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 from (dd mm yyyy) 0 1 | | | | | | | | **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** | | | | | | | | **ID/Passport number**

Telephone (Home) | **Telephone (Work)**

Cellphone number | **Fax**

E-mail address

Postal address

Physical address

Passport size photo

Are you changing your medical scheme due to a change in your employment? Yes No

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

Branch name

Bank branch code

Type of account | Other (Specify)

Account number

Date (dd mm yyyy) | | | | | | | | |

Account holder's signature

SECTION 4: SPOUSE DETAILS

Passport size photo

Title | Initials | Gender M F | First name/s

Surname | Maiden name (if applicable)

Cellphone number | E-mail address

ID/Passport/Birth Certificate number | D.O.B

Primary GP | OB/GYN

SECTION 5: DEPENDANTS YOU WISH TO REGISTER

	1	2	3	4
	Passport size photo	Passport size photo	Passport size photo	Passport size photo
	Adult ☐ Child ☐ Gender M F	Adult ☐ Child ☐ Gender M F	Adult ☐ Child ☐ Gender M F	Adult ☐ Child ☐ Gender M F
Title	Initials / Relationship to member	Initials / Relationship to member	Initials / Relationship to member	Initials / Relationship to member
Surname				
First name/s				
Date of birth	Marital status	Marital status	Marital status	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 7: 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 8: CURRENT CHRONIC MEDICATION *(Please use a separate page if more than three chronic medications are used)*

Initials **Registered first name**

Surname **Medicine**

Duration of use **From** (dd mm yyyy) **To** (dd mm yyyy)

Initials **Registered first name**

Surname **Medicine**

Duration of use **From** (dd mm yyyy) **To** (dd mm yyyy)

Initials **Registered first name**

Surname **Medicine**

Duration of use **From** (dd mm yyyy) **To** (dd mm yyyy)

SECTION 9: PAYMENT BY DEBIT ORDER (Individual member only)

I hereby agree to arrange with a financial institution to pay my monthly contribution to MedHealth as well as to update my stop order with every premium increase. The monthly contribution is payable in advance by the first of the month.

	MONTHLY CONTRIBUTION	NO. OF PERSONS	SUBTOTAL
Main member	MK		MK
Spouse dependant	MK		MK
Adult dependant	MK		MK
Child dependant	MK		MK
Student dependant	MK		MK
Special dependant	MK		MK
Monthly saving amount			MK
TOTAL MONTHLY CONTRIBUTION CALCULATION			MK

Name of account holder

Name of Bank

Type of account

Other (Specify)

Branch name

Account number

Bank branch code

Date of first deduction

Account holder's Signature

Date

SECTION 10: EMPLOYER INFORMATION

This section must be completed by your employer only if employer pays your contribution

I, (responsible officer)

of (name of employer)

hereby state that the applicant:

(a) has been employed since (dd mm yyyy)

(b) qualifies for membership (dd mm yyyy)

(c) as participating member under option

☐ Care option ☐ CarePlus option ☐ MediSave option

☐ MediCare option ☐ MediPlus option ☐ PremiumCare option

(e) and has the personnel number of

Branch

Signature (on behalf of employer)

Employer Stamp

Date (dd mm yyyy)

SECTION 11: 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 undertake to pay any other amount due to MedHealth, on default. I hereby authorise my employer to deduct the due amount from my salary or any other monies due by me.

(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.

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

Signature of Application _____ **Date (dd mm yyy)** | | | | | | | | |

SECTION 12: DOCUMENT CHECKLIST

In order to avoid delays in processing your application please provide the following documents:	PLEASE TICK
Photo	
Student certificate (for child dependant over 21 that is studying)	

SECTION 13: FOR OFFICIAL USE ONLY

	NAME	DATE	SIGNATURE
Received by			
Checked by			
Approved by			