ORACLEMED HEALTH

Application Form

All the information supplied will be treated in strict confidence.

A. PERSONAL DETAILS - APPLICANT

1. Title: 2. First Names:

3. Surname: 4. Date of Birth: Y Y Y Y M M D D

5. Passport No: 6. Gender: Male ◯ Female ◯

7. Country of employment:

8. Full residential address:

Postal Code

9. Postal address:

Postal Code

10. Home Tel: Area code: Tel No: Mobile No:

11. E-mail address:

12. Employer name:

B. DEPENDENT/S DETAILS (Persons qualifying as dependents whom you wish to nominate)

Dependent 1:

1. Title: 2. First Names:

3. Surname: 4. Date of birth: Y Y Y Y M M D D

5. Passport No: 6. Gender: Male ◯ Female ◯

7. Relationship to applicant:

Dependent 2:

1. Title: 2. First Names:

3. Surname: 4. Date of birth: Y Y Y Y M M D D

5. Passport No: 6. Gender: Male ◯ Female ◯

7. Relationship to applicant:

Dependent 3:

1. Title: 2. First Names:

3. Surname: 4. Date of birth: Y Y Y Y M M D D

5. Passport No: 6. Gender: Male ◯ Female ◯

7. Relationship to applicant:

Dependent 4:

1. Title: 2. First Names:

3. Surname: 4. Date of birth: Y Y Y Y M M D D

5. Passport No: 6. Gender: Male ◯ Female ◯

7. Relationship to applicant:

C. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS

Have you or any of your dependents ever experienced any of the following?	Yes	No
1. Are you, or have you, in the last 24 months been a smoker?	○	○
2. Any disorder of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	○	○
3. High blood pressure or disease of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder)?	○	○
4. Any respiratory or lung trouble (e.g. asthma, bronchitis, persistent cough, tuberculosis)?	○	○
5. Any disorder of the digestive system, gall bladder, liver or pancreas (e.g. gastric or duodenal ulcer, pancreatitis, recurrent indigestion, hiatus hernia, Hepatitis B or persistent diarrhoea)?	○	○
6. Any disease or disorder of the kidneys, bladder or reproductive organs (e.g. albumin in urine, kidney stones, problems with female organs or venereal disease)?	○	○
7. Any nervous or mental complaint (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety state or depression)?	○	○
8. Any ear, eye, nose or throat disorder (e.g. discharge, defective vision, wear spectacles/contact lenses, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment, chronic sinusitis, allergic rhinitis)?	○	○
9.Any disorder or disease of muscles, bones, joirt s, limbs or spine (e.g. rheumatism, arthritis, gout, osteoporosis, slipped disc or other back trouble)?	○	○
10. Diabetes, thyroid or other glandular or blood disorder?	○	○
11. Any lumps, growths (benign or malignant), types of cancers (including Hodgkin's and Leukaemia) skin cancer or skin disorders?	○	○
12. Any tropical disease (e.g. bilharzia, malaria, cholera)?	○	○
13. Been tested for, or received or expect to receive, any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or an AIDS-related condition or any sexually transmitted disease e.g. Hepatitis B, gonorrhoea or syphilis?	○	○
14. Are you (if female) or any of your dependents pregnant? If yes, state expected date of confinement in section D below.	○	○

If you answered "Yes" to any of the questions above, please complete details below in full. If additional space is required, please complete Section D and/or a separate sheet of paper and attach it to the application. Please attach relevant medical reports if available.

Patient's name	Illness	Type of treatment	Date of last treatment	Present state of health

D. ADDITIONAL MEDICAL INFORMATION

E. DECLARATION BY THE APPLICANT (Must always be signed by the applicant)

1. I declare that all answers given in this application are true, correct and complete in every respect, and that I will notify the underwriter should any alteration, in any circumstance in which the assessment is based occur after the date of this application and before the date of the Policy's commencement.
2. I further declare that any false statement in this application or the non-disclosure of any material information will render my policy null and void.
3. I understand pre-existing conditions to mean any pre-existing physical defect, infirmity or illness experienced in the last 24 months, for which prescribed medication and/or treatment or advice was necessary or received, will not be covered under the policy for the first 12 months.
4. Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits in respect of me, as the applicant, I irrevocably authorize the underwriter to obtain from any person, any information which the underwriter deems necessary, at any time (even after my death).
5. On signing, I acknowledge and accept that I will be held personally responsible for all amounts (membership fee and claims)
6. For group membership only: I hereby authorize my Employer to deduct from my salary and pay to the underwriter all amounts that may be due by me.
7. I understand that my cover will commence on the date of acceptance providing the membership fee due have been paid.
8. I shall obtain authorisation from the call centre should I or any other dependent require hospitalisation for a non-emergency event at least 10 days before the event. I acknowledge that failure to do so may result in a reduction of benefits by the underwriter for any procedure taken.
9. No benefit will be payable unless the underwriter is satisfied as to the validity of a claim and has received all the information which they may deem necessary, including but not limited to the results of any medical examinations and tests which they may require me or my dependents to take.
10. I undertake to obtain the necessary consent from any dependent to whom these conditions apply and indemnify the underwriter against any claim which may arise of my failure to do so.
11. I undertake to give 30 days' written notice in the case of the termination of my policy.

Agreed Membership Fee:

Signed at: **on** D D **of** M M **20** Y Y

Signature of applicant:_____

F. TO BE FILLED BY AUTHORIZED PERSONNEL ONLY

Commencement Date: Y Y Y Y M M D D

Authorised Salesperson/ Agent

Administered By:

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