Amendment 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

- ☐ Change of address / contact details
- ☐ Change of bank details
- ☐ Change of marital status
- ☐ Termination of dependant membership
- ☐ Registration of births and adoptions
- ☐ Additional adult and children dependants
- ☐ Change primary G.P | Paediatrician | OB/GYN
- ☐ Change of membership card photo

SECTION 1: DETAILS OF PRINCIPAL MEMBER

First name/s | Surname

Initial | Membership No.

SECTION 2: CHANGE OF ADDRESS / CONTACT DETAILS

Telephone (Home) | Telephone (Work)

Cellphone no. | Fax

E-mail address

Postal address

Physical address

SECTION 3: CHANGE OF BANK DETAILS OF PRINCIPAL MEMBER

Refund of claims and debit order instruction

I hereby instruct MedHealth to electronically deposit claims refunds, using the information provided.
I understand that transfers cannot be done to and from 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: CHANGE OF MARITAL STATUS

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ | Effective date of change (dd mm yyyy)

Full new name

SECTION 5: TERMINATION OF BENEFICIARY REGISTRATION

Full name/s as reflected on your membership card	Date of birth (dd mm yyyy)	Deletion date (last day of the month) (dd mm yyyy)

Reason for termination

SECTION 6: ADDITION OF BENEFICIARY

Please note:
Any dependent over the age of 21 must furnish either proof of registration from a full time tertiary institution for the current year.
For any dependent, other than your biological children, under the age of 21, you are required to furnish supporting legal documentation of adoption or foster arrangement; as well as an affidavit confirming residency, employment and marital status of both child and natural parents.

Compulsory documentation to be submitted together with this form:
- Proof of registration with an academic institution where the dependent is studying full time; for dependents seeking student dependent rates.
- Legal documentation of adoption or foster arrangements, as well as an affidavit confirming residency, employment and marital status of parents and children; this is applicable to dependents below the age of 21 and are not the biological children of the applicant.

1 Adult ☐ Child ☐

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/Passport/Birth Certificate number | D.O.B d d m m y y y y

Cellphone number | E-mail address

2 Adult ☐ Child ☐

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/Passport/Birth Certificate number | D.O.B d d m m y y y y

Cellphone number | E-mail address

3 Adult ☐ Child ☐

Title | Initials | First name/s

Surname

Relationship to principal member | Gender M F

ID/Passport/Birth Certificate number | D.O.B d d m m y y y y

Cellphone number | E-mail address

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 requsted 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, Gallstones, 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: CHANGE OF OPTION

Current option - name of option

New option - name of option

SECTION 10: CHANGE OF PRIMARY DOCTOR

Name of member

Current GP | Paediatrician | OB/GYN

New GP | Paediatrician | OB/GYN

Reason of change

Effective date of change
(dd mm yyyy)

Member's signature

MedHealth Approval

SECTION 11: CHANGE OF PHOTO

Name of member

Employer

Membership No.

Reason of change

New photo

Passport
size photo

Please submit your MedHealth membership card together with the new passport ized photo

SECTION 12: 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) d d m m y y y y

(b) qualifies for membership (dd mm yyyy) d d m m y y y y

(c) as participang 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) d d m m y y y y

SECTION 13: DECLARATION BY MAIN MEMBER

I hereby declare that to the best of my knowledge, the information herein this document is true and correct.

Signature

Date (dd mm yyyy)

SECTION 14: 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)	
Death certificate	

SECTION 15: 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	
Amended by		d d m m y y y y	