Heritage Insurance Company

A member of the LIBERTY Group

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Group Medical Aid Scheme

Membership Application Form

Section A to be completed by member; Section B to be completed by member; Section C to be completed by employer.

SECTION A - EMPLOYEE DETAILS

Employer / Scheme

Full Names of Employee

Date of Birth D D - M M - Y Y Y Y Sex ☐ M ☐ F

Occupation

SECTION B

Dependants to be Included to the medical cover

	First Name	Middle Name	Surname	Date of Birth	Sex	Relationship to you (Wife, son etc)
1.				D D M M Y Y		
2.				D D M M Y Y		
3.				D D M M Y Y		
4.				D D M M Y Y		
5.				D D M M Y Y		
6.				D D M M Y Y		
7.				D D M M Y Y		

NB: Please use an additional form if dependannts are more than 7 (Seven)

HEALTH DECLARATION BY MEMBER

PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE OR BELIEF

1. a) Name and address of your present doctor

   b) Date last consulted (if within last 10 years) Reason ?

   c) What Treatement was given or medication prescribed ?

Attach 1 recent passport photo for you and each of your dependants

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* PLEASE NOTE TO COMPLETE PAGE 2 OF THIS FORM

	TICK APPLICABLE ITEMS	Yes	No	If the answer to any question is "Yes", Identify question number and include diagnosis, dates, duration, degree of recovery or results and names and addresses of all attending physicians and medical facilities in the space beow.
2.	Are you under medical treatment by diet, medicine or other means ?	☐	☐	
3.	Have you ever had or sought advise for :			
	a) Chest pain, high blood pressure, heart murmur, heart or circulation disorder?	☐	☐	
	b) asthma, chronic cough, shortness of breath or lung disorder?	☐	☐	
	c) diabetes or sugar in urine?	☐	☐	
	d) Ulcer, Colitis, liver or digestive disorder?	☐	☐	
	e) cancer, tumor or enlarged glands?	☐	☐	
	f) anaemia, bleeding or blood disorder?	☐	☐	
	g) dizzy or fainting spells, epilepsy, nervous system or mental disorder ?	☐	☐	
	h) urine, kidney or bladder disorder?	☐	☐	
	i) atrhritis or other joint disorder?	☐	☐	
	j) any other illness, surgery or injury?	☐	☐	
	k) Have you or any of the insured members ever been diagnosed with a congenital condition?	☐	☐	
4.	a) Have you received medical advise or treatment in connection with AIDS or an HIV / AIDS related condition or sexually transmitted disease?	☐	☐	
	b) have you been told you have HIV/AIDS or an HIV/AIDS related complex?	☐	☐	
	c) have had or been told you had a positive blood test for antibodies to the virus (Human Immune Deficiency Virus)	☐	☐	
	d) Do you have any of the following which are unexplained : Fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lessions?	☐	☐	
5.	Have you within the past 5 years :			
	a) had any mental or physical disease or disorder not listed above	☐	☐	
	b) had a check-up, consultation, illness, injury or surgery	☐	☐	
	c) been a patient in a hospital, clinic, sanotoruim, or other medical facility?	☐	☐	
	d) had electrocardogram, X-ray, other diagonistic test ?	☐	☐	
	e) been advised to have any diagonistic test, hospitalization, or surgery which was not completed.	☐	☐	
	f) had blood transfusion?	☐	☐	
6.	Is any of the named members presently pregnant?	☐	☐	If Yes give name
7.	Are you aware of any conditions in yourself or member of your family necessitating medical, surgical, dental or optical treatment at the present time? If so give full particulars :			

DECLARATION

I hereby declare that the statements in this form are true and complete. I further declare that I have not withheld any material information in regard to this application that ought to be disclosed to the Company. I agree to abide by rules governing the scheme and further agree that this declaration and the answers given in this application form shall be the basis of the contract between me and the Insurance Company.
I consent to the Company seeking information from any doctor, hospital or clinic I have consulted or from any Company I made a proposal for Insurance and I hereby authorise the giving of such information.

MEMBER NAME : _____ DATE : _____ Members Signature _____

SECTION C

As Employer I confirm that the information given in Section "A" above is correct.
This employee and his/her dependants is/are to be included in the Scheme with effect from (Date) :

_____	_____	_____
Signature and Stamp of Employer	Date of Signing	Position in Company