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CHANGE IN HEALTH STATUS

PLEASE USE BLOCK LETTERS

SURNAME	FIRST NAME	MIDDLE
MEMBER'S NAME IN FULL:		BIRTHDATE:
NAME OF EMPLOYER:		POL NO:
		TEL NO.:
<p>1. In the past policy year have you or any of your dependants suffered from any of the following diseases? If yes give details; Dates & Duration</p>		

	IF YES GIVE DATES & DURATION
A. Any Disability or physical defect	YES/NO
B. Nervous breakdown	YES/NO
C. Fainting episodes	YES/NO
D. Fits/Seizures/ Convulsions	YES/NO
E. Heart Attack	YES/NO
F. Heart Enlargement	YES/NO
G. Paralysis of any kind	YES/NO
H. High Blood Pressure	YES/NO
I. Diabetes	YES/NO
J. Asthma / Other Respiratory Condition	YES/NO
K. Hernia	YES/NO
L. Piles	YES/NO
M. Slipped Disc	YES/NO
N. Joint Disease/ Rheumatism	YES/NO
O. Fibroid	YES/NO
P. Cancer	YES/NO
Q. Stroke	YES/NO
R. Varicose Veins	YES/NO
S. Urinary Tract Disease	YES/NO
T. Stomach Ulcer	YES/NO
U. Allergy	YES/NO
V. Jaundice	YES/NO
W. Sexually Transmitted Diseases including genital sores.	YES/NO
X. Glaucoma/ Cataract	YES/NO
Y. Sickle Cell Disease	YES/NO
Z. Are you Pregnant?	YES/NO

Z (a) Any Other Condition(s) apart from the above mentioned:

2. Have you been told by your Doctor that you will need Surgery in the coming year? YES/NO

If so for what condition:

3. List current medications and dosage

4. Selected Clinic Name: Dentist's/Clinic Name:

NOTES: 1. Failure to disclose relevant information may lead to cancellation of membership or denial of claim.
 2. The obligation of Gemini Health Care commences only after this application has been duly accepted

EMAIL ADDRESS:

Signature: Date: