# Individual Membership Application Form

**PLEASE MAIL COMPLETED FORM TO:**
P.O. Box 31737, Lilongwe 3, Malawi
**OR E-MAIL TO:** info@medhealth.mw

Kang'ombe House, 1st Floor, East Wing, City Centre, Lilongwe, Malawi
**TEL**: +265 1771 978 | +265 1771 979

## SECTION 1: OPTION

*Choose ONE product option by placing "x" in the appropriate box*

☐ CARE ☐ CAREPLUS ☐ MEDISAVE ☐ MEDICARE ☐ MEDIPLUS ☐ PREMIUMCARE

I wish to join the scheme on 0 1 m m y y y y

Membership number (administrative use only)

## SECTION 2: DETAILS OF PRINCIPAL MEMBER

Surname

Maiden name (if applicable)

Title

First name/s

Initials

Gender M F

D.O.B d d m m y y y y

ID

Cellphone number

Telephone ( Work )

Passport Number (For Foreign Nationals)

E-mail address

Postal address

Passport size photo

Have you had previous medical aid cover? Yes No *If yes, please provide details below*

| Name of previous medical scheme | Membership number | Date joined | Date left |
|---|---|---|---|
| | | | |

**Marital status**
*FOR STATISTICAL PURPOSES ONLY*

Single ☐ Married ☐ Divorced ☐ Widowed ☐

## SECTION 3: BANK DETAILS OF APPLICANT

*Refund of claims and debit order instruction*

I hereby instruct MedHealth to electronically collect contributions and to deposit claims refunds, using the information provided.
I understand that transfers cannot be done to and credit card accounts. I hereby authorise MedHealth to reverse any erroneous transactions and/ or rectify any EFT errors without prior notice.

Name of account holder

Name of bank

Type of account: Current | Savings | Other (Specify)

Branch name

Account number

Bank branch code

Date (dd mm yyyy)

Account holder's signature

## SECTION 4: DEPENDANTS YOU WISH TO REGISTER

### 1

Passport size photo

Adult ☐ Child ☐

Gender M F

Relationship to member

Surname

Firstname/s

Date of birth (d d m m y y y y) Marital status

Primary doctor
G.P | Paediatrician | OB/GYN

ID/Passport number

Cellphone number

E-mail address

### 2

Passport size photo

Adult ☐ Child ☐

Gender M F

Relationship to member

Surname

Firstname/s

Date of birth (d d m m y y y y) Marital status

Primary doctor
G.P | Paediatrician | OB/GYN

ID/Passport number

Cellphone number

E-mail address

### 3

Passport size photo

Adult ☐ Child ☐

Gender M F

Relationship to member

Surname

Firstname/s

Date of birth (d d m m y y y y) Marital status

Primary doctor
G.P | Paediatrician | OB/GYN

ID/Passport number

Cellphone number

E-mail address

### 4

Passport size photo

Adult ☐ Child ☐

Gender M F

Relationship to member

Surname

Firstname/s

Date of birth (d d m m y y y y) Marital status

Primary doctor
G.P | Paediatrician | OB/GYN

ID/Passport number

Cellphone number

E-mail address

### 5

Passport size photo

Adult ☐ Child ☐

Gender M F

Relationship to member

Surname

Firstname/s

Date of birth (d d m m y y y y) Marital status

Primary doctor
G.P | Paediatrician | OB/GYN

ID/Passport number

Cellphone number

E-mail address

### 6

Passport size photo

Adult ☐ Child ☐

Gender M F

Relationship to member

Surname

Firstname/s

Date of birth (d d m m y y y y) Marital status

Primary doctor
G.P | Paediatrician | OB/GYN

ID/Passport number

Cellphone number

E-mail address

**Please note:**
Any dependant over the age of 21 must furnish proof of registration from a full time tertiary institution for the current year and an affidavit confirming residency, marital status, employment status and income. The following documentation must be furnished to MedHealth for any child dependent other than the principal member's biological children: legal documentation of adoption or foster arrangement, affidavit confirming residency, income, employment and marital status of both the child and the biological parents of the child.

## SECTION 5: MEDICAL HISTORY OF MAIN MEMBER AND DEPENDANTS

Any previous or current treatment for a disorder or condition must be marked as YES. Answer all questions by selecting YES or NO. Where the answer is Yes, please give full details. A doctor's report may be requested in some cases.

*Please circle the specific condition*

EXAMPLE

| Condition | Yes | No |
|---|---|---|
| **Birth defects & inherited disorders** - Spina Bifida, Injuries, (Heart Disorders) or other. | | |

| | Condition | Yes | No |
|---|---|---|---|
| 01 | **Birth Defects & Inherited Disorders -** Spina Bifida, Injuries, Heart Disorder or other. | Y | N |
| 02 | **Dermatological** - Acne, Eczema, Pemphigus, Psoriasis, Fungal infections or other. | Y | N |
| 03 | **Musculo-Skeletal** - Osteo-arthritis, Rheumatoid Arthritis Osteo-sarcoma, Gout, Osteoporosis, Lupus Erythematosus or other. | Y | N |
| 04 | **Ear, Nose and Throat** - Deafness/Hearing impairment, Allergic Rhinitus, Recurrent Throat Infections, Vertigo, Chronic Sinusitis, Meniere's Disese or other. | Y | N |
| 05 | **Respiratory Disorders** - Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis, Bronchiectasis or other. | Y | N |
| 06 | **Gastro-Intestinal** - Hiatus Hernia, Chronic Peptic Ulcer, Crohn's disease, Oesophageal feflux, Spastic Colon, Ulcerative Colitis, Malbsorbtion Syndrome or Other. | Y | N |
| 07 | **Urological Disorders** - Chronic Renal Failure, Kidney Stones, Chronic Pyelonephritis or Prostatic Hypertrophy, Neurogenic bladder, Urinary Incontinence, Urinary retention or other. | Y | N |
| 08 | **Neurological** - Cerebro Vascular Accident, Neuropathy, Epilepsy, Multiple Sclerosis, Neuralgia, Migraine, Parkinson's Disease, Myasthenia Gravis, Stroke, Alzheimer's, Narcolepsy or other. | Y | N |
| 09 | **Psychiatric** - Anxiety, Depression, Bipolar Mood Disorder, Schizophrenia, Sleep Disorders, Attention Deficit Hyperctivity Disorder, Neurosis, Obsessive-Compulsive Disorder or other. | Y | N |

| | Condition | Yes | No |
|---|---|---|---|
| 10. | **Metabolic Disorder** - Lipid Disorders Porphyria or other | Y | N |
| 11. | **Cardiovascular** - Hypertension, Hypotension, Dysrrhythmias, Cardiac Failure, Hypercholesterolaemia, Aneurysm, Angina, Ischaemic Heart Disease, Peripheral Vascular or other. | Y | N |
| 12. | **Liver and Pancreas Disorders** - Hepatitus, Cirrhosis, Gall-stones, Pancreatitis, Chronic Cholecystitis or other. | Y | N |
| 13. | **Blood Disorder** - Anaemia, Leukemia, Haemophilia, Clotting Disorder, Thrombocytopenia or other. | Y | N |
| 14. | **Endocrie Disorders** - Diabetes Insipidus, Hypothyroidism, Hyperthyroidism, Addison's Disease, Cushing's Syndrome, Diabetes, Mellitus, Hypoglycemia or other. | Y | N |
| 15. | **Infecetions** - HIV, Hepatitus or any sexually trasmitted disease | Y | N |
| 16. | **Cancer** - any form | Y | N |
| 17. | **Gynaecologist System** - infertility, Endometriosis, Ovarian Cysts, Menopause,,Menstrual Disoders, Mastalgia or other | Y | N |
| 18. | **Eye Disorder** - Impaired Vision, Glaucoma, Retinopathy, other | Y | N |
| 19. | **Have/are you being compensated for any disability?** | Y | N |
| 20. | **Are you pregnant or do you suspect you are?** | Y | N |
| 21. | **Any previous surgery?** | Y | N |
| 22. | **Any exclusions on previous medical aid?** | Y | N |

**Any other conditions** *(Please use a separate page if more than two conditions)*

**If YES to any of the previous questions complete the section below, and fill in the applicable condition number:**
**(Please use a separate page if more information applies to relevant questions)**

**Condition No.** **Patient** **Doctor**

**Treatment** **Last date of treatment** (dd mm yyyy)

**Condition No.** **Patient** **Doctor**

**Treatment** **Last date of treatment** (dd mm yyyy)

**Condition No.** **Patient** **Doctor**

**Treatment** **Last date of treatment** (dd mm yyyy)

## SECTION 6 : STATEMENT BY MAIN MEMBER

I, _____ hereby state that:

(a) Should I be enrolled as a member of The Scheme, I will subject myself to the rules of MedHealth. The Information herein is completed true to the best of my knowledge and conviction. No relevant information has been omitted. If after my admission to MedHealth, it is found that my statement or information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to MedHealth all payments which MedHealth have made on my behalf and to relinquish any claim to any benefits on the part of MedHealth.

(b) Should there by any deterioration or change in my state of health or in that of any of my dependants before the date or event to be set by Medhealth for the commencement of membership or the date of acceptance of this application by MedHealth; or the date of receipt of the first contribution, (whichever date is the latest), Medhealth will be entitled to reconsider the application and propose new terms of admission or declare the membership null and void.

(c) Any monies paid to MedHealth in terms of this membership, before MedHealth is informed of the change, shall be forfeited and benefits paid by MedHealth, shall immediately be refunded to MedHealth

(d) I am bound now, and in the future, if we (myself and my dependants) are accepted as members, to give MedHealth all such information and evidence to MedHealth as they require from time to time. I authourise the attending medical practitioner or any other provider, to provide MedHealth with such information as it may require, hereby waiving the provisions of any law or regulation restricting the giving of such information.

(e) I acknowedge that on default MedHealth shall use any lawful means to collect the contribution owned to the scheme, and that i am responsible for all collections costs incurred.

(f) In the event of voluntary resignation from MedHealth agree to give MedHealth three calendar months notice, which must be received by MedHealth in writing by no later than the 15th of the month for the following month.

(g) I agree to call MedHealth client services with regards to any queries and pre-authorise any treatment as required by MedHealth.

(h) I acknowledge that i have read and understood the content of this application form. I confirm the content of this application form and the implication thereof have been read and explained to me.

(i) Applicants joining the scheme for the first time will be subjected to all applicable waiting perionds as specified in the scheme rules (Please read the scheme rules).

(j) I agree to pay over and above my benefits if I exceed them.

**Signature of Application** _____

**Date (dd mm yyy)** d d m m y y y y

## SECTION 7 : FOR OFFICIAL USE ONLY

| | NAME | DATE | SIGNATURE |
|---|---|---|---|
| **Received by** | | d d m m y y y y | |
| **Checked by** | | d d m m y y y y | |
| **Approved by** | | d d m m y y y y | |

## SECTION 8 : KNOW YOUR CUSTOMER KYC CHECKLIST - INDIVIDUALS

Full Legal Name of Customer

ID Number (NRB Citizen Identification Number)

Passport Number (For foreign Nationals)

Place Of Employment/Nature Of Business

Company Address

Telephone Number(s)

Email Address

Next Of Kin Details

Name :

Relationship :

Cellphone :

Email Address :

Proof Of Place Of Residence (Utility Bill)

Map of the Physical Address

*Copies of relevant identity of all members to be attached*

Name

Designation / Occupation

Date (dd mm yyyy)

Signature