P. 0. Box 4251, Accra-north, Tel. 020 0203967, 0302 255742 Fax. 233-0302 246169
E-mail: gip@glicohealth.com/customerservices@glicohealth.com, website: www.glicohealth.com

MEMBER APPLICATION FORM:
PERSONAL DETAILS-PRINCIPAL CARD HOLDER/EMPLOYEE PLEASE COMPLETE IN BLOCK CAPITALS

1. FAMILY NAME (SURNAME) ....
2. FIRST NAME..
3. OTHER NAMES ....
4. SEX: MALE ☐ FEMALE ☐
5. DATE OF BIRTH .... TITLE ....
6. OCCUPATION... TEL NO...
7. EMAIL.. ....
8. POSTAL ADDRESS ....
9. PHYSICAL ADDRESS ....
10. HOME TELEPHONE .... MOBILE ....
11. WORK TELEPHONE .... TOWN OF RESIDENCE ....
12. NAME OF EMPLOYER.. EMPLOYEE CODE/NUMBER ....
13. IN CASE OF EMERGENCY CONTACT MR./MRS/MS.. TEL ....
14. ARE YOU NHIS SUBSCRIBER? YE NO
    IF YES, PROVIDE NHIS NUMBER: ....
15. PLEASE TICK TO INDICATE PACKAGE GIP PACKAGE ☐

REGISTRATION OF DEPENDANTS-PLEASE COMPLETE IN BLOCK CAPITALS

16. PLEASE ORDER DEPENDANTS FROM OLDEST TO YOUNGEST AFTER PRINCIPAL MEMBER.

DEPENDENT'S	TOWN/VIL	OCCUPATION DATE OF BIRTH	GEND	RELATIONSHIP	PRESENT

NAME(PLEASE PUT FULL NAME WHICH WILL APPEAR ON THE MEMBERSHIP CARD (SURNAME FIRST)	LAGE OF RESIDENCE	DAY/MONTH/YEAR	ER (M/F)	TO PRINCIPAL MEMBER	STATE OF HEALTH

17. Do you or any of your dependents wear corrective lenses (spectacles)? ☐ Y ☐ No

If yes, please state date of last change of lenses……………………………………………………………………………………….

11a. Give details in respect of yourself or any of your listed dependents

I. Any condition, disability or physical defect?
II. Any specialist consultation, any admission to a hospital for 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 general practitioner, dentist or surgeon during the last 12c months?
IV. Any condition of nervous breakdown or mental disorder, fainting episode, blackout, fit or paralysis of any kind?

11b. Have you or any of your dependents suffered from any of the following diseases? If yes, give details

IF YES, PLEASE GIVE DETAILS (DATES & DURATION)		
1. Any Disability or physical defect	Yes/No	
2. Any Psychiatric/Psychological condition	Yes/No	
3. Fainting episodes	Yes/No	
4. Fits/Seizures/convulsions	Yes/No	
5. Heart Attack	Yes/No	
6. Heart Enlargement	Yes/No	
7. Paralysis of any kind	Yes/No	
8. High Blood Pressure	Yes/No	
9. Diabetes	Yes/No	
10. Asthma/Other respiratory condition	Yes/No	
11. Hernia	Yes/No	
12. Piles/Hemorrhoids	Yes/No	
13. Slipped Disc/Any Spine Condition	Yes/No	
14. Joint Disease/Rheumatism	Yes/No	
15. Fibroid	Yes/No	
16. Cancer	Yes/No	
17. Stroke	Yes/No	
18. Varicose veins	Yes/No	
19. Urinary Tract Infection (UTI)	Yes/No	
20. Stomach Ulcer	Yes/No	
21. Allergy	Yes/No	
22. Jaundice	Yes/No	
23. Sexually Transmitted Diseases	Yes/No	

including genital sores		
24. Glaucoma/Cataract	Yes/No	
25. Sickle Cell Disease	Yes/No	
26. Are you pregnant?	Yes/No	
27. Hepatitis B & C	Yes/No	
Any other condition(s) apart from the above	Yes/No	

11c. Have you ever had or been advised to have a blood test for AIDS or an AIDS related condition? Yes No

11d. Have you ever been refused as a blood donor? Give details ………………………………………………………………………………

12. Have you been told by your Doctor that you will need surgery in the coming year? Yes No

If yes, what condition? …….

List current medications and dosage ………

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

13. Name and location of usual medical attendant: ………………………………………………………………………………………………

i. How long has s/he known you? ………………………………………………………………………………………………………

ii. When did you last see him/her? ……………………………………………………………………………………………………

14. You may choose to continue with the services of your treating Doctor provided he/she is listed on our provider’s list. Otherwise, select a Doctor and Dentist from the list provided.

DOCTOR’S/CLINIC NAME	DENTIST’S/ CLINIC NAME

15. List below or attach a sheet and indicate the clinics each dependent will attend, if different from yours.

DEPENDANT’S NAME	CLINIC	DENTIST

PHOTOGRAPHS OF ENROLLEES

PRINCIPAL MEMBER DEPENDENT 1
DEP

NAME ………………………
NAME ……………………… NAME ………………………

…………………………………
…………………………………
…………………………………

………………………………… …………………………………
…………………………………

DEPENDENT 3 DEPENDENT 4
DEP

NAME ………………………
NAME ……………………… NAME ………………………

…………………………………
…………………………………
…………………………………

………………………………… …………………………………
…………………………………

DECLARATION:

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

I have read the notes to this form and understand that this information forms part of a contract with GLICO HEALTHCARE 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 HEALTHCARE.

I also agree that GLICO HEALTHCARE 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 dependents who are to be included in the scheme should be added to the form. Any dependent who is suffering from any illness or disability on the date of this application will not be covered unless such conditions has been disclosed on this form and accepted by GLICO HEALTHCARE.

2. The obligation of GLICO HEALTHCARE commences only after this application has been accepted by underwriters.

HEAD OFFICE USE ONLY

Policy No.	Premium Payable	Benefits Provided	Approved By	Effective Date
………………………………	………………………………	………………………………	………………………………	………………………………