

Request for Proposals (RFP) JN/0001/2025

**The International Center for Tropical Agriculture
(Hereafter referred to as CIAT)**

**Procurement of Group Medical Insurance
for CIAT Employees in Rwanda**

Date of Issuance:

January 23, 2025

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Organization Overview

CIAT is an international not-for-profit organization that is part of CGIAR, a global research partnership uniting organization engaged in research for a food secure Future. CIAT mandate is to reduce hunger and poverty, improve human nutrition in the tropics through research aimed at increasing eco-efficiency of agriculture.

CIAT has different projects across Africa, with its main regional office for Africa based in Nairobi, Kenya with Sub Regions office in Rwanda, Uganda, Tanzania, Malawi, Zimbabwe, DR Congo, and Zambia.

1. Purpose and Eligibility

1.1. Purpose

The Purpose of this RFP is to invite prospective Offerors to submit separate proposals for Group Medical Insurance for Approximately 29 Employees plus up to Four (4) Dependents for each employee in 2025.

The Provider must be established in Rwanda and able to prove that it has sufficient capacity to extend services to the locations referenced in the RFP. The Medical Coverage proposed should be define and include the type of coverage for both in/outpatient for individual and family: The type of coverage for maternity, pre-existing conditions and including the preexisting chronic diseases, vision, dental and any other services that the company offers.

1.2. Eligibility

The procurement is open to offers from Organization incorporated or legally registered under the laws of the Republic of Rwanda.

2. General Information

2.1. Original RFP Document

CIAT shall retain the RFP, and all related terms and conditions exhibits and other attachments, in original form in an archival copy. Any modification of these, in the offeror's submission or subsequent contract, is ground for immediate disqualification.

2.2. RFP Provisions

1. All information provided in this RFP is offered in good faith. CIAT makes no certification that any item is without error. CIAT is not responsible or liable for any use of information or for any claims asserted there from.
2. This RFP under any circumstances does not Commit CIAT to pay any cost incurred by the offeror in the submission of a proposals. This is the Offeror's responsibility.
3. All Materials Submitted in response to this RFP shall become the property of CIAT upon delivery to CIAT.

4. Additional documentation may be required prior selection.
5. All proposals in response to this RFP and other communications related must be in English.

2.3. Schedule of Events

The Following Schedule applies to this RFP but may change in accordance with CIAT needs or unforeseen Circumstances. Any changes made to the stated timeline will be announced as a formal modification to RFP.

| | Time | DATE | Step |
|---|-------|---------------------------------------|--|
| A | | January 23, 2025 | Advertisement of RFP |
| B | 5: PM | January 23, 2025, to January 28, 2025 | Open for request for clarification from CIAT, Question must be submitted in writing to Via email to a.umugwaneza@cgiar.org with a CC to r.habimana@cgiar.org , v.delahaye@cgiar.org , esther.kariuki@cgiar.org |
| C | 5: PM | January 29 to January 31, 2025 | Estimate dates for issuance of any clarifications by CIAT. All questions will be answered in one document and sent directly to all offerors receiving this request for proposal |
| D | 5: PM | February 07, 2025 | Deadline for submission of proposal, submitted in writing Via email. |

Any proposal received after the deadline for submission of the proposal, pursuant to the close deadline for the submission of the proposal, will be rejected.

3. Proposal Submission and Selection.

3.1. Offeror's Understanding of the RFP

In responding to this RFP, the offeror fully understands the RFP in its entirety and in details, including making any inquiries to CIAT as necessary to gain such understanding. Clarification questions must be submitted by potential offerors-in-writing-by the date and time designated above in line B of the chart in section 2.3.

Response will be done via email in writing and shared to all the offerors. CIAT reserves the right to disqualify at its sole discretion any offeror who submits a proposal that is not responsive or that demonstrates less than such understanding. Such disqualification and/or cancellation shall be at no fault, cost, or liability whatsoever to CIAT.

3.2. Communication

Verbal Communication shall not be effective. In no case shall verbal; communication govern over the written communications.

Offerors' inquiries, questions, and request for clarification related to this RFP are to be directed to in writing in English by the date and time designated in line B of the chart 2.3 to:

International Center for Tropical Agriculture

Attention to: Procurement Unit

Email: a.umugwaneza@cgiar.org

CC; "r.habimana@cgiar.org", "v.delahaye@cgiar.org" "esther.kariuki@cgiar.org"

Email Subject: Question regarding RFP No: JN/0001/2025

3.3. *Proposal Submission*

Proposals must be provided on the offerors' letterhead or stationery and sent via email to the above emails mentioned.

Proposals must have the subject line of "Proposal in response to RFP NO JN/0001/2025 and must include the number of email (for example email 1 of 2, email 2 of 2, etc.) in the subject line. The proposal itself must include all the documents required by the RFP in word, Excel or PDF and those documents must be attached to the same email message: all the attachments must be clearly labeled and must be numbered sequentially for CIAT to review the proposal. If the proposal is sent in more than one email message the offeror must send all the emails with the proposal submission on the same day and time the sending of the emails as closely as practicable.

It is the responsibility of the offeror to ensure timely delivery of the proposal by the date and time specified above.

3.4. *Eligibility of the proposals*

3.4.1. *Complete Proposals*

Offerors must submit all components required by this RFP, including its annexes, in order for their proposal to be complete. Before evaluating proposals, CIAT will determine which proposals include the components required by the RFP to be considered complete proposals. Please note that although CIAT will determine certain proposals to be considered complete, this determination does not signify that an award will be made to one or any other offerors with complete proposals. Only Complete proposals will be evaluated and considered for an award.

3.4.2. *Past performance*

Offerors may be disqualified if a check of past performance demonstrates that the offeror has not been able to deliver similar services on time and in a satisfactory manner.

3.5. *Evaluation Criteria.*

CIAT shall evaluate all eligible proposals based on price. To be considered eligible, offerors must meet and demonstrate the following minimum requirements:

Technical Evaluation/Requirement

| | Evaluation Criteria | Max. Points |
|---|---|-------------|
| 1 | Experience of the Firm including Number of years in Business (Minimum 3 Years) | 20 |
| 2 | Current and/or Past Performance Reference | 20 |
| 3 | Administration of Medical Scheme <ul style="list-style-type: none">• Schedule of Benefits.• Online services (Bank Transfer, electronic claims, and online network information).• Card issuance.• Provision of 24/7 helpline facility• Regional cover (in multiple country)• International Travel Insurance• Timely benefits utilizations statements• Service levels and appointment of health care providers, and• Members record maintenance.• Turnaround time for claim processing | 40 |
| 4 | Services Distribution Network through Rwanda and regional. And or a list of names Hospital and Pharmacy linkages | 20 |
| | TOTAL POINTS | 100 |

Note: Offeror Failing to meet the score of 70 will be rendered nonresponsive and will not be considered for the financial evaluation.

Cost/ Financial Evaluation

The Financial proposal for the different categories of issuances should clearly identify as a separate amount the fees, levies and other impositions imposed under the applicable law, on the service providers, in relation to the assignment.

The offerors shall use an appropriate price template, **Annex C**. An example of which is contained in the solicitation document, the prices of services it proposes to supply under the contract. All Rates, Premiums and Prices shall be quoted in Rwandan Francs (RWF).

3.6. Selection

CIAT may award a contract without discussions with Offerors. As such, Offerors are strongly encouraged to submit their best Proposals with their original submissions. CIAT reserves the right to site visits and/or to conduct discussions, which may result in revisions to Proposals, with one or more

than one or all Offeror(s) if CIAT determines, at its sole discretion, discussions to be necessary. Discussions may include oral presentations provided by the Offeror.

4. Technical Specifications and Requirements

4.1. Specifications

The insurance plan offered must meet the “menu” of coverage choices and include at a minimum, the following coverage categories:

- a. Membership Eligibility (married employees, single employees, single parent employees)
- b. Manner of avilment (e.g. clinic-based, hospital-based)
- c. Pre-existing conditions coverage
- d. Pre-existing chronic diseases
- e. Room and Board (per day): open private or semi-private
- f. Maximum Benefit Limit (MBL): per year per person (for principal and dependent(s))
- g. Annual Check-up Benefit (itemized)
- h. Preventive Care
- i. Out-Patient Benefits
- j. In-Patient Benefits
- k. Special Procedures and Modalities
- l. Maternity Benefits
- m. Emergency Care
- n. Dental Services
- o. Optics services
- p. Covid19 diagnosis and treatment and regional coverage
- q. Last expense (Member and dependents).
- r. Counselling
- s. Psychiatric Treatment and rehabilitation services
- t. Maternity complications
- u. Antenatal and Postnatal check-up, and ultrasound
- v. 1st Emergency Caesarean Section

- w. Post Hospitalization
- x. Emergency Treatment outside Rwanda
- y. Overseas Referral for treatment not available locally.
- z. STD's
- aa. Lodger fees.
- bb. Travel Insurance.
- cc. Hepatitis B vaccine.
- dd. Wellness programs

Kindly note that ALL benefits are to be activated from day one upon payment of premium.

Please see **Annex B** for detailed Technical Specifications.

CIAT Rwanda has approximately 29 employees. **The required coverage period will be for 14 months so as to run from 1st March 2025 to 30th April 2026.** Offerors should provide complete details of their “medical provider networks” (including options for seeing doctors both inside and outside those networks). Offerors should also provide details on the processes for reimbursement of expenses and/or patient co-payment terms to medical providers. All proposed plan options should include coverage for the employee and dependents (up to four (4) dependents).

The Offeror should have a countrywide network of coverage in Rwanda and in the region including hospital linkages, customer care, and services. Offerors are required to provide the project with their established terms and conditions for payment and reimbursement. ***The Offeror are encouraged to include the name and contact information of their hospital linkages and pharmacies.***

4.1.2. Delivery Schedule and Location.

The Proposal must be based on the following delivery schedule, considering the delivery location specified below.

| Deliverables | Delivery Schedule | Location |
|--|---|---------------------|
| All services detailed in Section 4.1.1 | Insurance services to start for a 14-month period following award of contract for 29 employees and their dependents, up to four (4) | Rwanda and Regional |

4. Proposals Requirements

4.1. General Requirements

Offeror must submit:

1. A Detailed technical proposal explaining the services the Offeror proposes to meet the requirements of CIAT as described in Section 4. The Proposals must include all the necessary technical information specified in **Annex B**.
2. A Price Proposal for the Medical including the maximum limits
3. A detailed policy regarding the insurance the Offeror intends to provide CIAT in response to this RFP.
4. The forms and certifications specified in Section 7.
5. A completed proposal checklist specified in **Annex D**.
6. If applicable, a price adjustment plan to match the employee number increase is preferred.

4.2. Price Proposal Requirements

The price proposal must indicate the coverage of the technical specifications in Section 4. The Proposals must follow the format provided in **Annex C**. The Price Proposal must be in Rwandan Francs (RWF). All Offerors must provide a price guarantee that the Proposal price remains valid for 90 days from the date of the Proposals.

5. Contract Type and Payment

One or more contracts may be awarded in response to this RFP. The payment schedule for any resultant task order under the contract is anticipated to be as follows:

| Deliverable | Payment Amount |
|--|---|
| Provision of agreed-upon medical coverage; | To be approved based upon submission of invoice based upon the number of enrolled employee or the based on the group policy |

The anticipated contract terms and conditions for any resultant contract are provided in **Annex E**. CIAT reserves the right, at its sole discretion, to revise the contract terms and conditions before issuance of a contract.

6. Organization Overview and Offeror Certification

6.1. Organization Overview and Certification.

For the proposal to be considered, the offeror must complete and submit the proof of their business registration, valid license issued by the National Bank of Rwanda and Up to date Tax Certificate as an attachment to this RFP.

Annex A- Organizational Information and Certification form

The offeror must ensure that this form is duly completed and correctly executed by an authorized officer of the organization.

A.1. Organizational Information.

Full legal name of the offeror company: _____

Year the Offeror's company was established: _____

Contact information regarding the proposal:

- Individual full name and title: _____
- Full Office address: _____
- Telephone Number: _____
- Email address: _____

A2. References

Please list the names, email addresses, phone numbers, and contact people at three organizations to which the Offeror has provided services of a similar or larger size and scope during the last 24 months, whom CIAT can call on as references, and a description of the services provided to each organization. It is recommended that the Offeror alert the contracts that their names have been submitted and that they are authorized to provide performance information if requested by CIAT.

Reference #1:

Organization Name: _____

Contact Person: _____

Email Address: _____

Telephone Number: _____

Type of Service provided: _____

Value of service provided: _____

Month and Year During which services were provided: _____

Reference #2:

Organization Name: _____

Contact Person: _____

Email Address: _____

Telephone Number: _____

Type of Service provided: _____

Value of service provided: _____

Month and Year During which services were provided: _____

Reference #3:

Organization Name: _____

Contact Person: _____

Email Address: _____

Telephone Number: _____

Type of Service provided: _____

Value of service provided: _____

Month and Year During which services were provided: _____

A3. Incorporation, Registration, and Litigation

The following documents must be included in your proposal.

Documentation showing the Offeror's current legal incorporation in the country in which it is incorporated:

☐ Attached

A copy of the Offeror's currently active registration in Rwanda, demonstrating that the organization can legally operate in Rwanda *if the Offeror will complete any work under a contract resulting from this RFP in Rwanda.*

☐ Attached

☐ Offeror certifies that it will not complete any work under a contract resulting from this RFP in Rwanda and further certifies that it can legally operate in the country(ies) in which all work under a contract resulting from this RFP will take place. Information regarding any current lawsuits, legal proceedings, court cases, or other litigation in which the Offeror, or any of the entities in the collaboration, are involved, regardless of the jurisdiction where the litigation resides.

☐ Attached

☐ Offeror certifies that it is not currently involved in any lawsuits, legal proceedings, court cases, or other litigation.

A4. Key Individuals

The names and titles of the Offerors' key individuals are:

(a) the principal officers of the organization's governing body (e.g., chairman, vice chairman, treasurer, and secretary of the board of directors or board of trustees): _____

(b) the principal officer and deputy principal officer of the organization (e.g., executive director, deputy director, president, vice president): _____

(c) the program manager(s) for the proposed contract: _____

(d) any other person who will have significant responsibilities for the administration of the RFP or resources under the proposed delivery of the services:

A5. Awareness and Agreement to the Content of this RFP

By signing this form, the Offeror attests to its awareness and agreement to the content of this RFP and all accompanying calendar schedules and terms and provisions contained herein, including but not limited to the payment terms in Section 6.

A8. Proposals Validity

This proposal is submitted in response to an RFP issued by CIAT. The undersigned is a duly authorized officer and hereby certifies that:

(Offeror Name)

agrees to be bound by the content of these Technical and Cost Proposals and agrees to comply with the terms, conditions, and provisions of the referenced RFP. The Proposals shall remain in effect for a period of 90 calendar days as of the Due Date of the RFP.

A9. Authorized Negotiators

Person[s] authorized to negotiate on behalf of this firm for purposes of this RFP are:

| | | |
|------------|--------|--|
| Name: | Title: | |
| Signature: | Date: | |
| Name: | Title: | |
| Signature: | Date: | |

A10. Signature

Signature of Authorized Officer:

| | | |
|------------|--------|--|
| Name: | Title: | |
| Signature: | Date: | |

Annex B- Technical Specifications/Scope of Work
Medical Insurance

| No. | Services Required |
|-----|---|
| 1 | Cover Limit (14 Months) <ul style="list-style-type: none"> • In RWF / person/ year |
| 2 | Emergency services (Emergency Rescue / Air Evacuation) |
| 3 | Out-Patient Services: <ul style="list-style-type: none"> • Annual Out-patient Limit • Medical practitioner and specialist appointment coverage • Diagnostic procedures including Laboratory & Diagnostics • Drugs, dressings, and medicines including Covid19 diagnosis and medications. • Physiotherapy • Alternative treatment (i.e. chiropractic care) • Coverage of outpatient is 100% • Maternity • Counselling • Psychiatric Treatment • Post Hospitalization • Overseas referral for treatment not available locally • STD's |
| 4 | In-patient Services: <ul style="list-style-type: none"> • Annual In-patient Limit • Hospitalization (Daily Room and Board Limit) • ICU • A medical practitioner, specialists, nurse fees |

| No. | Services Required |
|-----|---|
| | <ul style="list-style-type: none"> • Surgical Fees, including anesthesia and theatre charges Physician, Surgeon, Assistant & Anesthetist fees Surgical appliances and prosthesis (if surgically required) • Diagnostic and surgical procedures including Laboratory & Diagnostics • Drugs, dressings, and medicines (including vitamins) • Appliances (devices and equipment used as an integral part of hospitalization / surgery) • Prescribed Physiotherapy • Emergency Service Inside & Outside Network • Parent Accommodation up to 18 years • Coverage of the Medication is 100% for in-patient. • Lodger fees |
| 5 | Dental Care <ul style="list-style-type: none"> • Limit per person • Oral Examination and consultation • Tartar/Plaque Cleaning • X-ray examination prior to dental treatment • Tooth extraction • Oral surgery • Local anesthesia for localized oral surgery, including root canals. • Treatment of gums • False teeth • Polishing & Crowns |
| 6 | Out-Patient Prescription Drugs |

| No. | Services Required |
|-----|--|
| 7 | Immunization <ul style="list-style-type: none"> • Baby friendly vaccines and private vaccines for children • Private vaccines for adults |
| 8 | Maternity <ul style="list-style-type: none"> • Annual Maternity Limit (for Normal delivery + ANC) • Annual Maternity Limit (for LSC Section + ANC) • Legal Abortion to be included with limit. • Maternity complications • Antenatal and postnatal checkup and ultrasound. • 1st Emergency Caesarian Section |
| 9 | Wellness programs <ul style="list-style-type: none"> • Annual Medical Checkups/screenings • Lifestyle management programs e.g thematic medical talks, etc |
| 10 | Chronic Diseases <ul style="list-style-type: none"> • New Joiners • Pre-existing (no specific limit but included in the annual limit) |
| 11 | Oncology |
| 12 | Vision/Optical Care (detailed coverage, including glasses) <ul style="list-style-type: none"> • Eye exams • Prescription glasses • Necessary surgeries |
| 13 | Mental Health <ul style="list-style-type: none"> • Inpatient psychiatry and rehabilitation • Employee Assistance Programs e.g counselling services |
| 14 | Rehabilitation Services <ul style="list-style-type: none"> • Rehabilitation for drug abuse and alcohol due to psychiatric ailment |
| 15 | Other services as may be available (i.e. flexibility in number and definition of dependents, coverage for infants starting from birth, |

| No. | Services Required |
|-----|--|
| | flexibility in maximum age for participants, no pre-existing conditions term) |
| 16 | Doctor on Site Visit |
| 17 | Home Visits |
| 18 | Coverage Network: local (national), East Africa, and international coverage options, ensuring employees/members have access to healthcare services within the country, across the East African region, and internationally in case of specialized treatments. |
| 19 | Congenital Conditions and Hearing Aids |
| 20 | Last Expense |
| 21 | Travel insurance |

Annex C- Template for Price/Financial Proposal
The proposal shall be for Group Medical insurance.

Pricing is to be offered with the options of the maximum yearly benefit.

Table C.a

Indicate if the requested service is included in your price or not and feel free to propose an alternative if possible.

| No. | Healthcare Services | Please indicate if the needed service is included in your price offer | | |
|----------|---|---|--------------------------|------------------------|
| | | Included | Not included | Other (please propose) |
| 1 | Ambulance/ Emergency Rescue Services | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2 | Out-Patient Services: | | | |
| 2.a | Annual Out-patient Limit | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.b | Medical practitioner and specialist | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.c | Appointment coverage | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.d | Diagnostic procedures including Laboratory & Diagnostics | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.e | Drugs, dressings, and medicines including - Covid19 diagnosis and medications | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.f | Physiotherapy | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.g | Alternative treatment (i.e. chiropractic care) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.h | Coverage of outpatient is 100% | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2.i | Skin related treatment on prescription | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3 | In-Patient Services: | | | |
| 3.a | Annual Out-patient Limit (14 months) | <input type="checkbox"/> | <input type="checkbox"/> | |

| No. | Healthcare Services | Please indicate if the needed service is included in your price offer | | |
|-----|--|---|--------------------------|------------------------|
| | | Included | Not included | Other (please propose) |
| 3.b | Hospitalization (Daily Room and Board Limit) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.c | ICU | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.d | medical practitioner, specialists, nurse fees | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.e | Surgical Fees, including anesthesia and theatre charges Physician, Surgeon, Assistant & Anesthetist fees Surgical appliances and prosthesis (if surgically required) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.f | Diagnostic and surgical procedures including Laboratory & Diagnostics | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.g | Drugs, dressings and medicines (including vitamins) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.h | Surgical Fees, including anesthesia and theatre charges Physician, Surgeon, Assistant & Anesthetist fees Surgical appliances and prosthesis (if surgically required) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.i | Diagnostic and surgical procedures including Laboratory & Diagnostics | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.j | Drugs, dressings and medicines (including vitamins) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.k | Appliances (devices and equipment used as an integral part of hospitalization / surgery) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.l | Prescribed Physiotherapy | <input type="checkbox"/> | <input type="checkbox"/> | |

| No. | Healthcare Services | Please indicate if the needed service is included in your price offer | | |
|----------|--|---|--------------------------|------------------------|
| | | Included | Not included | Other (please propose) |
| 3.m | Emergency Service Inside & Outside Network | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.n | Parent Accommodation up to 18 years | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.o | Coverage of the Medication is 100% for in-patient | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.p | Inpatient psychiatry | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.q | Non - accidental ophthalmologic in-patient | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.r | Non-accidental dental in-patient | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.s | Gynecological Surgery (excluding Infertility treatment) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3.t | Illness related Reconstructive surgery (Excludes cosmetic, geriatric related, colporrhaphy and perineorrhaphy) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4 | Dental Care | | | |
| 4.a | Limit per person | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.b | Oral Examination and consultation | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.c | Tartar/Plaque Cleaning | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.d | X-ray examination prior to dental treatment | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.e | Tooth extraction | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.f | Oral surgery | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.g | Local anesthetic for localized oral surgery, including root canals | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.h | Treatment of gums | <input type="checkbox"/> | <input type="checkbox"/> | |

| No. | Healthcare Services | Please indicate if the needed service is included in your price offer | | |
|-----|--|---|--------------------------|------------------------|
| | | Included | Not included | Other (please propose) |
| 4.i | False teeth | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4.j | Polishing & Crowns | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5 | Out-Patient Prescription Drugs | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6 | Immunization | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6.A | Baby friendly vaccines and private vaccines for children | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6.B | Supplements and vitamins covered on prescription (both adults & children) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6.c | Private vaccines for adults | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7 | Maternity | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7.A | Annual Maternity Limit (for Normal delivery + ANC) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7.B | Annual Maternity Limit (for LSC Section + ANC) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7.c | Legal Abortion is included with limit | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8 | Annual Medical Checkups | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9 | Chronic Disease | | | |
| 9.A | New Joiners | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9.B | Pre-existing to be included (no specific limit but included in the annual limit) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10 | Oncology | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11 | Vision/Optical Care (detailed coverage, including glasses) Annual limit for glasses | <input type="checkbox"/> | <input type="checkbox"/> | |

| No. | Healthcare Services | Please indicate if the needed service is included in your price offer | | |
|------|---|---|--------------------------|------------------------|
| | | Included | Not included | Other (please propose) |
| 12 | Other services as may be available | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.A | (i.e. flexibility in number and definition of dependents, coverage for infants starting from birth, flexibility in maximum age for participants, no pre-existing conditions term) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.B | Organ transplantation cover (Cost of donor or securing the organ is excluded) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.C | Kidney dialysis | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.D | Learning difficulties and/or disorders, developmental disorders, and speech/or voice | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.E | Total Permanent Disability- Waiting period of 6 months | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.F | Critical illness-The benefit shall only become payable once the member has exhausted their preexisting and chronic related conditions. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.G | School Fees Benefit upon death of an employee. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.H | Rehabilitation for drug abuse and alcohol due to psychiatric ailment | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.I | Last Expense/Death | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.J | Repatriation of remains | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12.K | Congenital Conditions and Hearing Aids | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13 | Doctor on site visit | <input type="checkbox"/> | <input type="checkbox"/> | |

| No. | Healthcare Services | Please indicate if the needed service is included in your price offer | | |
|-----|---|---|--------------------------|------------------------|
| | | Included | Not included | Other (please propose) |
| 14 | Home visits | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15 | Wellness Calendar & employee assistant programs | <input type="checkbox"/> | <input type="checkbox"/> | |

Table C.b

Price according to the current number of employees totaling Twenty-six (26)

| | | |
|---|---------------------|----------------------|
| Price for the services indicated in table C.a | MBL RWF | |
| | For Employee in RWF | For Dependent in RWF |
| Total Price | RWF | RWF |

C.c Payment Terms:

Kindly indicate if you accept Semi-annual payments.

C.d Preconditions

Kindly list any prerequisites before contracting.

1.
2.
3.
4.

Authorized Signatory's Name and Title: _____

Authorized Signatory's Signature: _____

Date: _____

Annex D - RFP Checklist

Please include this checklist with your Proposals

Name of Vendor: _____

| Items to be included with Proposals | Submitted |
|---|------------------|
| 1. Proposals on Letterhead | |
| 2. Price guarantee valid for 60 days | |
| 3. Proposal that responds to the technical specifications/scope of work and details the types of insurance the Offeror intends to provide for in/out-patient service by category based on each premium offered. | |
| 4. Annex A – Organizational Information & Certification (completed and | |
| a. Certificate of Incorporation in Rwanda | |
| b. Valid insurance license | |
| c. List of Key Personnel | |
| d. References (3) | |
| 5. Up-to-date Tax Certification | |
| 6. List of names of hospitals and Pharmacy linkages throughout Rwanda | |
| 7. Annex C - Price Template/Financial Proposal | |

Dr. Eliud Abucheli Birachi

Rwanda CIAT Country Representative