NON-CORPORATES & AFFINITY GROUPS HEALTH INSURANCE

Full Name: ______________________________
Email: ______________________________
Phone #: ______________________________

GENERAL POLICY TERMS

Eligibility
Eligible for the main member and his/her dependents from birth (provided it is a term baby of 38 weeks) to 80years. Existing members can continue on cover subject to underwriting review. Children above 18 years will enjoy their own cover as principal members.
For members joining from age 55 and above, medical reports will be required. Please Ask for Our Approved Panel of Doctor's / Clinics / Laboratories.
Waiting Periods
Treatment for pre-existing, and/or chronic, psychiatric, congenital, organ transplant, HIV/Aids and related treatment, inpatient non-accidental related ophthalmology, dental surgery, fibroids and all gynecological illness and treatment, adenoidectomy, hemorrhoidectomy, hernias, tonsillectomy and thyroidectomy procedures, and colonoscopy shall be subject to 6 months waiting period or higher as advised on a case by case basis.
Maternity and first ever caesarean section have a 10 months waiting period.
Inpatient dental, Inpatient Optical, psychiatric illnesses have a 6 months waiting period.
In the event of illness, waiting period is 30 days & 90 days for surgical procedures except for accidents.
NHIF
All eligible members must have valid NHIF membership. Eligible members in this case imply Kenyan citizens in formal employment.
Hospital bills shall be undertaken net of NHIF where applicable and will be advised from time to time by the scheme administrator according to NHIF guidelines.
All admissions/hospitalizations are done net of NHIF rebates.
Territorial Limit
Kenya, Uganda & Tanzania.
Members can submit claims accessed within the first 60 days outside of the territorial scope. The claims must be
Submitted within 60 days from the date of service.

PRODUCT TERMS
SCOPE OF COVER

Services covered in-patient & day-patient

- Lodger Fee for Accompanying Parent
- ICU/HDU and Theatre Charges
- Doctor's fees; Physician, Surgeon & Anesthetist
- Organ Transplant
- Psychiatric and Psychological Illnesses
- Home nursing care
- Day Care Surgery
- Emergency Road DR and Air Evacuations subject to overall cover limit
- Post Hospitalization 21 Days after discharge (Up to Sub-Limit)
- Pathology, X-ray, Ultrasound, ECG and CT scans, PET & MRI Scans.
- Drugs/Medicines, Dressings and Internal Surgical appliances

The services listed above are repayable within the respective sub-limit or as specified in the policy details.

Premium Payment(s)
Premiums are payable up front unless authorized otherwise by the Company, where an approved payment plan is sought by the insured.
Hospitalization costs and professional fees
a) Shall be as per pre-negotiated tariffs between the Company and its service providers, and subject to the Company's reasonable and customary rates.
b) Services sought at non-panel providers will be reimbursed at 80% of the reasonable and customary rates.
Policy Validity
This policy is valid for one(1)year as specified above, unless cancelled by either party by giving a one (1) month notice.
Overseas Referral (for treatment not available in Kenya)
The Company has credit facilities in India, and the referral must be approved by the company and respective government department.
Airfare for patient and accompanying person one economy class is payable from the overall cover limit (inpatient), while accommodation costs are excluded.
Air fare shall be paid by member and reimbursed by the company, unless where the APA has been able to procure a ticket.
Lodger fee is payable for children within the lodger fee age.
Cards;
Medical Cards shall be issued to all members of the scheme.
Healthcare Providers:
Restricted to only APA Panel of providers within the territorial scope. In case of genuine reasons for using a nonpanel provider, reimbursement shall be allowed subject to APA's reimbursement policy.

OakenTrust Insurance Agencies Limited
Phone: +254 115 639 830
Email: medical@oakentrust.com
Website: www.oakentrust.com
Location: 3rd Floor, Minoki Building, Oginga Odinga Street, Kisumu

GENERAL POLICY EXCLUSIONS

Treatments within the waiting periods indicated in the terms policy terms above.
Cosmetic surgery unless caused by an accident
Pandemics & epidemics (Other than Covid-19), natural disasters and unknown illnesses covering a wide geographical area.
Vaccinations other than as specified in the cover scope.
Weight management treatments and drugs.
Participations in professional & hazardous sports e.g. Bungee jumping, paragliding.
Family planning, Impotence, Infertility related treatment.
Treatment other than by registered medical practitioner.
Self-referred or self-prescribed treatment.
Drugs dispensed by the treating doctor.
Nutritional supplements unless prescribed as part of medical treatment.
Alternative treatment - Chiropractors, Acupuncturist.
Drunkenness, Alcoholism, drug addiction, Intentional self-injury, attempted suicide.
Participation in Riot, Strike and Civil commotion
Naval, Military or Airforce operations
Expenses recoverable under any other insurance e.g. NHIF,GPA,WIBA
Beauty treatment in nature cure clinics or health hydro's
Purchase of external surgical appliances(frames, wheelchairs),available on lease
Diagnostic equipment(e.g. Glucometers, BP Machines)
Experimental treatment.
Contamination by radioactivity from nuclear fuel, waste or fission
Benefits not purchased or indicated in the underwriting summary
Dental Exclusions: where dental outpatient cover is provided
o Crowns, Caps, Bridges, Orthodontics, Dentures, Self-prescribed scaling.
o Replacement or repair of old dentures bridges and plates unless damage to dentures, bridges and plates becomes necessary as a result of accident.
Optical Exclusions: where Optical outpatient cover is provided
o Replacement of broken or lost spectacles
o Photo chromatic and/or anti-glare lenses where a significant Refractive error is not the cause for prescription
o Disposable Contact lenses and Plano lenses
o Designer frames and lenses
*THIS LIST IS NOT EXHAUSTIVE. PLEASE REFER TO THE POLICY DOCUMENT

SCOPE OF IN-PATIENT COVER

Inpatient	Option 1	Option 2	Option 3	Option 4
Overall Limit	500,000	2,500,000	5,000,000	10,000,000
Bed	General Ward Bed	Private Room	Private Room	Private Room
	KES. 12,000	KES. 18,500	KES. 27,000	KES. 32,000
Lodger fee for accompanying parent	Children 12 Years & below	Children 12 Years & below	Children 12 Years & below	Children 12 Years & below
Emergency Evacuation Within East Africa	Road Ambulance Only	Air & Road Ambulance	Air & Road Ambulance	Air & Road Ambulance
Post Hospitalization 21 days after discharge (On Pre-authorization)	KES 20,000	KES 32,500	KES 45,000	KES 60,000
Last Expense	KES. 75,000 per person	KES. 115,000 per person	KES. 150,000 per person	KES. 150,000 per person
Home Nursing (Subject to Preauthorization)	To the relevant sub-limit	To the relevant sub-limit	To the relevant sub-limit	To the relevant sub-limit
Acute Illnesses & Accidents	Full Inpatient Limit	Full Inpatient Limit	Full Inpatient Limit	Full Inpatient Limit
Pre-existing Conditions, Chronic illnesses; newly diagnosed or not, Congenital Conditions, Prematurity	KES 275,000	KES 500,000	KES 750,000	KES 1,250,000
Organ Transplant excluding the cost of donor and securing the organ	KES 100,000	KES 200,000	KES 400,000	KES 1,000,000
Psychiatric and Psychological Illnesses	KES 225,000	KES 285,000	KES 350,000	KES 400,000
First Ever Emergency Caesarian Section	KES 75,000	KES 135,000	KES 200,000	KES 300,000
Non-accidental Optical in-patient Illnesses, includes cover for laser treatment, and Cataract	KES 75,000	KES 135,000	KES 200,000	KES 300,000

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Accident Related Dental and Optical Treatment	Full Inpatient Limit	Full Inpatient Limit	Full Inpatient Limit	Full Inpatient Limit
Non accidental Inpatient Dental Due to Illness	KES 75,000	KES 135,000	KES 200,000	KES 300,000
Reconstructive surgery following an accident	Full Inpatient Limit	Full Inpatient Limit	Full Inpatient Limit	Full Inpatient Limit
Passive War /Terrorism and Political Violence treatments	KES 200,000	KES 200,000	KES 500,000	KES 500,000
Cover for Covid19 (critical cases only requiring hospitalization) - Non Vaccinated Members will be covered up to a maximum of 50% of Covid19 limit, or Kes 250,000 whichever is higher from Jan 2022.	KES 200,000	KES 300,000	KES 500,000	KES 1,000,000
Ayurveda Treatment	KES. 75,000	KES. 115,000	KES. 150,000	KES. 150,000

INPATIENT PREMIUM SCHEDULE

38 week to 65 Years	500,000	2,500,000	5,000,000	10,000,000
M	20,131	31,570	44,392	58,707
M+1	26,827	42,094	59,229	78,555
M+2	34,575	54,273	76,397	101,521
M+3	42,969	67,465	94,997	126,401
M+4	51,362	80,658	113,596	151,282
M+5	61,435	96,489	135,916	181,138

Premium(66– 80Years) Rates apply after renewal beyond 80 Years subject to underwriting review.

M	49,006	96,371	154,431	192,746
M+1	66,158	114,039	203,252	253,010

Optional Maternity Premium Rates

Cover Limit	150,000	200,000	300,000
Purchased with IP Option	Option I, Option II, Option III or Option IV	Option III or Option IV	Option IV only
Premium	26,250	30,625	39,375

NOTE: ABOVE PREMIUMS ARE BASIC PREMIUMS. TRAINING LEVY @ 0.2% AND POLICY HOLDERS' COMPENSATION FUND LEVY @ 0.25% APPLY ON THE PREMIUM IN ADDITION TO STAMP DUTY OF KSHS. 40/- FOR EVERY POLICY AT THE INCEPTION OF THE POLICY.

INDIVIDUAL HEALTH APPLICATION FORM

Policy Holder's Details

Title: Male ☐ Female ☐

Applicants Name (first, middle, surname): ____________________

Date of Birth: ____________________

Occupation: ____________________

I.D/ Passport: ____________________

Email Address: ____________________

Physical Address: ____________________

KRA Pin: ____________________

P.O Box Number: ____________________

Postal Code: ____________________

City / Town: ____________________

Mobile Number: ____________________

Dependant's Details

Please attached birth certificate copy for dependants' under 18 years of age

Full Name (First, Middle, Surname)	Date of Birth	Gender (M/F)	Relationship

Nominee/ Beneficiary for last expense benefit. Name: ____________________ Passport/ID: ____________________

Email: ____________________ Phone number: ____________________

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Plan Details (Tick what is applicable)

Inpatient Cover Limit	
500,000	
2,500,000	
5,000,000	
10,000,000	

Family Size	
M	
M+1	
M+2	
M+3	
M+4	
M+5	

Gross Premium ______________________

Levies (0.45%) ______________________

Stamp Duty 40% ______________________

Total ______________________

Health Declaration

1a) Name & Address of Present Doctor ______________

____

b) Date and Reason Last consulted (if within 5 years)

____

c) Treatment/ Medicine Prescribed

____

*You may be required to submit a separate medical report or questionnaire

Maternity Cover Limit (Optional): ______________

	Indicate Yes / No					
Name of Principal/ Member to be insured:						
Do you or your dependant for insurance have any deformity, impairment or loss of hearing, vision (other than defective vision that can be corrected by spectacles/contact lenses) or limbs?						
Ever been admitted into a hospital or undergone a surgical operation?						
Ever been advised to have a surgical operation which has not been performed?						
To the best of your knowledge and belief, have you or your dependants for insurance ever had or have been told that you or your dependants have any disorder or disease of the following:						
(a) Skin, ears, nose, throat, eyes e.g. otitis media, hearing problems, sinusitis, cataracts, glaucoma, detached retina?						
(b) Stomach, intestines, liver, kidneys, gall-bladder, pancreas, bladder, prostrate, urinary tract e.g. hernia, cirrhosis, diabetes, protein in urine, piles? (c) Lungs, bones, joints, cartilage, for example asthma, bronchitis,						
pneumonia, tuberculosis, slipped disc, fractures, arthritis, polio, muscular dystrophy?						
(d)Heart, brain, mental or nervous disorder e.g. low or high blood pressure, stroke, paralysis?						
(e) Lymphatic system for example goiter, gout, thyroid?						
(f)Cancer, tumour, cyst or growth of any kind?						
(g) Female reproductive system for example, cysts or fibroids, cysts of the breast, uterus, or ovaries, cervix, fallopian tubes?						
(h) Any other conditions not listed above?						
During the past 5 years, have you or your dependant for insurance consulted a physician for a general examination or for any reason not previously noted on this form?						
Are you currently taking any medication or treatment regularly?						
Are you currently suffering from any symptoms for which you have not yet consulted a doctor?						
Are you or your dependants currently insured under any other medical, hospitalisation, accident or life insurance. If yes, please give insurer details:						
Have you or your dependants for insurance ever had any medical hospitalisation, accident or life insurance rejected, cancelled, restricted, subjected to special terms or renewal declined?						

MEMBERS DECLARATION

I confirm that all the above statements are true and complete to the best of my knowledge and belief and I understand that the Company, believing them to be such, will rely on them for purposes of acceptance of this application. I consent to APA Insurance Limited seeking any information of my health records or health conditions from any physician or health care provider or any organization on my behalf and I hereby authorise the release of such information. A photocopy of this statement shall be as effective and valid as the original.

This policy will only be effective after this application has been accepted by APA Insurance Limited and the premium price paid in full. The insured accepts APA's condition that pre-existing and chronic conditions will not be covered for the first 12 months based on the information in the completed and signed health declaration. Pre-existing conditions are not covered unless they have been declared by you in the Health Declaration Section and accepted by APA Insurance. The Insured hereby obliged on request to provide any further information that might be required.

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 the Insured is in any doubt as to whether a fact is material then it should be disclosed.

Date:

Signature of Principal Member: