INDIVIDUAL APPLICATION FORM

PACKAGE: **Platinum** ☐ **Gold** ☐ **Silver** ☐ **Bronze** ☐ **Copper Plus** ☐ **Copper** ☐

MEMBER INFORMATION

Title:	**Initial(s):**	**Region:**
Surname:	First Name:	
Other Names:	Maiden Name:	
Marital Status: Single ☐ Married ☐	Divorced ☐	Widowed ☐
Hometown :	Gender: M ☐ F ☐	Date of Birth:__/__/ __(D/M/Y)
Employer:		
Weight (KG):	Height (M):	Smoking: Yes ☐ No ☐
Identification: ☐ Staff ID ☐ National ID ☐ Passport ☐ National Health ID ☐ Others		
ID Number:		
Date of Issue:	Date of Expiry:	

CONTACT DETAILS

Postal Address:	
Residential Address:	
City/ Town:	Region:
Digital Address:	Email Address:
Mobile No 1:	Mobile No. 2:

Please provide at least one telephone number. This field is mandatory.

CONDITION	**NO**	**YES**	**FULL PARTICULARS**
Any previous operations?			
Any exclusions/special conditions on previous medical aid?			
Have you been paid/compensated for any disability?			
Any disease that you have been born with/same as your parent?			
Are you pregnant at present?			
How many times have you been pregnant?			
How many pregnancies have you lost/miscarried?			
How many babies do you have?			
Any gynaecological problems such as heavy bleeding, infertility, ovarian cysts, fibroids, menopause?			

Have you had Hepatitis?			
Have you had any cancer?			
Have you been in hospital the past year?			
How many times have you been admitted to hospital the past year?			
Chest: Have you had TB infection or asthma or other chest/lung disease?			
Have you had Hepatitis?			
Have you had any cancer?			
Have you been in hospital the past year?			
How many times have you been admitted to hospital the past year?			
Chest: Have you had TB infection or asthma or other chest/lung disease?			
Are you breathless and do you cough all the time?			
Heart: have you had any heart disease/rheumatic fever?			
Have you had or do you have high blood pressure?			
Abdominal: have you had any problems with your bowels such as swallowing. ulcers, Hepatitis, pancreatitis, gall-bladder disease or any other?			
Any problem with your kidneys, or bladder or prostate or problems with passing urine?			
ENT: any problems with your nose or ears or throat such as allergies with a blocked nose or sinusitis, hearing problems, sore throat?			
Any eye problems such as blurring, poor eyesight, high eyeball pressure, pain. cataracts, infections?			
Any emotional or psychological problems such as stress, anxiety, depression, suicide attempt?			
Any neurological problems such as a stroke, weakness of arm/leg, unsteady walk, tremor, fits/ epilepsy, confusion, memory loss?			
Do you suffer from a Chronic condition such as: Diabetes, Thyroid disease. High cholesterol, HIV. Asthma			
Any problems with joints or muscles such as arthritis, gout?			
Any disorder of the blood such as anaemia, sickle cell disease, bleeding or clotting disorder?			
Any problems with skin such as rashes, infection, colour change?			

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE, PLEASE PROVIDE DETAILS BELOW:

Member Name	Gender (M/F)	Medication currently in use	Duration in use

PAYMENT METHOD & INFORMATION

I hereby agree to arrange with a financial institution to pay my annual contribution to this Health Plan as well as to update my stop order with every premium increase.

TRANSFER PAYMENT (ONE TIME PAYMENT) ◯

Annual Premium Amount	Name of Account Holder:	
Amount Number:	Name of Bank	Branch:
Signature of Account Holder:		Date:

INSTALMENT PAYMENT ◯

Annual Premium Amount	Name of Staff:	
Company Name:	Department:	Staff ID
Applicant Signature:		Date:

USSD ◯

Annual Premium Amount	Service Provider:	Mobile/Momo Number:
	MTN ◯ **AIRTEL/TIGO** ◯ **TELECEL** ◯	

DECLARATION BY MEMBER

I ______________________ hereby state that:

A. Should I be enrolled as a member of The Scheme, I will subject myself to the rules of The Scheme. The information herein is completed true to the best of my knowledge and conviction. No relevant information has been omitted. If after my admission to The Scheme, it is found that my statement or information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to The Scheme all payments which The Scheme have made on my behalf and to relinquish any claim to any benefits on the part of The Scheme.

B. Should there by any deterioration or change in my state of health or in that of any of my dependants before the date or event to be set by The Scheme for the commencement of membership or the date of acceptance of this application by The Scheme; or the date of receipt of the first contribution, (whichever date is the latest), The Scheme will be entitled to reconsider the application and propose new terms of admission or declare the membership null and void.

C. Any monies paid to The Scheme in terms of this membership, before The Scheme is informed of the change, shall be forfeited and benefits paid by The Scheme, shall immediately be refunded to The Scheme.

D. I am bound now, and in the future, if we (myself and my dependants) are accepted as members, to give The Scheme all suchinformation and evidence to The Scheme as they require from time to time. I authorise the attending medical practitioner or any other provider, to provide The Scheme with such information as it may require, hereby waiving the provisions of any law or regulation restricting the giving of such information.

E. I undertake to pay any other amount due to The Scheme, on default. I hereby authorise my employer to deduct the due amount from my salary or any other monies due by me.

F. In the event of voluntary resignation from The Scheme, I agree to give The Scheme one calender month notice, which must be received by The Scheme in writing by no later than the 7th of the month.

G. I agree to call The Scheme client services with regards to any queries and pre-authorise any treatment as required by The Scheme.

Signature of Applicant:	Date: D D M M Y Y Y Y

OFFICIAL USE ONLY Receving Officer: ______________________

Signature: ______________ *Date:* ______________

Peace Of Mind............Always.