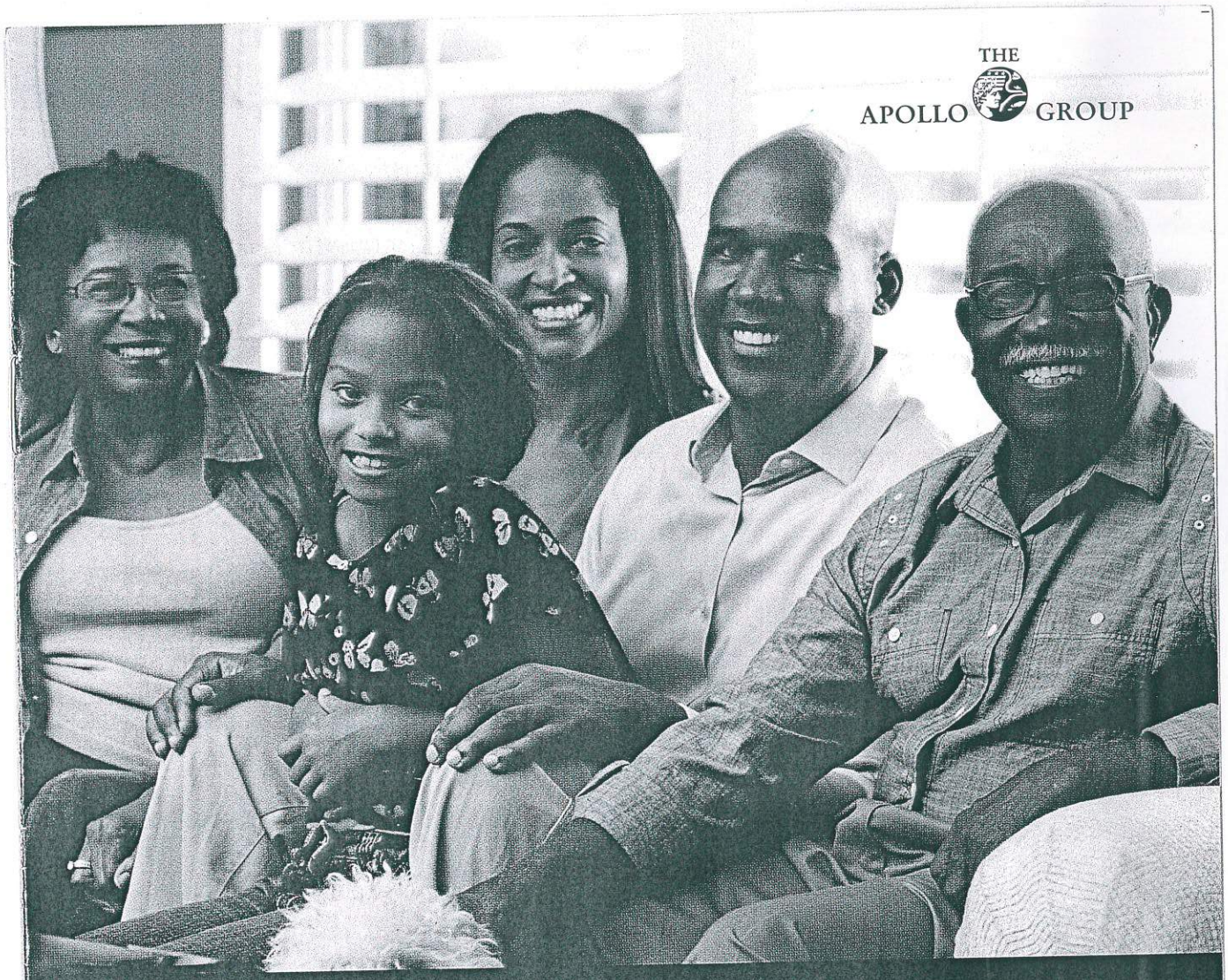

Because, some relationships are priceless!

APA Jamii Plus. The first comprehensive health insurance that also provides cover for the elderly members of your family.

APA INSURANCE

GENERAL • LIFE • HEALTH

At APA Insurance we understand that a family is incomplete without all its members. Which is why we can't understand that when it comes to the health and wellbeing of the elderly in your family, why should your health insurance discriminate. With Jamii Plus, we have rewritten the rules of insurance once again and today we are proud to present a unique family health insurance plan that covers all members of your family, aged between 1 month to 75 years.

Pre-existing and chronic diseases: Life is full of uncertainties. But that doesn't mean we should give up! Now with Jamii Plus' pre-existing and chronic diseases cover that includes HIV/AIDS, you don't have to worry about any expenses arising after 12-months from the policy purchase date.

Best network of hospitals: When it comes to your family, you always want the best. And at times, the best often means more money. That's why Jamii Plus offers a superior health cover of up to 10 Million KShs. that will take care of all in-patient expenses that you may incur for treatment at any of the best hospitals in Kenya or India.

Maternity expenses: Why should health insurance provide cover only for unfortunate events? Good news in the family is more than welcome with Jamii Plus' superior maternity protection that covers for all in-patient and out-patient expenses incurred during child birth.

Complete protection: Jamii Plus' comprehensive health insurance takes care of:

1) Bed charges: All accommodation expenses during your stay in the hospital whether in the ward, HDU or ICU.
2) Doctors fees: All doctor-related charges, including those for physicians, surgeons, anesthetists and specialists for visits and consultations.
3) Drugs: All medicines prescribed for your speedy recovery.
4) Diagnostics: Including laboratory tests, X-rays, ultrasounds, MRI and CT Scans.

Where to get Jamii Plus?
Jamii Plus is available at all our branches countrywide. is available at all our branches countrywide. Just visit or call the nearest APA branch for details on how to sign up.

Terms and conditions: Bed charges are maximums per annual limit net of NHIF.

Core Plans Category Overall maximum benefit per year	DAZZLE 10,000,000	BRILLIANT 5,000,000	TOSHA 2,000,000	POA 1,000,000	CLASSIC 500,000
Bed limits In-patient Benefits	Private room upto Kshs 20,000/=	Ensuite up to Kshs. 15,000/=	SPR upto Kshs 10,000	General Ward Bed	General Ward Bed
Prescription drugs and dressings - discharge drugs allowed up to a maximum of 14 days supply	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Physicians, Specialist & Surgical fees, including anaesthetist fees subject to APA panel rates	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Theatre charges, HDU & ICU	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Diagnostic tests	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Physiotherapy as part of treatment	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Pre-existing / chronic conditions/HIV/AIDS after 12 months of cover and on full disclosure at the time of joining	1,000,000	500,000	350,000	300,000	200,000
Newly diagnosed chronic conditions	Diagnosis within 1st 6 months covered within pre-existing / Chronic sublimit. Diagnosis after 6 months covered to full limit	Diagnosis within 1st 6 months covered within pre-existing / Chronic sublimit. Diagnosis after 6 months covered to full limit	Diagnosis within 1st 6 months covered within pre-existing / Chronic sublimit. Diagnosis after 6 months covered to full limit	Diagnosis within 1st 6 months covered within pre-existing / Chronic sublimit. Diagnosis after 6 months covered to full limit	Diagnosis within 1st 6 months covered within pre-existing / Chronic sublimit. Diagnosis after 6 months covered to full limit
Organ transplantation (3rd year) excluding cost of obtaining the donor organ. Covers operation costs for Kidney,Heart ,Liver, Lung and Bone Marrow transplants	500,000	500,000	300,000	200,000	100,000
Surgical appliances and internal prostheses	500,000	500,000	300,000	200,000	100,000

Psychiatry and psychotherapy (2nd year)	500,000	250,000	200,000	150,000	100,000
Post Hospitalization Treatment- reimbursement only limited to the first 2 weeks after discharge	50,000	30,000	30,000	15,000	10,000
Accommodation costs for 1 parent staying in hospital with insured child under 5 years	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Day Care Surgery under General anaesthesia	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Nursing at home (on doctor's recommendation)	30 Days	30 Days	30 Days	30 Days	30 Days
Local ambulance to hospital for emergency cases	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Treatment outside Kenya RESTRICTED TO INDIA where treatment is not locally available (Pre-authorisation required) On reimbursement basis	Allowed	Allowed	Allowed	Allowed	Allowed
Air fare Costs – scheduled flight (Economy Class)	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Expenses for one person accompanying an evacuated person	Not covered	Not covered	Not covered	Not covered	Not covered
CT, MRI and PET scans subject to pre authorisation	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
1st emergency C-section & / or maternity complications after 10 months on cover	100,000	60,000	50,000	40,000	40,000
In Patient Ophthalmology : includes cost of cataract removal	100,000	70,000	60,000	40,000	30,000
In Patient Dental	100,000	50,000	40,000	30,000	20,000
Congenital conditions	Not covered	Not covered	Not covered	Not covered	Not covered
Reconstructive surgery following an accident	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Emergency dental / optical treatment following accident	Paid In Full	Paid In Full	Paid In Full	Paid In Full	Paid In Full
Funeral expenses – No Exclusions	100,000	50,000	40,000	30,000	25,000
All expenses are subject to maximum insured values					

OPTIONAL OUT PATIENT COVER PER PERSON			
Annual Limits Per Person	50,000	75,000	100,000
Maximum Consultation Limit per visit	1,500	2,000	2,500
Physicians consultation fees	Covered	Covered	Covered
Prescription drugs up to a maximum of 30 days	Covered	Covered	Covered
Specialists fees (strictly on referral by a GP)	Covered	Covered	Covered
X-Ray, MRI's, CT and other diagnostic tests	Covered	Covered	Covered
Physiotherapy prescribed by a GP	Covered	Covered	Covered
Treatment by chiropractors and osteopaths if on referral by a GP	Covered	Covered	Covered
Pre-existing/ Chronic Conditions/ HIV AIDS after 12 months of cover & full disclosure at the time of joining.	Covered	Covered	Covered
OPTIONAL MATERNITY COVER PER PERSON (FEMALE PRINCIPLE OR SPOUSE)			
Annual Limits Per Person	50,000	100,000	120,000
All Consultation fees prior to delivery	Covered after 10 months of cover	Covered after 10 months of cover	Covered after 10 months of cover
Standard Pre natal testing	Covered after 10 months of cover	Covered after 10 months of cover	Covered after 10 months of cover
Maximum 2 Obstetric scans	Covered after 10 months of cover	Covered after 10 months of cover	Covered after 10 months of cover
Post natal consultation	Covered after 10 months of cover	Covered after 10 months of cover	Covered after 10 months of cover
Normal Delivery	Covered after 10 months of cover	Covered after 10 months of cover	Covered after 10 months of cover
Elective C-Section	Covered after 10 months of cover	Covered after 10 months of cover	Covered after 10 months of cover
OPTIONAL DENTAL COVER PER PERSON			
Annual Limits Per Person	10,000	20,000	30,000
Dental consultations	Covered	Covered	Covered
Extractions	Covered	Covered	Covered
Fillings	Covered	Covered	Covered
Dental X-rays & Prescription	Covered	Covered	Covered
OPTIONAL OPTICAL COVER PER PERSON			
Annual Limits Per Person	10,000	20,000	30,000
Maximum on Frames	5,000	10,000	10,000
Eye Check-up	1 per annum	1 per annum	1 per annum
Change of lenses due to change of prescription	Covered	Covered	Covered
Replacement of frames	After 2 Years	After 2 Years	After 2 Years

SPECIAL CONDITIONS AND EXCLUSIONS

Special Conditions

* All Premiums must be paid in full before commencement of cover
* All In Patient Bills will be paid nett of National Hospital Insurance Fund (NHIF)
* Doctor's Fee is paid at 100% if APA panel is used, if you use your own doctor we settle 85% of the total bill or subject to APA panel rates
* All scheduled admissions must be reported to APA Insurance with at least 48 hours notice. Member must await APA preauthorisation before proceeding
* For emergency admissions the hospitals will contact APA within 48 hours of admission
* All waiting periods are subject to continuous renewal with no break in cover. Where there is a break in cover the waiting periods will apply afresh
* Fibroids, Hernias, Adenoidectomy and Haemorrhoids shall have a waiting period of 12 months
* Members must produce their medical cards to enable them access treatment at the accredited panel of providers
* Premiums are calculated based on the members age at next birthday
* Waiting Period 30 days for illness & 90 days for surgical procedures, waived for accident cases
* Age Limits: 1 months – 75 years (Maximum joining age 75 years). All renewals are subject to claims experience and underwriting guidelines.
* Benefits may not be payable if there is no full disclosure of any material facts that could influence our assessment and acceptance of this application.

APA reserves the right to decline an application or renewal

* Medical Report for all members joining who are 55 years and above will be required
* Out Patient cover will be based on use of Smart cards at all service providers
* Cover outside Kenya up to 6 weeks for business or leisure travel on reimbursement basis
* Geographical limit – Kenya
* Time bar at sixty (60) days from the day of ailment for reimbursement claims.
* No return premium for deleted individuals after six (6) months of cover or where claims have been incurred
* Cancellation notice of 14 days by either party

Exclusions

* General Health check-ups
* Pre-existing & chronic conditions occurring within the first 12 months of cover
* War and Kindred risks
* HIV/AIDS and related ailments occuring within the first 12 months of cover
* Cosmetic surgery unless caused by accident
* Maternity- Normal deliveries, pre & post natal expenses
* Senility
* Congenital (present at birth) conditions
* Family planning or Infertility related conditions
* Treatment other than by registered medical practitioner
* Acupuncturist, Herbalists and Ayurvedic treatment,
* Intentional self-injury, drunkenness, drug abuse addiction
* Naval, Military or Airforce operations
* Hearing aids
* Eye glasses/lenses, eye testing except for Inpatient Ophthalmology as specified above
* Dental treatment unless for Inpatient Cases as specified above
* Expenses recoverable under any other insurance
* Beauty treatment in nature cure clinics or health hydros
* Contamination by radio activity from nuclear fuel, waste or fission

FAMILY COVER	JAMII PLUS				
Annual Cover Limits Shared per family	10,000,000	5,000,000	2,000,000	1,000,000	500,000
Principal					
21 years - 40 Years	51,744	36,960	30,492	25,872	18,480
Spouse					
21 years - 40 Years	41,395	29,568	24,394	20,698	14,784
Child					
1 Month - 20 Years	30,276	16,704	13,781	11,693	8,352
Principal					
41 years - 54 Years	68,544	48,960	40,392	34,272	24,480
Spouse					
41 years - 54 Years	54,835	39,168	32,314	27,418	19,584
Child					
1 Month - 20 Years	30,276	16,704	13,781	11,693	8,352
Principal					
55 years -65 Years	0	86,170	56,981	48,348	34,534
Spouse					
55 years -65 Years	0	73,244	48,434	41,096	29,354
Child					
1 Month - 20 Years	30,276	16,704	13,781	11,693	8,352
Principal					
66 years -70Years	0	0	68,378	58,018	41,441
Spouse					
66 years -70Years	0	0	58,121	49,315	35,225
Child					
1 Month - 20 Years	30,276	16,704	13,781	11,693	8,352
Principal					
71 years -75Years	0	0	0	63,820	45,585
Spouse					
71 years -75Years	0	0	0	54,247	38,748
Child					
1 Month - 20 Years	30,276	16,704	13,781	11,693	8,352

OPTIONAL OUT PATIENT COVER PER PERSON			
Annual Limits Per Person	50,000	75,000	100,000
Annual Premiums excluding taxes	22,680	28,500	35,580
OPTIONAL MATERNITY COVER PER PERSON (FEMALE PRINCIPLE OR SPOUSE)			
Annual Limits Per Person	50,000	100,000	120,000
Annual Premiums excluding taxes	10,000	20,000	24,000
OPTIONAL DENTAL COVER PER PERSON			
Annual Limits Per Person	10,000	20,000	30,000
Annual Premiums excluding taxes	3,440	6,000	8,645
OPTIONAL OPTICAL COVER PER PERSON			
Annual Limits Per Person	10,000	20,000	30,000
Annual Premiums excluding taxes	3,440	6,000	8,645

Outpatient Service Access:
Co-Pay @ Kshs.1,000/-
Aga Khan University Hospital & Satelittes

Co-Pay @ Kshs.500/-
Gertrudes Garden Children's Hospital

Co-Pay @ Kshs.300/-
All others (refer to panel)

HEAD OFFICE
Apollo Centre, Westlands Nairobi
Tel: 020 286 2000
Email: info@apainsurance.org

PROPOSAL FORM

APA INDIVIDUAL COVER

Please read the following carefully, completing all relevant information in BLOCK CAPITALS and ticking the relevant boxes.

Policy Holder Details

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐

First Names

Surname

Postal Address

Telephone Home Office

Mobile Fax

Email Address

How would you prefer us to communicate with you? Tick Appropriate box.

Fax ☐ Phone ☐ Email ☐ SMS ☐

The following section is only to be filled in if you already have an existing cover.

Company Name

Insurer

Member No.

Expiry Date

Policy Commencement Date

Please indicate the month and year you wish your cover to commence Month Year

Please note that the APA Individual Cover will commence on the 1st and 15th of every month,Cover is conditional upon acceptance of your Proposal, which is only confirmed when you receive your Policy Document

Plan Details

Please tick to indicate the plan you require.

	Core Plan	Benefit
☐	Brilliant	5,000,000
☐	Tosha	2,000,000
☐	Poa	1,000,000
☐	Classic	500,000

Year of being on the APA Individual Cover
1st Yr ☐ 2nd Yr ☐ 3rd Yr ☐ 4th Yr ☐

Please note that the area of cover is within the geographical limits of Kenya,treatment outside Kenya is restricted to India, Pakistan and South Africa

Payment Details

All cheque payments must be made to APA Insurance with the Policy Holder's name and Policy Number marked clearly on the back of the cheque.All bank transfers must be clearly marked with the Policy Holder's name and Policy Number. We will only accept payment by credit card via Master Card or VISA. APA Insurance does not accept liability for any payment which does not clearly identify the Policy Holder.

Please note that Insurance Premium Tax and other government levies will apply.Any Tax Relief that applies accordingly will also apply Where such taxes, levies or reliefs apply, they will be detailed on your invoice / payment details.

If you choose to pay by credit card please provide the following information:

Type of credit card MasterCard ☐ VISA ☐

Card Number

Credit card authorisation

I authorise APA Insurance to charge my credit card account unspecified amounts in respect of premiums for any health care cover as and when these become due, until the instruction is cancelled by my giving written notice to APA Insurance.
I understand I will be given one month's notice of any premium increase.

Card Holder's name

Card Holder's signature Date

Details of Person(s) to be Covered

Please enter the details of all persons to be covered under this Policy including the Policy Holder. This can include your spouse, and any children financially dependent on the Policy Holder and not more than 18 years old, or not more than 25 years old if in full-time education. Where a child is more than 18 years old, please attach a letter from college / university confirming his / her student status.

	Policy Holder	Dependant 1	Dependant 2	Dependant 3
Title (Mr, Mrs, Ms, Miss, Other)	AS ABOVE			
Surname	AS ABOVE			
First Name	AS ABOVE			
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Relationship	SELF	Spouse ☐ Child ☐	Spouse ☐ Child ☐	Spouse ☐ Child ☐
Date of Birth	___/___/____	___/___/____	___/___/____	___/___/____
Occupation				
Town of Residence				
ID / PP No.				
Name of any other current cover				
Name of Insurer				
Policy Number				
Start Date				

If space is not sufficient for dependants, please use an additional Proposal Form

Pre-existing Conditions

Pre-existing conditions are not covered unless they have been declared by you in the Health Declaration section and accepted by APA Insurance. Conditions arising between signing the Proposal Form and confirmation of acceptance by the underwriting department of APA Insurance, will equally be deemed to be pre-existing. Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this Proposal and acceptance by us. You are hereby obliged on request to provide any further information that we might require.

Pre-existing conditions are medical conditions or any related conditions, for which symptoms have been shown at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew, or could reasonably have beenassumed to have known, will be deemed to be pre-existing.

Health Declaration

All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is any information that would be likely to influence the Insurer's assessment and acceptance of this Proposal Form. If you are in any doubt whether a fact is material then it should be disclosed.

Health Declaration				
	Policy Holder	Dependant 1	Dependant 2	Dependant 3
Height / Weight	cm _____ kg _____	cm _____ kg _____	cm _____ kg _____	cm _____ kg _____
1. Are you currently suffering from any complaints, illnesses, aftereffects of an accident, mental or physical disabilities, psychiatric disorders and chronic / long term medical or dental conditions?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
2. Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for: Rheumatism, gout, arthritis or disease of the muscles or joints including the back?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
3. Epilepsy or other neurological disorder?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
4. Any digestive disorder including stomach and / or bowel problems?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
5. Anxiety, depression or psychiatric or mental illness?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
6. Gynaecological disorders?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
7. Any disorder of the kidneys, bladder or liver / pancreas including diabetes?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
8. Any lump, cyst, mole or cancer	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
Any skin disorder?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
9. Have you ever been advised to consult a doctor for a recurrent complaint, or been advised to have any diagnostic test or treatment which has not been completed or that you still await the results of?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
Health Declaration				
10. Have you been tested for HIV - antibodies?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
If yes, please state when	____/____/_____	____/____/_____	____/____/_____	____/____/_____
.Was the result HIV - positive?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
11. Are you pregnant?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐
Please state expected date of childbirth	____/____/_____	____/____/_____	____/____/_____	____/____/_____
12. Have either of your parents or any of your brothers or sisters, living or deceased, suffered before the age of 65, from diabetes, heart disease, high blood pressure, cancer, kidney disease, raised cholestrol, nervous or brain disorders such as Alzheimer's, Parkinson's, or M.S., eye, hearing or speech disorders or any family disorder?	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐

Telephone number of your family doctor

Name	
Address	
Telephone	

Additional Information

If you answered yes to any of the questions from 1 to 12, please give all necessary details in the box below (in BLOCK CAPITALS) Failure to provide complete information may result in APA Insurance seeking the information from your family doctor. This may in turn result in a delay in proceeding with any Proposal. If in doubt whether a fact or information is material, then it must be disclosed.

Name	Number of question with "yes" answer		Where applicable, please provide date of 1st diagnosis / consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current and known future treatment.

Data Protection Legislation

APA Insurance would like to assure you that all personal information and medical data will be dealt with in strict confidence. Personal data may be given to hospitals and / or medical providers with relation to medical insurance claim services provided by us to you. You have a right to access the personal data that is held about you. You also have the right to ammend or delete any information we hold about you if you believe that it is inaccurate or out of date.

APA Insurance, or an organisation appointed by us, might contact you in the future in relation to other products / services that you might be interested in.

Do you wish to receive information on other products or services from us? Yes ☐ No ☐

Declaration

I declare that all information supplied above is true and complete, including those answers that are not in my own hand-writing. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this Proposal shall be the basis of the contract between APA Insurance and I, and that any false, incorrect or misleading statement may render this insurance null and void.

I undertake to inform APA Insurance immediately in writing of any change in my or my dependants' state of health occurring after the Proposal Form has been signed and before the commencement date.

I understand that I can withdraw my Proposal in writing by letter, email or fax, within 14 days from the Policy's date of commencement and provided that I have not submitted a claim, I am entitled to a full refund of the premium.

I accept that it is my responsibility to check the accuracy of the information contained within the Policy Document once issued. If the content is not in accordance with the Proposal Form, the situation will be considered accepted if I enter no protest within 14 days following the issue date of the Policy Document.

I consent to the fact that APA Insurance, if it considers it appropriate, will check statements concerning the condition of my health and will check with other health insurers all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, members of medical professions, employees of hospitals and health authorities as well as medical facilities to release my medical records to APA Insurance. I also make this statement for my co-insured children as well as for the co-insured persons for whom I am responsible, or those who cannot assess the meaning of this statement.

I accept that the Policy will be subject to the standard Policy Terms and Conditions effective at the time of Policy commencement.

I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this Policy including the exclusion relating to pre-existing conditions.

Policy Holder's Signature

Signature of all adult dependants

Date _____/_____/_____

Please return this fully completed form to the following address:

APA INSURANCE LIMITED
6TH FLOOR, HUGHES BUILDING
KENYATTA AVENUE
P. O. BOX 30065
NAIROBI 00100
TEL: 286 2000

MOBILE: 0720-652272
MOBILE: 0734-652272
EMAIL: info@apainsurance.org
www.apainsurance.org

FOR OFFICIAL USE ONLY:

Agent Details

STAMP