MEMBER ENROLMENT FORM FOR MEDLAND PRUDENTIAL MEDICAL SCHEME

Hospital Stamp

Name:.....

Signature:.....

Date:.....

PRUDENTIAL

MEMBER ENROLMENT FORM

Please ensure that all relevant sections are completed

(If insufficient space, please attach separated sheet with additional information)

Passport Size Photo

1. PERSONAL DETAILS

SURNAME

OTHER NAMES

NRC/PASSPORT NO. DOB

OCCUPATION SEX

POSTAL ADDRESS

PROFILE PLAN MEMBER JOIN DATE

MOBILE NUMBER

EMAIL ADDRESS

2. PERSONS TO BE COVERED

If the scheme covers your spouse/children and or insured dependants provide information required below (S-Spouse, C - Child & O-Other-Niece, Nephew)

S/N	SURNAME	OTHER NAMES	NRC/PP NUMBER	SEX	DATE OF BIRTH	R/SHIP

3.1 Are you or any other person to be insured covered by another medical scheme?

if yes, please give details.

4. CONFIDENTIAL MEDICAL HISTORY (Please tick YES/NO)

4.1 Are you or any other person to be insured in very good health now and usually enjoy good health?

☐ YES ☐ NO

4.2 Have you or any other person to be covered ever been hospitalized in the previous 36months?

☐ YES ☐ NO

4.3 Have you or any other person suffered or incurred in the previous 12 months treatment of diseases such as cataract, benign prostatic hypertrophy, hysterectomy for menorrhagia of fibromyoma, hernia, hydrocele, congenital internal diseases, fistula in anus, piles, sinusitis and related disorders.

☐ YES ☐ NO

PRUDENTIAL

4.4 Have you or any other person suffered or incurred in the previous 12 months treatment of diseases such as diabetes, nervous disorder, tuberculosis, asthma, epilepsy, stroke or any form of heart disease or disorder of the lungs? if yes please give details.

☐ YES ☐ NO

4.5 Are you or any of the persons to be covered pregnant?

☐ YES ☐ NO

4.6 Are you or any of the persons to be covered wearing spectacles or uses contact lenses?

☐ YES ☐ NO

4.7 Have you or any of the persons to be covered had any dental treatment?

☐ YES ☐ NO

4.8 Have you or any of the persons to be covered ever suffered from impairment of vision?

☐ YES ☐ NO

4.9 Are you or any persons to be covered ever experienced depression or psychiatric disaorders?

☐ YES ☐ NO

4.10 Are you or any persons to be covered ever suffered from jaundice, liver conditions, gall bladder disease?

☐ YES ☐ NO

4.11 Are you or any persons to be covered ever experienced back, neck, joint problems, arthritis, gout, any physical disability or muscular disorder?

☐ YES ☐ NO

4.11 Is there any illness/factor not mentioned on this proposal that might affect your health in the next 12 months?

☐ YES ☐ NO

IF YOU TICKED YES FOR ANY OF THE ABOVE, (EXCEPT 4.1) PLEASE COMPLETE THE SECTION BELOW ALL IMPORTANT INFOMATION MUST BE DISCLOSED.

Question Number	Member Name (This includes main member as well as any dependents)	Date	Please supply full details of disorder, date, duration of treatment, medication (if any)

PLEASE ATTACH ANY RELEVANT MEDICAL REPORTS

5. HEALTHCARE INFORMATION

NAME OF YOUR FAMILY /USUAL DOCTOR

POSTAL ADDRESS

PHYSICAL ADDRESS

MOBILE NUMBER

6. DECLARATION

I DECLARE THAT ANY FALSE STATMENT IN THE PROPOSAL FORM OR NON DISCLOSURE OR ANY MATERIAL INFORMATION WILL RENDER THE MEMBERSHIP THEREBY NULL AND VOID

I ACKNOWLEDGE THAT ANY BENEFITS PAID BUT NOT COVERED BY THE TERMS AND CONDITIONS OF THE MEDLAND PRUDENTIAL MEDICAL SCHEME WILL BE REFUNDED TO THE SCHEME ADMINISTRATOR.

MEMBER SIGNATURE: _____ DATE: _____

PRUDENTIAL

PROMED CHRONIC MEDICINE

Patient's Details	First name.....Middle name.....Family name/Last name..... Date of birth...../ ..... / ..... Age..... Sex..... Mobile Number.....
Principal Member	First name..... Middle name.....Family name/Last name..... Date of birth...../ ..... / ..... Age..... Sex..... Mobile Number.....

Provider Details	Hospital Name... ... . Address.. ..... Phone..... Doctor's first name..... Surname..... Speciality..... Practice no.....

To be completed by treating Doctor in Block letters

TESTS DONE

.....
.....
.....

DATE OF TEST

.....
.....
.....

Doctor's Comments

.....
.....
.....
.....

Diagonosis/ICD 9/ICD 10 CODE		MEDICINE TRADE NAME	ACTIVE INGREDIENT	STRENGTH (e.g 10mg)	DIRECTIONS (e.g 1 tab TDS)

Doctor's declaration

I certify that the particulars are, to the best of my knowledge and belief, true and accurate. I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

DR'S SIGNATURE: _____ DATE: _____

I hereby declare that the information in this form is true and correct. I am aware that the scheme administrator may request medical information form any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires. In order to fully assess this application for benefits, I hereby give my consent for the scheme administrator to obtain this information. I understand that this application is subject to the Medland Prudential Medical Scheme conditions and benefits.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____