Liberty Health Cover
Amendment Form (Group)

LIBERTY

LIFE INVESTMENTS INSURANCE **HEALTH** PROPERTIES ADVICE

Important: please read the following before completing this Amendment Form
- Please write clearly using capital and block letters.
- Please complete only relevant section(s).
- Please submit your completed forms and documents required (see table below) to our Liberty Health Cover in-country office.
- Each page other than the signature page is to be initialled by the Principal Member.

DOCUMENTS REQUIRED FOR REGISTRATION

WHO DOES THIS APPLY TO	DOCUMENT/S REQUIRED AS PROOF
Your spouse	• Marriage Certificate
Your living-in partner	• Proof of Dependency Affidavit stating how long the couple has been living together, which is signed and stamped by a Commissioner of Oaths
Your adopted child / child placed in custody of principal member or their spouse or living-in partner	• Copy of the abridged birth certificate • Proof of legal adoption • Proof of custody
Your or your spouse or living-in partner's biological or natural child (including stepchildren)	• Copy of the birth certificate, or hospital confirmation reflecting baby's name (for newborns)
A child dependant due to disability	• Medical report as proof of disability
A child dependant student (up to 25 years of age)	• A dependant who is up to the age of 22 • A dependant up to the age of 25 provided that the Principal Member submits proof of studies, e.g., written proof of registration for this dependant

1. DETAILS OF MEMBER

Please complete in block capitals

Last name

First name(s) Title

Member number Initials

Employee number Date of birth Y Y Y Y M M D D

2. CHANGE IN CONTACT DETAILS

Please complete in block capitals

Postal Address

Postal Code

Physical Address

Postal Code

E-mail

Home telephone (please include country and area code)

Work telephone (please include country and area code)

Mobile (please include country and area code)

Effective date of change Y Y Y Y M M D D

3. BANKING DETAILS

Please complete in block capitals

Account holder name

Account number

Account type ☐ Savings ☐ Cheque ☐ Transmission ☐ Other

Bank

Branch name Branch code

NIB (if applicable) Swift code

IBAN (if applicable)

Signature of Account Holder

Effective date of change Y Y Y Y M M D D

4. OPTION CHANGE (ONLY APPLICABLE AT TIME OF RENEWAL)

PLEASE NOTE THAT THIS OPTION CHANGE WILL BE APPLIED TO ALL DEPENDANTS REGISTERED UNDER THE PRINCIPAL MEMBER

Plan Option (tick new plan)

☐ Lite ☐ Classic ☐ Classic Tariff (Zimbabwe only) ☐ Classic Evacuation

☐ Classic Roaming ☐ Enhanced ☐ Core (Kenya only) ☐ Plus ☐ Elite

Effective date of change Y Y Y Y M M D D

5. OTHER CHANGES AND DOCUMENTS REQUIRED

Please tick appropriate block

Type of change		Effective date of change	Requirements and/or documentation
1. Reinstate membership	☐	Y Y Y Y M M D D	Reason for reinstatement Proof of payment where applicable
2. Deaths	☐	Y Y Y Y M M D D	Death Certificate Name and postal address of Executor of Estate
3. Transfer	☐	Y Y Y Y M M D D	Instruction from new company on letterhead with effective date
4. Resignation	☐	Y Y Y Y M M D D	Documentation from payroll officer stating reason for cancellation

Company Stamp

6. REGISTRATION OF DEPENDANTS

Please complete in block capitals

Dependant 1

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to Principal Member

Effective date of registration Y Y Y Y M M D D

Dependant 2

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to Principal Member

Effective date of registration Y Y Y Y M M D D

Dependant 3

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to Principal Member

Effective date of registration Y Y Y Y M M D D

Dependant 4

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to Principal Member

Effective date of registration Y Y Y Y M M D D

Dependant 5

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to Principal Member

Effective date of registration Y Y Y Y M M D D

Dependant 6

Full Name

Please put the full name that will appear on the Liberty Health Cover membership card

Town/Village of residence

Date of birth Y Y Y Y M M D D Gender M F Relationship to Principal Member

Effective date of registration Y Y Y Y M M D D

Please see the descriptions of type of relationship to Principal Member in the first column of the first table on page 01 of this document.

7. PERSONAL DETAILS - NEW DEPENDANTS

Please complete in block capitals. Please order dependants from oldest to youngest when completing the photo section below

To register the new dependants on Liberty Health Cover, please fill in all the details below. Please attach the photographs of the dependants to this page. Please note that all photographs should have the relevant name written on the back of the photo.
Please note that these photos will not be returned to you.

DEPENDANT 1

NAME

DEPENDANT 2

NAME

DEPENDANT 3

NAME

DEPENDANT 4

NAME

DEPENDANT 5

NAME

DEPENDANT 6

NAME

I

(Name of Principal Member)

of

(Company Name)

certify that the persons whose names and photographs appear above, are my legal, registered dependants to be included under my Liberty Health Cover. I am aware that any false representation of any person as my dependant will result in me and all my dependants being removed from Liberty Health Cover, and I will be liable for any cost incurred for health services provided.

Signature of Principal Member

Date signed | Y | Y | Y | Y | M | M | D | D |

8. HEALTH STATEMENT

Please complete in block capitals. All sections below must be completed - failure to do so will delay processing.

Note: If you answer "YES" to any of the questions in this section, and if the space provided to complete your answer is not sufficient to disclose the necessary information, please provide additional information on separate pages.

Name and last name of current family doctor

Telephone

How long has he/she been your doctor? year(s)

Postal address

Postal code

Have any of your nominated dependants received medical advice, care or treatment for any of the following?

1. Heart & Circulation	e.g. Chest pain/Angina; Heart attack; Heart failure; Heart valve defects; Rheumatic fever; High blood pressure (Hypertension); High cholesterol; Heart murmurs; Circulatory problems/disorders; Varicose veins; Deep Vein Thrombosis (DVT) or any other heart or circulatory problems.	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

2. Breathing & Respiratory	e.g. Asthma; Difficulty with breathing; Bronchospasm; Tuberculosis (TB); Coughing up blood; Emphysema; Pneumonia; Cystic Fibrosis; Chronic bronchitis; Shortness of breath or any other respiratory problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

3. Bladder & Kidneys	e.g. Blood in urine; Kidney failure; Polycystic kidneys; Kidney or bladder infections; Kidney removal (Nephrectomy); Kidney stones; Abnormal kidney or urine tests or any other bladder or kidney problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

4. Reproductive Organs	e.g. Endometriosis; Infertility; Ovarian cysts; Hysterectomy; Abnormal pap smears; Cervix or breast biopsies; Fibro-adenosis of the breast; Laparoscopies; Hormone Replacement Therapy (HRT); Prostate infections or surgery; Prostate enlargement or any other reproductive problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

5. Digestive System	e.g. Duodenal ulcers; Gastric ulcers; Hiatus hernia; Colon problems; Crohn' s Disease; Ulcerative Colitis; Gall bladder problems; Pancreas; Liver problems or any other digestive system problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

6. Ear, Nose & Throat	e.g. Deafness; Ear infections; Sinus problems; Nasal surgery; Throat surgery; Orthodontics; Dental surgery; Speech impairments; Harelip; Cleft Palate or any other nose or throat problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

7. Eyes	e.g.Blindness (partial or full); Eye surgery; Lens implants; Cataracts; Glaucoma; Retinitis Pigmentosa; Retinal detachment; Impaired vision or any other eye or eyesight problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

8. Endocrine	e.g. Diabetes ("high blood sugar"); Underactive thyroid; Overactive thyroid; Thyroid surgery; Cushing's Syndrome; Addison's Disease; Pituitary gland problems or any other endocrine or glandular problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

9. Back & Muscles	e.g. Neck or back problems or operations; Recurrent back pain; Osteoporosis; Ankylosing spondylitis; Rheumatoid arthitis; Osteoarthritis; Paget's Disease or any other bone or skeletal disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

10. Neurological	e.g. Epilepsy; Stroke (CVA); Migraine; Brain injuries; Spinal cord injuries; Paralysis; Cerebral palsy; Multiple sclerosis; Mental retardation; Narcolepsy; Motor neuron disease; Parkinson's Disease; Alzheimer's Disease or any other neurological problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

11. Psychological	e.g. Depression; Anxiety; Psychosis; Suicide attempts; Bipolar disorders; Manic depression; "Stress"; Schizophrenia; Tourette's syndrome; Anorexia Nervosa; Received advice, counselling or treatment for alchohol or drug abuse; Attention Deficit Disorder, Bulimia or any other psychological problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

12. Tumours & Growths	e.g. Benign or malignant growths or lumps or tumours including but not limited to: Melanoma; Lymph gland cancer; Leukemia and breast cancer or any other tumors, growths and cancers	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

13. Blood	Blood or bleeding disorders e.g. Haemophilia; Christmas factor deficiency; Platelet or any other blood clotting disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

14. Skin	e.g. Eczema; Acne; Dermatomyositis; Pemphigus; Psoriasis; Scleroderma or any other skin disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

15. Sexuality Transmitted Diseases (STIs)	e.g. Advice, treatment or counselling for any of the following: HIV/AIDS; Syphilis; Gonorrhoea; Herpes; Genital ulcers; Pelvic Infectious Disease (PID); Genital warts; Hepatitis B or any other STI or disorder	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

16. Pregnancy	Are you or any of your dependants currently pregnant? Y N **If the answer to this question is "Yes", when is the expected date of delivery?** Y Y Y Y M M D D Name of patient:

17. Other medical conditions	Do you or any of your nominated dependants have any medical condition not mentioned in the above questions 1 to 16?	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

9. DECLARATION BY PRINCIPAL MEMBER

1. I, the undersigned, hereby apply to have my nominated dependants sign up for Liberty Health Cover.

2. I understand that this application, together with any supporting documents and the rules of the Liberty Health Cover Policy Conditions, form the basis of my contract with the Insurer.

3. Declaration in respect of my partner (if applicable): I confirm that my partner and I are in a committed relationship akin to a marriage based on mutual dependency and a shared household.

4. Liberty Health Cover Policy Conditions and benefits
a. I agree that I and my dependants will be bound by the Liberty Health Cover Policy Conditions and will abide by them.
b. The Insurer shall not be bound in any way by any representations or undertakings made or given by any person save as contained in the registered rules of the Liberty Health Cover Policy Conditions.

5. Exclusions
a. I understand that the Insurer may impose exclusions in respect of myself and / or any of my nominated dependants.
b. I accept any such exclusion that may be imposed in terms of the Liberty Health Cover Policy Conditions.

6. Banking Details
a. I agree to advise the Insurer in writing of any changes to my banking details.
b. I understand that failure to do so will result in me being liable for any subsequent banking charges or other costs / losses incurred due to the use of the incorrect banking details.

7. Premiums and amounts owed to the Insurer
a. I hereby acknowledge that any credit extended by the Insurer to myself in terms of the Liberty Health Cover Policy Conditions will become payable in full by the end of the benefit year in which it arose and that interest may be charged on all amounts due and owing to the Insurer.
b. I acknowledge that it remains my responsibility to ensure that any amounts due by me to the Insurer are paid to the Insurer.
c. I agree that any amounts owing by me may be off-set against any benefits or payments that may be due to me by the Insurer.
d. I also accept that I will be responsible for any costs associated with the recovery of any debts.

8. Disclosure of information
a. I confirm that I have the necessary authorisations to disclose the information that the Insurer may require and provide the necessary authorisations in respect of my nominated dependant/s.
b. I confirm that the information provided in this application, and in any other documents submitted in support of this application, is true, correct and complete and that I have not withheld, concealed or misstated any information.
c. I furthermore confirm that I understand that my membership will become null and void should the above statement be found to be incorrect and that in such an event, all monies paid in respect of my membership shall be forfeited and that the Insurer shall furthermore be entitled to recover any amounts paid for services rendered from the provider and/or myself.
d. I undertake to promptly advise the Insurer of any change in status of health of myself and any of my nominated dependants that occurs prior to the date of registration with the Insurer and acknowledge that the additional information may be subject to underwriting. I acknowledge that not doing so may lead to the Insurer reconsidering the basis of my membership application.
e. I indemnify Liberty Health Cover and its trustees, agents and administrator against any claim, of whatever nature, which may be made against them as a result of or arising out of the disclosure of any medical information in fulfilling this agreement.
f. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information about my own, or my nominated dependants' health status to the Insurer or any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement and I agree that this authorisation shall remain in force after my/their death/s.
g. I irrevocably authorise the Insurer to collect, process and share my personal information and that of any nominated dependants/s with any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement. I agree that this authorisation shall remain in force after my/their death/s and understand that this may partially limit my/their right to privacy.

9. Resignation
a. I hereby acknowledge that any credit extended by the Insurer to myself in terms of the rules of the Liberty Health Cover Policy Conditions will become payable in full upon resignation of my membership with the Insurer and that interest may be charged on all amounts due and owing to the Insurer.
b. I further acknowledge that on resignation from Liberty Health Cover, any amounts owing to the Insurer will be deducted from any amounts due to me.
c. I confirm that I and all my dependants will cease our current health insurance cover prior to commencement on Liberty Health Cover.

10. Personal contact
a. I consent to the use of any of the contact details given in this application to send me information pertaining to my membership (confidential or other).
b. I undertake to inform the Insurer of any change of address and contact details. The Insurer shall not be held liable as a result of my neglecting to inform the Insurer of any changes to the aforementioned.
c. I consent to my telephone conversations with the Insurer being recorded and forming part of the Insurer's records. I also agree that such records shall remain the sole property of the Insurer.

11. Marketing
In order to keep you updated on activities about Liberty Health Cover (LHC), we would like to communicate, where necessary, via email, SMS or post.

a. Do you wish to receive LHC marketing communications? Y | N

b. If yes, how would you like to receive them? Email Y | N SMS Y | N Post Y | N

c. I consent to LHC marketing products, services and special offers being sent to me from time to time. Y | N

d. I consent that any Third Party contracted to perform services relating to Liberty Health Cover may contact me from time to time regarding their products, services and special offers. Y | N

Signed at _____ on this_____day of _____20___

Signature of Principal Member _____