GLICO HEALTHCARE LIMITED, 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: DD/MM/YYYY	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 ☐	

2. REGISTRATION OF DEPENDANTS – PLEASE COMPLETE IN BLOCK LETTERS

NAME (PLEASE PUT THE FULL NAME WHICH WILL APPEAR ON THE MEMBERSHIP ID CARD)	GENDER	DATE OF BIRTH (DD/MM/YYYY)	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 the following diseases/pre-existing conditions? If YES give details (Enrollee Name/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?			

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

5. Are you or any of your dependants pregnant? Yes/No
If Yes;
Name of enrollee:
Number of weeks pregnant:

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

7. Have you ever been refused as a blood donor? Yes/No
Give details..

8. Have you been told by your Doctor that you/any of your dependants will need Surgery in the coming year? Yes/No
If Yes;
Name of Enrollee:
Condition:
List current medications and dosage:

NOTE: Attach all relevant medical reports
Failure to disclose relevant information may lead to cancellation of Membership or denial of claim.

9. Name and location of usual medical attendant:

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

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

10. **List below or indicate the hospital/clinic each Dependant will attend if different from yours.**

Member Name	Hospital/Clinic Name

11. **Please attach passport size photographs with white background of all enrollees indicating their names.**

Principal Member Name:	Dependant 1 Name:
Dependant 2 Name:	Dependant 3 Name:
Dependant 4 Name:	Dependant 5 Name:

Declaration

I .... declare that, to the best of my knowledge, the statements in this form are true and correct. I have read the notes contained in this form and understand that they constitute 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 in time unless such 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

For Illiterate or Person Whom Form is Read to by a Third Party

I .... agree that, the content of this form has been truly and audibly read over and interpreted

to me in the .... language by .... of ....

and I seemed perfectly to understand same and affix my mark in the presence of ....

Mark of Customer/ Thumbprint /Signature

Mark of Interpreter/ Thumbprint /Signature

....
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 or before the date of this application will not be covered unless such a condition has been disclosed in this form and same 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