GLICO HEALTHCARE, GLICO HOUSE NO. 47 KWAME NKRUMAH AVENUE ADABRAKA
P. O. Box 4251, Accra-north, Tel: 020 0203967, 0302 255742, Fax 233-0302 246169
E-mail: info@glicohealth.com, website:www.glicohealth.com

OFFICIAL USE ONLY MEMBER NUMBER

MEMBER APPLICATION FORM

1 PERSONAL DETAILS - PRINCIPAL CARD HOLDER / EMPLOYEE PLEASE COMPLETE IN BLOCK CAPITALS

FAMILY NAME (SURNAME)

FIRST NAME

OTHER NAMES

DATE OF BIRTH TITLE MALE FEMALE

PERMANENT EMPLOYMENT START DATE COMMENCEMENT DATE OF COVER

PLAN OPTION (TICK WHERE APPROPRIATE)

STANDARD ENHANCED ENHANCED PLUS ULTIMATE PLUS OTHER

POSTAL ADDRESS

PHYSICAL ADDRESS

NAME OF EMPLOYER

EMPLOYEE CODE / NUMBER OCCUPATION

HOME TELEPHONE (PLEASE INCLUDE COUNTRY AND AREA CODE) MOBILE (PLEASE INCLUDE COUNTRY AND AREA CODE)

WORK TELEPHONE (PLEASE INCLUDE COUNTRY AND AREA CODE) TOWN OF RESIDENCE

E-MAIL

2 REGISTRATION OF DEPENDANTS - PLEASE COMPLETE IN BLOCK CAPITALS

PLEASE ORDER DEPENDANTS FROM OLDEST TO YOUNGEST AFTER PRINCIPAL MEMBER

	NAME (PLEASE PUT THE FULL NAME WHICH WILL APPEAR ON THE MEMBERSHIP CARD)	TOWN/VILLAGE OF RESIDENCE	DATE OF BIRTH	GENDER (M/F)	RELATIONSHIP TO PRINCIPAL MEMBER	PRESENT STATE OF HEALTH
1			D D M M Y Y Y Y	MALE / FEMALE		
2			D D M M Y Y Y Y	MALE / FEMALE		
3			D D M M Y Y Y Y	MALE / FEMALE		

1		D D M M Y Y Y Y	☐ MALE ☐ FEMALE		
2		D D M M Y Y Y Y	☐ MALE ☐ FEMALE		
3		D D M M Y Y Y Y	☐ MALE ☐ FEMALE		

3. Do you or any of your dependants wear corrective lenses (spectacles)?

Yes ☐ No ☐

If yes state date you last changed the lenses...

4a.Give details in respect of yourself or any of your listed dependants

i. Any condition, disability or physical defect
ii. Any specialist consultation, any admission to a hospital for a disability or physical defect or history of a long protracted illness of more than 7 days, during the last 3 years?
iii. Any consultation, with a general practitioner, dentist or surgeon during the last 12 months?
iv. Any condition of nervous breakdown or mental disorder, fainting episode, blackout, fit or paralysis of any kind?

4b. Have you or any of your dependants surffered from any of following diseases? If yes give details

	IF YES GIVE DATEs & DURATION
A. Fainting episodes	
B. Fits/Seizures/ Convulsions	
C. Heart Attack	
D. Heart Enlargement	
E. High Blood Pressure	
F. Diabetes	
G. Asthma / Other Respiratory Condition	
H. Hernia	
I. Piles	
J. Slipped Disc	
K. Fibroid	
L. Cancer	
M. Stroke	
N. Stomach ulcer	
O. Jaundice	
P. Sickle Cell Disease	
Q. Are you Pregnant?	
List any other condition(s) apart from the above mentioned	

4c. Have you ever had or been advised to have a blood test for AIDS or an AIDS related condition?

4d. Have you ever been refused as a blood donor? Give details...

5. Have you been told by your Doctor that you will need Surgery in the coming year?
   If so what condition:
   List current medications and dosage

NOTE: Failure to disclose relevant information may lead to cancellation of Membership or denial of claim

6. Name and location of usual medical attendant:...

   i. How long has he known you?...

   ii. When did you last see him?...

7. You may choose to continue with the services of your treating doctor provided he/she is listed on our provider' List Otherwise, select a doctor and Dentist from the list provided

DOCTOR'S / CLINIC NAME	DENTIST / CLINIC NAME

8. List below or attach a sheet and indicate the clinics each dependant will attend if different from yours.

Dependant's Name	Clinic	Dentist

PHOTOGRAPHS OF ENROLLEES

PRINCIPAL MEMBER

NAME

DEPENDANT 1

NAME

DEPENDANT 2

NAME

DEPENDANT 3

NAME

DEPENDANT 4

NAME

DEPENDANT 5

NAME

Declaration

I declare that to the best of my knowledge the statements in this form are true and correct.

I have read the notes to this form and understand that this forms part of a contract with the Glico Health Care that no liability will be accepted for any condition that originated before the date of commencement of the policy, or the date of acceptance of this application, whichever is later unless the condition is disclosed on this application form and accepted by Glico Health Care.

I also agree that Glico health Care may seek any information from any doctor who has attended to me and I authorize the giving of such information.

Signature of Applicant Date

NOTE:

1 Particulars of the dependants who are to be included in the scheme should be furnished, and any dependant who is suffering from any illness or disability on the date of this application will not be covered unless such a condition has been disclosed on this form and accepted by Glico Health Care

2. The obligation of Glico Health Care commences only after this application has been accepted by its underwriter.

Head Office Use Only

Policy No.	Premium Payable	Benefits Option	Approved By	Effective Date