(**A Private Commercial Health Insurance Scheme)**
P. O. Box 4251 Tel. (233-302) 255742, 020 0203967 Fax: 0302 246169

GLICO HEALTHPLAN

AMENDMENT OF MEMBERSHIP DETAILS FORM

(THIS INFORMATION WILL BE TREATED AS PRIVATE AND CONFIDENTIAL)

To be completed only by current members who wish to add or remove dependants or change some to the membership details. If you are adding a dependant, please include 2 passport size photographs. THANK YOU.

PLEASE USE BLOCK LETTERS

SURNAME FIRST NAME MIDDLE

MEMBER'S NAME IN FULL:

ADDRESS: EMAIL ADDRESS:

NAME OF EMPLOYER:

TELEPHONE: POLICY /MEMBER NUMBER:

PACKAGE TYPE:

STANDARD ☐ ENHANCED ☐ ENHANCED PLUS ☐

TYPE OF CHANGES YOU ARE REQUESTING

I. CHANGE OF NAME:

I wish to be called .....
(Surname) (First) Middle

Effective Date: .....

Reason:.....

I wish to change my hospital from..... to .....

II. ADDITION/DELETION

Name in full (Surname, First name, Middle)	Sex M/F	Relation-ship	Occupation	Date of birth (Day/Month/Year)	Add	Remove	Effective Date

(Please provide information in detail. Attach additional sheets if necessary)

III. SERVICE PROVIDER FOR NEW ADDITIONS IF DIFFERENT FROM THAT OF PRINCIPAL

DEPENDANT'S NAME **CLINIC** **DENTIST**

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.....

IV HEALTH STATUS OF ADDED DEPENDANTS

1. Does any of your added dependants wear corrective lenses (spectacles)? YES/NO

If yes state date you last changed the lenses……

2. Does any of your added dependants suffer from any of the following conditions?

		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 Conditions	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 Track 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:		
3. Is any of your dependants to undergo surgery soon?	YES/NO	
4. If currently on medication, list drugs and dosages		

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 the application will not be covered unless such a condition 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 it's underwriter.

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 Gemini 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 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