HEALTH INSURANCE
APPLICATION FORM

NAME OF EMPLOYER/COMPANY NAME:……..……..

P.O. BOX: ……..……..

APPLICANT'S NAMES: ……..……

DATE OF BIRTH: ……..……..……ID NO……..……..……Employee/Payroll No..……

Office No……..……..……Cell phone No: ……..……..……Email address:……...……..……..……

PERIOD OF INSURANCE: From…….…… To……..……..……

LIMIT OF PLAN SELECTED:……..……..……..……..……..……..……..……..……..……

1. The persons to be Insured are named below (please use a separate sheet of paper if more names are to be added than the space provided)

NAMES IN FULL	RELATIONSHIP TO MEMBER	OCCUPATION	DATE OF BIRTH (dd/mm/yyyy)	SEX (F/M)	ID// PASSPORT NUMBER

MEDICAL HISTORY

1. Name of the Family Doctor……..……..

Address……..……..

Answers to the following questions will be treated in strict confidence:

	Answer Yes or No	Name and details of complaint, illness or disease and dates
2. Have you or any member of your family any physical defects, Infirmity or disease?		
3. Is any condition known to exist in respect of yourself or any member of your family which may necessitate medical or surgical treatment now or in the future?		
4. Give details of any illness or disease, operation or injury suffered or sustained by yourself or any member of your family.		
5. Have you or any member of your family been under the care of a doctor during the past twelve months?		
6. Have you or any member of your family received hospital or Nursing Home treatment during the past twelve months?		
7. Has any Medical Insurance application by you or your family been declined or accepted with specific exclusions.		

DECLARATION:

I hereby declare that the answers given above are to the best of my knowledge true and complete. I have declared all material facts which relate to this application. I understand that any chronic or pre-existing condition will not be covered under the terms of the policy unless declared and otherwise agreed with The Insurer. I authorise The Insurer to contact the doctor I have consulted or any Doctor of their choice if need be. I shall willingly submit myself for any medical examination if so required by The Insurer.

Date ……..

SIGNED ……..……..

GA Insurance Limited
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