Heritage
Insurance Company
A member of LIBERTY

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Health Cover Membership Application Form

Section A and B to be completed by employee; Section C to be completed by employer.

SECTION A – EMPLOYEE DETAILS

Employer / Scheme

Full names of employee

Telephone no. (w)
Please include country and area code

Telephone no. (h)
Please include country and area code

Cell phone

Email address

ID number

Date of birth D D – M M – Y Y Y Y

Gender M F

PIN number

Occupation

SECTION B

Dependants to be included under your health insurance cover:

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

NB: Please use an additional form if there are more than seven (7) dependants

HEALTH DECLARATION BY EMPLOYEE

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 treatment was given or medication prescribed?

Attach 1 recent passport photo for you and each of your dependants (not required for groups on smart cards)

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

*** PLEASE NOTE TO COMPLETE PAGE 2 OF THIS FORM**

If the answer to any question is "Yes", Identify the question number and include diagnosis, dates, duration, degree of recovery or results and names and addresses of all attending medical practitioners and medical facilities in the space below.

If you or any of your insured dependants have a known chronic / recurring condition, each affected person should also complete a Heritage Insurance Managed Healthcare Application Form.

TICK APPLICABLE ITEMS

		Yes	No
2.	Are you or any of your dependants under medical treatment by diet, medicine or other means?	☐	☐
3.	Have you or any of your dependants ever had or sought advice 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 dependants to be covered, ever been diagnosed with a congenital condition?	☐	☐
4.	Do you or any of your dependants have any of the following which are unexplained: Fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐	☐
5.	Have you or any of your dependants 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 a electrocardogram, X-ray, other diagonistic test?	☐	☐
	e) been advised to have any diagonistic test, hospitalisation, or surgery which was not completed.	☐	☐
	f) had a blood transfusion?	☐	☐
6.	Are you or any of the named dependants presently pregnant?	☐	☐

If Yes give name _____

7. Are you or any of your dependants aware of a condition(s) that require 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 Insurer. I agree to abide by rules governing the Insurer 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 Insurer.

I consent to the Insurer seeking information from any doctor, hospital or clinic I have consulted or from any Company from whom I have requested insurance and I hereby authorise the giving of such information.

Employee name: _____ Date: D D - M M - Y Y Y Y Employee's 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): D D - M M - Y Y Y Y

_____ D D - M M - Y Y Y Y _____

Signature and stamp of employer | Date of signing | Position in company