GLICO HEALTHCARE, GLICO HOUSE NO. 47 KWAME NKRUMAH AVENUE ADABRAKA
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MEMBER APPLICATION FORM

1. PERSONAL DETAILS – PRINCIPAL CARD HOLDER / EMPLOYEE PLEASE COMPLETE IN BLOCK LETTERS

SURNAME:			
FIRST NAME:			
OTHER NAMES:			
DATE OF BIRTH:	TITLE:	MALE ☐	FEMALE ☐
HEIGHT:	WEIGHT:		
POSTAL ADDRESS:			
PHYSICAL ADDRESS:			
CONTACT NUMBER 1:		CONTACT NUMBER 2:	
E-MAIL:			
NAME OF EMPLOYER:			
BENEFIT OPTION: BASIC ☐	STANDARD ☐	ENHANCED ☐	ENHANCED PLUS ☐
ULTIMATE ☐	PLATINUM ☐	PLATINUM PLUS ☐	CUSTOMIZED PACKAGE ☐
NAME THE CUSTOMIZED PACKAGE:			

2. REGISTRATION OF DEPENDENTS – PLEASE COMPLETE IN BLOCK LETTERS

NAME (PLEASE PUT THE FULL NAME WHICH WILL APPEAR ON THE MEMBERSHIP ID CARD	GENDER	DATE OF BIRTH	RELATIONSHIP TO PRINCIPAL MEMBER	CONTACT NUMBER

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

Yes ☐ No ☐

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

4. Have you or any of your dependants suffered from any of following diseases? If yes give details (Medication/Date/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. Stomach ulcer	Yes/No
T. Jaundice	Yes/No
U. Glaucoma/ cataract	Yes/No
V. Sickle Cell Disease	Yes/No
W. Do you smoke?	Yes/No
X. Are you Pregnant? (If Yes, Number of weeks)	Yes/No
List any other condition(s) apart from the above mentioned	

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

6. Have you ever been refused as a blood donor? Yes/No

Give details.....

7. Have you been told by your Doctor that you/any of your dependents will need Surgery in the coming year? Yes/No

Name of Enrollee:

Condition:

List current medications and dosage:

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

8. Name and location of usual medical attendant:

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

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

9. List below or indicate the hospital/clinics each dependant will attend if different from yours.

Member Name	Hospital/Clinic Name

10. Please attach photographs of all enrollees indicating their names at the back of each picture.

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 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 dependants who are to be included in the scheme should be furnished, and any dependants who is suffering from any illness or disability on the date of this application will not be covered unless such a condition has been on this form and accepted by Glico Healthcare.
2. The obligation of Glico Healthcare commences only after this application has been accepted by its underwriter.

Office Use Only

Policy Number	Premium Payable	Benefits Option	Approved By	Effective Date