GLICO HEALTHCARE
we cushion you for life

Tel: 026 158 9927 / 050 148 2208

CHANGE IN HEALTH STATUS

PLEASE USE BLOCK LETTERS

1. Member's Name: ………

2. Date of Birth (DD/MM/YYYY):

3. Policy Number:

4. Contact Number:

5. Do You Have NHIS? Yes/No, If Yes Provide NHIS Registration Number:

6. In the past policy year have you or any of your dependants suffered from any of the below health conditions? If YES give details (Name of Enrollee/Medication/Dosage/Date/Duration). A doctor's report may be requested in some cases.

	Yes	No	Details
A. Any Disability or physical defect			
B. Nervous breakdown			
C. Fainting episodes			
D. Fits/Seizures/ Convulsions			
E. Heart Attack			
F. Heart Enlargement			
G. Paralysis of any kind			
H. High Blood Pressure			
I. Diabetes			
J. Asthma / Other Respiratory Condition			
K. Hernia			
L. Piles			
M. Slipped Disc			
N. Joint Disease/ Rheumatism			
O. Fibroid			
P. Cancer			
Q. Stroke			
R. Varicose Veins			
S. Stomach ulcer			
T. Jaundice			
U. Glaucoma/ cataract			
V. Sickle Cell Disease			
W. Do you smoke?			
X. Are you or any of your dependants Pregnant? (If Yes, Number of weeks)			

List any other condition(s) apart from the above mentioned

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

If Yes, Name of Enrollee:

Condition:

List current medications and dosage:

for what condition:

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

Signature: Date:

Email Address: