MEMBER APPLICATION FORM

LIBERTY MEDICAL HEALTH

Principal Member

Mr. ☐ Mrs ☐ Miss ☐ Other ☐

Surname: _____ Other Names _____

Maiden Name: _____

Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Gender: M F Date of Birth: D D M M Y Y Y Y

Employer: _____ Weight: _____ KG Height: _____ M

ID Type: ☐ Ghana Card: ☐ Passport: Staff ID _____ ID Number: _____

Principal Member Address

Postal Address: _____

Town/City: _____ Digital Address: _____

Residential Address: _____

Email Address: _____

Contact: _____ Cell No.: _____

Please note: ONE telephone number is compulsory

Spouse/Partner Details

Mr. ☐ Mrs ☐ Miss ☐ Other ☐

Surname: _____ Other Names _____

Maiden Name: _____

Weight: _____ KG Gender: M F Date of Birth: D D M M Y Y Y Y Cell No.: _____

Dependants

(Complete special dependant form for mother, father, adopted/foster child, brother, sister or other relatives. Also complete special dependant form for children over the age of 21 years.)

Please use a seperate page if you have more than six dependants.

Surname: _____ Other Names: _____

Gender: M F Date of Birth: D D M M Y Y Y Y Relationship: _____

Surname: _____ Other Names: _____

Gender: M F Date of Birth: D D M M Y Y Y Y Relationship: _____

Surname: _____ Other Names: _____

Gender: M F Date of Birth: D D M M Y Y Y Y Relationship: _____

Surname: _____ Other Names: _____

Gender: M F Date of Birth: D D M M Y Y Y Y Relationship: _____

Medical History of Main Member and Dependants

Any previous or current treatment for a disorder or condition must be marked as YES. Answer all questions by selecting YES or NO. Where the answer is Yes, please give full details. A doctor's report may be requested in some cases. (Please circle the specific condition)

CONDITION	NO	YES
Birth Defects & Inherited Disorders - Spina Bifida, Injuries, Heart Disorders.		
Dermatological - Acne, Eczema, Pemphigus, Psoriasis, Fungal infections.		
Musculo-Skeletal - Osteo-arthritis, Rheumatoid arthritis, Osteosarcoma, Gout, Osteoporosis, Lupus Erythematosus, joints or muscles disorder.		
Ear, Nose and Throat - Deafness/Hearing impairment, Allergic Rhinitis, Recurrent Throat Infections, Vertigo, Chronic Sinusitis, Meniere's Disease.		
Respiratory Disorders - Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis, Bronchiectasis, Covid-19 or others.		
Gastro-Intestinal - Hiatus Hernia, Chronic Peptic Ulcer, Crohn's disease, Oesophageal reflux, Spastic Colon, Ulcerative Colitis, Malabsorbtion Syndrome.		
Urological Disorders - Chronic Renal Failure, Kidney Stones, Chronic Pyelonephritis or Prostatic Hypertrophy, Neurogenic bladder, Urinary incontinence, Urinary retention.		
Neurological - Cerebro Vascular Accident, Neuropathy, Epilepsy, Multiple Sclerosis, Neuralgia, Migraine, Parkinson's disease, Myasthenia Gravis, Stroke, Alzheimer's, Narcolepsy.		
Psychiatric - Anxiety, Depression, Bipolar Mood Disorder, Schizophrenia, Sleep disorders, Attention Deficit Hyperactivity Disorder, Neurosis, Obsessive-Compulsive Disorder.		
Liver and Pancreas Disorders - Hepatitis, Cirrhosis, Gallstones, Pancreatitis, Chronic Cholecystitis.		

CONDITION	NO	YES
Cardiovascular - Hypertension, Hypotension, Dysrrhythmias, Cardiac Failure, Aneurysm, Ischaemic Heart Disease, Peripheral Vascular, Rheumatic fever, or other cardiovascular disorder/disease.		
Blood Disorders - Anaemia, Leukemia, Haemophilia, Clotting Disorders, Thrombocytopenia.		
Endocrine Disorders - Diabetes Insipidus, Hypothyroidism, Hyperthyroidism, Addison's Disease, Cushing's Syndrome, Diabetes, Mellitus, Hypoglycemia.		
Infections - HIV, Hepatitis, Sexually transmitted diseases.		
Cancer - any form		
Gynaecological System - Endometriosis, Ovarian cysts, Menstrual disorders, heavy bleeding, abnormal pap smear, or other gynaecological problems.		
Eye Disorders - Cataracts, Impaired vision, Glaucoma, Retinopathy and other eye conditions.		
Metabolic Disorders - Lipid Disorders, Porphyria.		
Have/are you been compensated for any disability?		
Is anyone to be insured on this policy: a. pregnant? If yes, please state the number of months? or b. had any medical conditions or complications of pregnancy?		
Any previous surgery?		
Any special terms, exclusions on any physical impairment, disability, prosthesis or medical aids?		

Are there any conditions, diseases, injury or illness not listed above?	Yes	No	State if yes
Any known or foreseeable need to consult any doctor or other health professionals?	Yes	No	State if yes

If YES to any of the previous questions please complete the section below, and fill in the applicable condition number:
(Please use a separate page if more information applies to relevant questions)

Condition No.: Patient: Doctor:

Treatment: Last Date of Treatment: D D M M Y Y Y Y

Condition No.: Patient: Doctor:

Treatment: Last Date of Treatment: D D M M Y Y Y Y

Condition No.: Patient: Doctor:

Treatment: Last Date of Treatment: D D M M Y Y Y Y

Current Chronic Medication (Please use a separate page if more than three chronic medications are used)

Initial(s): Registered First Name:

Surname: Medicine:

Duration of use: From: D D M M Y Y Y Y To D D M M Y Y Y Y

Initial(s): Registered First Name:

Surname: Medicine:

Duration of use: From: D D M M Y Y Y Y To D D M M Y Y Y Y

Initial(s): Registered First Name:

Surname: Medicine:

Duration of use: From: D D M M Y Y Y Y To D D M M Y Y Y Y

Statement by Employer concerning Main Member

I (Responsible Officer)

of (Name of Employer)

hereby state that the applicant is a certified staff member of the company and a participating member under:

Option: Platinum Gold Silver Bronze Copper Plus Copper

Statement by Main Member

I 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 such information 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

Peace of Mind.....Always.