INDIVIDUAL MEMBERSHIP PROPOSAL FORM

Please complete in full (in BLOCK letters) and attach two recent passport size photographs per applicant and copy of identification for policy holder and all dependants over 18. **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 _____

OCCUPATION _____ ID/PASSPORT NO: _____

POSTAL ADDRESS _____

PHYSICAL ADDRESS _____ E-MAIL _____

TELEPHONE NO. OFF. _____ RES. _____ MOBILE _____

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. Are you or any of your family named above, Member of any Rescue or Medical Insurance Scheme: 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							
	Epilepsy							
(e)	BLOOD DISORDERS							
	Sickle Cell Anemia							
	Leukemia							
	AIDS/HIV							
(f)	MUSCULOSKELETAL							
	Arthritis							
	Gout							
	Slipped Disc							
(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)	ON REGULAR PRESCRIBED MEDICATION							
00								
01								
02								
03								
04								
05								
06								

6. FAMILY DOCTOR'S INFORMATION

DOCTOR'S NAME: TEL NO. MOBILE NO.

CLINIC PHYSICAL ADDRESS

HE/SHE TREATES (NAME)

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

IF CHILD GIVE DETAILS OF GUARDIAN

NEXT OF KIN (NAME IN FULL)

RELATIONSHIP PASSPORT/ID NO.

ADDRESS TELEPHONE

8. MODE OF PAYMENT

☐ CASH ☐ CHEQUE ☐ CREDIT CARD

9. DECLARATION

How did you get to know about AAR INSURANCE (Please tick as applicable)

Friend ☐ Media ☐ AAR Member ☐ AAR Website ☐ Other ☐

For Official Use Only

Membership No. Cash Sale/Invoice No. Date

Corporation: Membership Valid to Membership approved by:

Membership since: Membership sold by:

HEAD OFFICE – DAR ES SALAAM TANZANIA

AAR INSURANCE (T) Ltd, A.H.Mwinyi Rd/Chato St, Plot1, P. O. Box 9600 Dar Es Salaam, Tanzania
Tel: +255 22 2701121/4, Fax: +255 22 2701120 Emergency 24hrs +255 754 760790
Customer Helpline 24hrs +255 786 747777, Email: Info.tz@aar-insurance.com

AAR 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 :**

DECLARATION

IMPORTANT: THE FOLLOWING IN CONJUNCTION WITH THE SCHEME RULES OR MEMBERSHIP CONSTITUTE THE CONCTRACT WITH AAR INSURANCE, SIGN BELOW, UNLESS ANYTHING IS NOT CLEAR IN WHICH CASE KINDLY SEEK FURTHER ADVICE FROM AAR INSURANCE. NOTE THAT ALL REFERENCE TO THE SINGULAR INCLUDES, THE CASE OF DEPENDANTS, ALL THOSE UNDER 18 YEARS. THE POLICY HOLDER MUST SIGN THE DECLARATION ON HIS/HER OWN BEHALF AND ON BEHALF OF ALL OTHER DEPENDANTS 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 AAR 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 AAR 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 AAR 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 AAR Insurance of any subsequent changes in my medical condition and understand that such changes may cause AAR Insurance to modify or discontinue my membership. Except as declared, I have not been a Member of AAR 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.

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 AAR 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, AAR 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 condition arises during these 90 days, whether in Eastern Africa or abroad, of which AAR Insurance was not aware at the appropriate commencement date and which might have affected AAR Insurance's decision to accept my membership, AAR Insurance may place an exclusion or cancel my membership and refund my fees.

7) Benefits do not extend to non-members.

8) AAR 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 AAR Insurance at least 48 hours prior to admission, and in the event of an emergency I must contact AAR Insurance within 24 hours of admission. Once AAR Insurance has agreed such admission, AAR 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 material information in this application from will render my membership invalid, and I will then forfeit my membership fees and be liable to refund to AAR Insurance on demand all costs incurred by it in connection with Rescue, Evacuation, hospitalization or other services provided by it.

11) AAR Insurance has the sole discretion in all cases to decide which doctor from its panel of doctors, hospitals or rescue facilities should be used in any particular case. Where a Member insists on using a doctor, hospital or rescue facility outside the choice of AAR Insurance, AAR 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) This contract is automatically renewed at the end of a Benefit Year upon the full payment of the renewal fee unless AAR Insurance decides otherwise in which case it shall confirm this to be the case to me in writing.

14) AAR 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 AAR Insurance on my behalf.

15) 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 AAR 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 AAR Insurance may at its own discretion decide if I or any Dependant attained the age of 65years and above.

16) 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 AAR Insurance my at its discretion require my fulfillment of new conditions to join including but not limited to medical examination and AAR Insurance's decision thereon and revised membership fees.

17) I understand that in the event of ARR 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 AAR Insurance reserves to take legal action.

18) I hereby consent to AAR 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 AAR Insurance or its advisers, and to provide access to my complete medical and hospital records whenever required.

SIGNATURE OF POLICY HOLDER: _____ DATE: _____

HEAD OFFICE – DAR ES SALAAM TANZANIA

AAR INSURANCE (T) Ltd, A.H.Mwinyi Rd/Chato St, Plot1, P.O. Box 9600 Dar Es Salaam, Tanzania
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