asked to do so, and I understand that Assmble Insurance has reserved the right to reject my application or terminate my membership at the end of any Benefit Year without divulging any reasons for doing so. I agree to notify Assemble Insurance of any subsequent changes in my medical condition and understand that such changes may cause Assemble Insurance to modify or discontinue my membership. Except as declared, I have not been a Member of Assemble Insurance before, either under my present or any other name, nor have I been rejected for membership of any similar organization or at life insurance health insurance or medical insurance provider. nor have I been rejected for membership of any similar organization or at life insurance health insurance or medical insurance provider.
   I understand and agree in particular that:-

5. I become a member from my commencement date and I understand that if the Membership is not renewed my Membership shall be terminated and I shall reapply for membership and shall be treated as a new Member.

i) Renewals shall be effected upon receipt by Assemble Insurance of written confirmation with the appropriate premium payment from the Member. Failure to renew before the end of the Benefit year, the Member shall forfeit his policy cover and submit and execute a new Membership Application Form. The Member shall forfeit his no claim discount, if applicable.

6. If I am a new Member, Assemble Insurance does not pay any costs of hospital admission for illness, nor for related Rescue and Evacuation, during the first 90 days of membership. A similar restriction applies in respect of the additional benefits available on upgrading my Service Combination for 90 days from the appropriate date of upgrading. If any medical condi- tion arises during these 90 days, whether in Eastern Africa or abroad, of which Assemble Insurance was not aware at the appro-priate commencement date and which might have affected Assemble Insurance's decision to accept my membership, Assemble Insurance may place an exclusion or cancel my membership and refund my fees.

7. Benefits do not extend to non -members.

8. Assemble Insurance will only provide services outside my country of residence during the first 45 days of absence from country of residence in any one benefit year (applicable as per membership Health Plan) elected.

9. I must arrange any scheduled hospitalization with Assemble Insurance at least 48 hours prior to admission, and in the event of an emergency I must contact Assemble Insurance within 24 hours of admission. O n c e Assemble Insurance has agreed such admission, Assemble Insurance will provide medical services directly and will not reimburse me for any medical bills paid by me or on my behalf.

10. Any misrepresentation, fraudulent act, false statement or non-disclosure of m a t e r i a l information in this application from will render my membership invalid, and I will then forfeit my membership fees and be liable to refund to Assemble Insurance on demand all costs incurred by it in connection with Rescue, Evacuation, hospitalization or other services provided by it.

11. Assemble Insurance has the sole discretion in all cases to decide which doctor from its panel of doctors, hospitals or rescue facility outside the choice of Assemble Insurance, Assemble Insurance shall only be liable to cover the costs chargeable by its panel doctors, hospital or facility of choice.

12. I will only be entitled to benefits as from the commencement date and subject to the overall limits of the selected Service Combination.

13. I understand and agree that no cover will be provided under the proposed insurance policy until the appropriate premium has been paid in full to Assemble Insurance Tanzania Limited. This contract is automatically renewed at the end of a Benefit Year upon the full payment of the renewal fee unless Assemble Insurance decides otherwise in which case it shall confirm this to be the case to me in writing.

14. Assemble Insurance will not refund any premiums unless I wish to cancel my membership within 30 days of my initial Commencement Date. In that case I may apply for a full refund provided no services have been rendered by Assemble Insurance on my behalf.

15. I understand and agree that Assemble Insurance have complied to all applicable laws relating to data protection and privacy including the data protection Act of Tanzania. I understand and agree that Assemble Insurance shall Implement appropriate technical and organization measures to protect personal data against unauthorized or unlawful

processing, accidental loss, destruction or damage. I understand and agree that In the event of data breach, Assemble Insurance will notify the policy holder within 24hrs of becoming aware of the breach and provide a detailed incident report within 72hrs.

16. I understand that medical evaluation is a mandatory requirement at the inception of this contract if I or any of the Dependants has attained 45 years of age.
However, regardless of the age of the applicants for membership Assemble Insurance may at its own discretion require a medical evaluation of any applicant. It is a mandatory requirement to undergo a medical evaluation on a yearly basis or at such other frequency as Assemble Insurance may at its own discretion decide if I or any Dependant attained the age of 65years and above.

17. I understand that if my membership is not renewed as per clause (a) (i) following the completion of the previous Benefit Year, this contract shall be deemed to have been terminated. I further understand in renegotiating a new contract Assemble Insurance my at its discretion require my fulfillment.

18. I hereby declare that the funds used for the payment of premiums and any other financial transactions related to this application are not derived from any illegal activities. I understand and acknowledge that the institution is required to comply with Anti-Money Laundering (AML) regulations and may request additional information or documentation to verify the source of funds. I further consent to the institution conducting due diligence checks, including identity verification and transaction monitoring, as required by applicable laws and regulations.
of new conditions to join including but not limited to medical examination and Assemble Insurance's decision thereon and revised membership fees.

19. I understand that in the event of Assemble Insurance not renewing my contract. I am required to surrender my membership card within 7 days. Failure to surrender the card or use after Membership has been terminated, shall be considered fraudulent and Assemble Insurance reserves to take legal action.

20. I hereby consent to Assemble Insurance contacting my doctor or medical institution to obtain medical information about me and I hereby authorise such doctor or institution to make full disclosure of such information to Assemble Insurance or its advisers, and to provide access to my complete medical and hospital records whenever require.

SIGNATURE OF POLICY HOLDER: ..... DATE: .....