www.savelifemedicalaid.co.zw

If returning by email please scan and email to
admin@savelifemedicalaid.co.zw

Application No.:

Proposal Form

This is an application for Insurance. Every Information this application seeks is important. Please read all questions and answer them carefully. You must provide complete and correct information. Incomplete/incorrect/partially correct information may lead to cancellation of proposal and policy even if it is issued. It is not obligatory for us to accept any risk or issue policy to anyone. Regulations mandate that the coverage can incept only after we have received the full amount of premium and have explicitly accepted the risk.

Please fill-up this form in CAPITAL LETTERS and attach a passport sized photograph for yourself and each person proposed to be insured and write the name of the person above the photograph.

1. PROPOSER DETAILS

Proposer: (Mr./Ms./Mrs.)			
	First Name	Middle Name	Last Name
Address:			
Pin Code:	Mobile:		City/Town:
Telephone:		E Mail:	

Nationality : _____ Marital Status: _____ Annual Income: _____

Profession : Employed☐ Self Employed ☐ Others ☐ Details _____

ID Proof Type : NID ☐ Passport ☐ Driving License ☐ If others, please specify _____

ID Proof No. :

D.O.B

☐ I would like to protect my environment and would like to help save paper by authorizing Savelife medical aid to send all my policy and service related communication to the email address as mentioned in the application form

2. PLAN DETAILS

Plan: Standard lite ☐ standard ☐ exclusive ☐ Premium ☐ Premium plus ☐ ☐

First Name	Surname	Relationship	D.O.B	ID	F/M	package	$Amount
Total							

5. HEALTH HISTORY AND LIFESTYLE INFORMATION

Medical History: Please answer the below mentioned questions individually in Yes(Y) / No (N):

	Has any application for life, health, hospital daily cash or critical illness insurance ever been declined, Postponed, loaded or been made subject to any special conditions by any insurance company?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
i.	High or low blood pressure, Chest Pain, or any other cardiac disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
ii.	Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
iii.	Ulcer(Stomach/Duodenal),liver or gall bladder disorder or any other digestive tract disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
iv.	Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/ urinary tract disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
v.	Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) Disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
vi.	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
vii.	Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
viii.	Arthritis, Spondylosis or any other disorder of the muscle/bone/joint	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
ix.	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error)?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
x.	HIV/AIDS or sexually transmitted diseases or any immune system disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xi.	Anaemia, Leukaemia, Lymphoma or any other blood/lymphatic system disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xii.	Psychiatric/Mental illnesses or sleep disorder	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xiii.	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xiv.	Any other illness or injury not mentioned above (other than common cold)?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xv.	Been addicted to alcohol, narcotics, and habit-forming drugs or been under detoxication therapy?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xvi.	Been under any regular medication (self/ prescribed)?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐

save life
MEDICAL AID FUND

xvii.	Undertaken any lab/blood tests, imaging tests viz. scans/MRI in the last 5 years other than routine health check-up or pre-employment check-up?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xviii.	Undertaken any surgery or a surgery been advised and have surgery still pending?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xix.	Suffered from any other disease/illness/accident/injury other than common cold or viral fever?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐
xx.	Is any of the insured pregnant? If yes please mention the expected date of delivery. Any complication during current or earlier pregnancy?	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐	Y ☐/N ☐

Insured Person 1 :					
Insured Person 2 :					
Insured Person 3 :					
Insured Person 4 :					
Insured Person 5 :					
Insured Person 6 :					

Name :			
Qualification :			
Address :			
Pin Code :		Mob. No. :	
Phone No :		Email ID :	

8. GENERAL EXCLUSIONS (UNDER THE POLICY) FOR MORE DETAILS PLEASE REFER TO THE POLICY WORDINGS

The following is an outline of the general exclusions under the policy. For more details on the exclusions and the waiting periods please refer to the policy wordings before purchasing this policy.

Waiting Periods - 30 days waiting period in the first year and is not applicable in subsequent renewals. 2 years waiting period for the specified illnesses/ surgeries. 3 years waiting period for Pre-existing conditions.

Non-medical - War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. Any Insured Person committing or attempting to commit a breach of law with criminal intent, or intentional self-injury or attempted suicide while sane or insane. Any Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing in professional or semi-professional nature.

Medical - Treatment of illness or injury as a consequence of the use of alcohol, tobacco, narcotic or psychotropic substances; Prosthetic and other devices which are self-detachable/removable without surgery involving anaesthesia; Treatment availed outside Zimbabwe Treatment at a healthcare facility that is not a Hospital; Treatment of obesity and any weight control program. ; Treatment for correction of eye sight due to refractive error; Cosmetic, aesthetic and re-shaping treatments and surgeries; Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns. Circumcisions (unless necessitated by Illness or injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations; Save as and to the extent provided for under 1 h.) Non allopathic treatment; Conditions for which treatment could have been done on an outpatient basis without any Hospitalization; Charges related to peritoneal dialysis, including supplies; Admission primarily for administration of monoclonal antibodies or IV immunoglobulin infusion; Experimental, investigational or unproven treatment devices and pharmacological regimens.; Admission primarily for diagnostic and evaluation purposes only ;Any diagnostic expenses which are not related and not incidental to any illness which is not covered in this Policy; Convalescence, rest cure, sanatorium treatment, rehabilitation measures, , respite care, long-term nursing care or custodial care. safe confinement, de-addiction, general debility or exhaustion ("run-down condition") Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment) ; Admission primarily for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements ; Save as and to the extent provided in 3 c.) Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.; Psychiatric, mental disorders (including mental health treatments), Parkinson and Alzheimer's disease, sleep-apnoea. Congenital external diseases, defects or anomalies, genetic disorders.; Stem cell Therapy or surgery, or growth hormone therapy. Venereal disease, sexually transmitted disease or illness; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis. Save as and to the extent provided for under 3a.) Pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or birth (including caesarean section) except in the case of ectopic pregnancy in relation to a claim under 1a) for In-patient Treatment only. Treatment for Sterility, infertility (primary or secondary) assisted conception or other related conditions and complications arising out of the same. Birth control, and similar procedures including complications arising out of the same. Expenses incurred by the insured on organ donation; Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle; Save as and to the extent provided for under 3) b), dental treatment and surgery of any kind, unless requiring Hospitalisation. mutilation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. Any non-medical expenses mentioned in Annexure I. Any Medical Expenses incurred using facility of any Medical Practitioners or institution that we have told You (in writing) is not to be used at the time of renewal or at any specific time during the policy period. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover. Charges related to a Hospital stay not expressly mentioned as being covered, including but not limited to charges for admission, discharge, administration, registration, documentation and filing. Any treatment or part of a treatment that is not of a reasonable charge and not Medically Necessary. Drugs or treatments which are not supported by a prescription.

Any specific time bound or lifetime exclusion(s) applied by Us and specified in the Schedule and accepted by the insured.

9. DECLARATION & WARRANTY ON BEHALF OF ALL PERSONS PROPOSED TO BE INSURED

- I/ We hereby declare, on my behalf and on behalf of all persons proposed to be insured that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/ are authorized to propose on behalf of these other persons.
- I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved underwriting policy of the Insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- I/ We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- I/We declare and consent to the company seeking medical information from any hospital who at any time has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- I/ We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory Authority.

Date: D D M M Y Y Time: : Place: Signature of the Proposer:

10. AGENT'S DECLARATION

I, Full Name) in my capacity as an Insurance Advisor/ Specified Person of the Corporate Agent/Authorised employee of the Broker/Relationship Officer, do hereby declare that I have explained all the contents of this Proposal Form, including the nature of the questions contained in this Proposal Form to the Proposer including statement(s), information and response(s) submitted by him/her in

this Proposal Form to questions contained herein or any details sought herein will form the basis of the Contract of Insurance between the Company and the Proposer, if this Proposal is accepted by the Company for issuance of the Policy. I have further explained that if any untrue statement(s)/ information/response(s) is/are contained in this Proposal Form/including addendum(s), affidavits, statements, submissions, furnished/to be furnished, the Company shall have the right to vary the benefits which may be payable and further more if there has been a non-disclosure of any material fact, the policy issued to his/her favour pursuant to this Proposal may be treated by the Company as null and void and all premiums paid under the Policy may be forfeited to the company.

License No. (Advisor/Corporate Agent/Broker/Relationship Officer):

Date: D D M M Y Y

Place:

Signature of Agent:

11. CHECKLIST

Please check the following documents are attached along with the proposal form

1. ID Proof: Passport/ National ID/ Driving License/ Letter from a recognized public authority
2. Proof of residence: Telephone Bill/ Bank Account Statement/ Letter from any recognized public authority/Electricity Bill/ Voters Card
3. Age Proof
4. Renewal Notice with claim details
5. Certification of previous insurer for previous claim details
6. Photocopies of all previous policies and endorsements

12. FOR OFFICE USE ONLY

Savelife Medical Aid Office Code	:	Advisors Code & Name	:
Branch Receipt Date	:	Channel Type	:
Business Type	:	Urban/ Rural/ Social	:

SaveLife
DD details

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Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account

Please select any one of the below options

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy:

- ☐ Bank account details as mentioned on the cheque* being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.
- ☐ I do not have any existing bank account. I agree to open a bank account and provide my bank account details to the Company for electronic fund transfer as mode of payment. I shall provide these details before renewal of my insurance policy or before any payment becomes due in relation to my insurance policy (whichever is earlier). I understand that as per regulatory requirement, Company shall process any payment in relation to my insurance policy only through electronic fund transfer after receipt of aforesaid pending bank details from me.
- ☐ Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the Company for electronic fund transfer as mode of payment. (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly)

Particulars of Bank Account:

Name as in Bank Account:																								
Bank Name:																								
Bank Branch:								Bank Account Number:																

I agree and undertake to intimate in writing to Savelife Medical Aid about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Proposer/Policy holder's Signature ☐

Date: D D M M Y Y

DISCLAIMER: Savelife Medical Aid shall not be liable to anybody, in any manner, whatsoever if the DD transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid DD transaction or incomplete/incorrect information by Customer/Policy Holder. Aforesaid DD transaction shall be governed by applicable Reserve Bank of Zimbabwe rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to DD facility. Savelife Medical Aid shall be indemnified against any loss/damage/claims caused to
Savelife Medical Aid in carrying out your aforesaid DD instructions.

Instructions:

- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/ details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested DD mandate is required.
- In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required

* in case the premium payment cheque does not have all the details required for electronic fund transfer, please fill the above table

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Acknowledgement

Application No : _____ Date : _____

Name of Proposer: _____

We acknowledge with thanks the receipt of your application and amount by cash/cheque/Demand Draft/others _____ of amount of $. _____ .

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if premium is not received by us in full and in time or is not realised or non-fulfilment of Pre-Policy Check-up. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

Signature of the receiver and official seal

Savelife Medical Aid 189 Samora Mache Ave Harare Zimbabwe