MEMBERSHIP APPLICATION FORM

Policy ID / Membership Number

Please read the following prior to completing this application form and complete in BLOCK CAPITALS.
You are required to disclose all material facts as failure to do so may invalidate your policy. Should you be uncertain as to whether a fact is relevant, it should be disclosed. All information supplied by yourself is treated as strictly confidential.

As the principal applicant, you should answer all the questions and sign the declaration on behalf of all persons included in this application.

SECTION 1 - MEMBERSHIP PLAN APPLIED FOR

Diamond Plan ☐ Optional Excess (Diamond Plan Only) Nil ☐ USD250 ☐ USD500 ☐ USD1000 ☐

Emerald Plan ☐ Garnet Evac Plus ☐ Personal Accident ☐ USD25,000 ☐ USD50,000 Office Use

SECTION 2 - PROPOSED COMMENCEMENT DATE

From: DD / MM / YYYY To: DD / MM / YYYY Commencement date subject to approval of your application and receipt of payment.

SECTION 3 - PRINCIPAL APPLICANT'S DETAILS

Surname: Title:

First Name(s):

Date of Birth: DD / MM / YYYY Age: Gender: Height: Weight:

Nationality: ID / Passport No:

Country of Residence:

Residential Address:

Occupation: Company Name:

Business Address:

Mobile No: Business No:

Primary Email: Secondary Email:

SECTION 4 - FAMILY MEMBERS TO BE INCLUDED ON COVER

(Please note children to be included under this plan must be under 18 years of age, or 23 years or under if they are in full-time education and are fully dependant upon YOU.)

DEPENDANT 1 (PARTNER / SPOUSE)

Surname: Title:

First Name(s):

Date of Birth: DD / MM / YYYY Age: Gender: Height: Weight:

Nationality: ID / Passport No:

Country of Residence:

Residential Address:

Relationship to Applicant: Occupation:

Mobile No: Business No:

SECTION 4 - FAMILY MEMBERS TO BE INCLUDED ON COVER (CONTINUED)

DEPENDANT 2

Surname: Title:

First Name(s):

Date of Birth: DD / MM / YYYY Age: Gender: Height: Weight:

Nationality: ID / Passport No:

Country of Residence:

Relationship to Applicant: Occupation:

DEPENDANT 3

Surname: Title:

First Name(s):

Date of Birth: DD / MM / YYYY Age: Gender: Height: Weight:

Nationality: ID / Passport No:

Country of Residence:

Relationship to Applicant: Occupation:

DEPENDANT 4

Surname: Title:

First Name(s):

Date of Birth: DD / MM / YYYY Age: Gender: Height: Weight:

Nationality: ID / Passport No:

Country of Residence:

Relationship to Applicant: Occupation:

DEPENDANT 5

Surname: Title:

First Name(s):

Date of Birth: DD / MM / YYYY Age: Gender: Height: Weight:

Nationality: ID / Passport No:

Country of Residence:

Relationship to Applicant: Occupation:

SECTION 5 - NEXT OF KIN

Surname: Title:

First Name: Relationship to Applicant:

Telephone No: Email:

SECTION 6 - CURRENT MEDICAL PROVIDERS

Current Medical Aid / Insurance Cover:

Current Travel Insurance Policies:

Doctor / GP:		TOWN	COUNTRY	TELEPHONE
Specialist:		TOWN	COUNTRY	TELEPHONE

Please state the name and telephone number of your General Practitioner as well as any Specialist you may have consulted in the last 3 months

SECTION 7 - CONFIDENTIAL MEDICAL HISTORY
FULL DISCLOSURE IS NECESSARY TO PREVENT FUTURE INVALIDATION OF MEMBERSHIP.

		Principal Applicant	Dependant One	Dependant Two	Dependant Three	Dependant Four	Dependant Five
1	**Medication** Are you, your spouse or any other dependant, currently taking any medication? Please detail the name, dosage and frequency in the Medication Section 8 on Page 5.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2	**Cardio Vascular** Chest pain/angina, heart attack, heart failure, heart valve disease, rheumatic fever, high blood pressure (hypertension), high cholesterol, heart murmurs, circulatory problems/disorders, varicose veins, deep vein thrombosis (DVT), or any other heart or circulatory problem.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3	**Respiratory & Breathing** Difficulty with breathing, bronchospasm, tuberculosis (TB), coughing up blood, emphysema, pneumonia, cystic fibrosis, chronic bronchitis, shortness of breath, asthma, sleep apnoea, any other breathing problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Have you ever been hospitalised for Asthma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4	**Bladder & Kidneys** Blood in urine, kidney failure, polycystic kidneys, kidney or bladder infections, removal of kidney (nephrectomy), kidney stones, abnormal kidney or urine tests or any other kidney problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5	**Reproductive & Gynaecological** Endometriosis, infertility, ovarian cysts, fibroids, hysterectomy, abnormal PAP smear, laser treatment, cervix and breast biopsies, fibro-adenosis of the breast, hormone replacement therapy, prostate infections or surgery, prostate enlargement or any other reproductive problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6	**Digestive System** Duodenal ulcers, gastric ulcers, pancreatitis, hiatus hernia, colon problems, crohn's disease, ulcerative colitis, gall bladder problems, liver problems or any other digestive conditions which may have needed a colonoscopy or endoscopy procedure.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7	**Ear, Nose & Throat** Deafness, ear infections, sinus problems, nasal surgery, throat surgery.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8	**Dental** Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, wisdom teeth (impacted or extractions) or any other such surgery or problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9	**Eyes** Blindness (partial or full), eye surgery, lens implant, cataracts, glaucoma, retinitis pigmentosa, retinal detachment, impaired vision, or any other eyesight or eyelid problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10	**Endocrine** Diabetes mellitus or insipidus, insulin resistance, underactive thyroid, overactive thyroid, thyroid surgery, cushing's syndrome, addison's disease, pituitary gland, or any other glandular problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If the answer to any question is YES, then please provide details in Section 9 provided on Page 5

SECTION 7 - CONFIDENTIAL MEDICAL HISTORY (CONTINUED)

		Principal Applicant	Dependant One	Dependant Two	Dependant Three	Dependant Four	Dependant Five
11	**Joint Disease** Rheumatoid arthritis, osteo-arthritis or any other joint disease.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12	**Musculoskeletal Disorders** Neck, back, knee or shoulder problems or operations, recurrent back pain, osteoporosis, ankylosing spondylitis, bunions or any other bone, skeletal or muscle disorders.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13	**Neurological** Epilepsy, stroke (CVA), migraine, brain or head injuries, spinal cord injuries, paralysis, multiple sclerosis, mental retardation, narcolepsy, motor neuron disease, parkinson's disease, alzheimer's disease, peripheral neuritis, any other neurological problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14	**Psychological** Depression, anxiety, psychosis, suicide attempts, bipolar disorders, manic depression, "stress", schizophrenia, tourette's syndrome, anorexia nervosa, received advice, counselling or hospitalisation for alcohol or drug abuse, bulimia or any other psychological conditions.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15	**Tumours & Growths** Benign or malignant growths (lumps or tumours) including melanoma, lymph gland cancer, leukaemia, breast cancer or any other tumours, growths and cancers.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
16	**Blood** Blood or bleeding disorders e.g. haemophilia, christmas disease, platelet or any other blood clotting disorders, or have you ever had a blood transfusion.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
17	**Skin** Eczema, acne, dermatovositis, psoriasis, scleroderma, skin cancer or any other skin disorders.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
18	**Sexually Transmitted Disease** Advice, treatment or counselling for any sexually transmitted disease or disorder.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
19	**Hospitalisation** Have you, your spouse or any dependants ever been hospitalised? If yes give details.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
20	**Tropical Diseases** Including malaria, bilharzia, yellow fever, tick bite fever and dengue fever.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
21	**Other** Are there any other Diseases / Conditions related to you or your spouse or any other dependant's health that are not disclosed or listed above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
22	**Pregnancy** Are you, your spouse, or any other dependants currently pregnant? When is the expected date of delivery (MM/MMMM)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
23	**Body Weight** Have you or your dependants body weight changed by more than 5kg in the past 12 months? If YES please explain why.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
24	**Hereditary Disorders / Family History** Are you aware of any family history of Cancer, High Cholesterol, Heart Attacks or any other hereditary conditions or predispositions?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If the answer to any question is YES, then please provide details in the Section 9 provided on Page 5

SECTION 8 - CURRENT MEDICATION DETAILS

(If You Have ticked YES to Question No. 1 in Section 7 kindly complete full details below)

Name of applicant	Condition being treated	Dosage, name & frequency of prescribed medication	Date treatment commenced

SECTION 9 - ADDITIONAL MEDICAL HISTORY INFORMATION

If you answered YES to any question in the confidential medical history, Section 7, you are required to give us more information for each instance in the table below. If the space is insufficient, please attach a separate sheet with complete information. Please attach relevant medical reports. **Full disclosure is necessary to prevent future invalidation of membership.**

Question Number	Names	Date of diagnosis/ treatment	Details of disorder, duration of treatment, medication and dosage

SECTION 10 - LIFESTYLE QUESTIONNAIRE (to be answered for principal member and all dependants).

Are you or any other dependant regularly involved in any hazardous sport, pastime, or occupation?
(eg: Racing of any kind, (other than on foot) skydiving, microlighting, piloting airplanes, bungee jumping, scuba diving, recreational water sports, mountain climbing, big game hunting, horse riding, BMX, karting, motocross, enduro, quad biking, or any type of off-road biking etc.)

Are you or any other dependant in receipt of payment for your services from any other source of employment?
(eg: Participation in Sport, Coaching, Guiding, etc.)

Do you or any other dependant consume alcohol, and how often? (tick as appropriate)

NAME OF APPLICANT	☐ Beer ☐ Spirits ☐ Wine	AVG. WEEKLY CONSUMPTION
NAME OF APPLICANT	☐ Beer ☐ Spirits ☐ Wine	AVG. WEEKLY CONSUMPTION
NAME OF APPLICANT	☐ Beer ☐ Spirits ☐ Wine	AVG. WEEKLY CONSUMPTION

Have you ever in the past consumed greater quantities, and if so why has this changed?

Do you or any other dependant smoke tobacco / e-cigarettes? (tick as appropriate)

NAME OF APPLICANT	☐ Tobacco ☐ E-Cigarettes	AVG. DAILY CONSUMPTION
NAME OF APPLICANT	☐ Tobacco ☐ E-Cigarettes	AVG. DAILY CONSUMPTION

Have you or any other dependant ever in the past smoked, and if so why has this changed?

Do you or any other dependant participate in regular physical exercise? (eg: Gym, Jogging, etc.)

Name of every applicant that participates:

If yes, please advise the type of physical exercise, and how often you or your dependants participate:

Are you or any other dependant allergic to any food stuffs, medication, or any other substances?

SECTION 11 - ADDITIONAL INFORMATION

Does your occupation require you to travel outside your country of residence for extended periods? ☐ Yes ☐ No

Where: Duration:

How did you hear about Health International Membership plans?
Website ☐ Facebook ☐ Current Health International Member ☐ Family/Friend ☐ Other ☐

SECTION 12 - PREVIOUS MEDICAL AID / MEDICAL INSURER

Have you or any member of the family previously applied for Health International Membership? ☐ Yes ☐ No

Have you or your Spouse previously applied for any other Medical Aid / Medical Insurance? ☐ Yes ☐ No

If YES and your applications were successful, please supply details:

Name of Previous Medical Aid / Insurer:

Reason for discontinuing membership:

Brief Claims History:

Have you or your spouse ever been declined by a Medical Aid / Insurer? ☐ Yes ☐ No

If YES, please give reason why:

SECTION 13 - DOCUMENTATION REQUIREMENTS

	Individuals & Families	Principal Applicant	Dependant One	Dependant Two	Dependant Three	Dependant Four	Dependant Five
1	**Proof of Identity Required*** Certified copy of **ONE** of the following documents: - Valid Passport - Valid Driver's Licence - Valid Identity Card	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes
2	**Verification of address† (Proof of Residence)** Certified copy of **ONE** of the following documents: - Recent^ utility bill or - Bank or Credit Card statement or - Reference from a Professional Person – (Accountant / Lawyer / Bank Manager) (Letter template available on request)#	☐ Yes	N/A	N/A	N/A	N/A	N/A

	Registered Private and Limited Companies	Private Limited Company	Limited Company
1	**Proof of Registration Required** Certified copy of the following documents: - Certificate of Incorporation - CR14	☐ Yes	☐ Yes
2	**Registered Office Address** Certified copy of **ONE** of the following documents: - Recent^ utility bill or - Bank or Credit Card statement or - Reference from a Professional Person – (Accountant / Lawyer / Bank Manager) (Letter template available on request)#	☐ Yes	☐ Yes
3	**Validation of Directors** Certified copy of the following documents for each person: - Valid Passport - Proof of Residence	☐ One Director ☐ Public Officer	☐ CEO (Head of Company) ☐ Chief Financial Officer

* Copy of photographic ID required for all family members including minors.
^ Recent means within the last 6 months.
† Address means physical, NOT a PO Box address, required for **PRINCIPAL MEMBER ONLY.**
# Member needs to be known by the professional person.

SECTION 14 - DECLARATION (PLEASE READ CAREFULLY)

1. On behalf of myself, the principal applicant, and for each person included on this application I authorise the aforementioned cited doctors to provide Health International with such information as they may seek in connection with this application.
2. I authorise Health International to have unrestricted access to my medical records and the medical records of each person included on this application, but require their confidentiality to be maintained.
3. I understand that any false statement made in this document or the non-disclosure of any material information will render the membership null and void.
4. I understand that any condition for which I or any person included on this application have received medical advice or treatment at any time in the past may be excluded from the benefit.
5. I understand that I or any person included on this application may be required to obtain a medical report, or to undergo a medical examination to provide further information on any of the declared conditions, at my own expense, and that any of the declared conditions may be excluded from the benefits.
6. I agree to accept written communications from the authorised representatives of Health International of any conditions excluded from the benefits.
7. I accept I will have to refund to Health International any benefit paid out but not covered by the Terms and Conditions.
8. I acknowledge that I shall be solely responsible for prompt and timeous payment of all and any premiums payable to Health International pursuant to this application, whether or not my employer or any other third party enters into any agreement or arrangement whatsoever with Health International regarding the same, and I specifically acknowledge further that, subject to the Terms and Conditions set out in the Membership Guide of Health International (which has been made available to me), in the event that any premiums or part thereof are due and payable are not paid timeously, Health International shall not be obliged to meet any claims arising on or after the date on which any such payment fell due.
9. DATA PROTECTION FAIR PROCESSING NOTICE. In your dealings with us you may provide information that includes data that is known as personal data. The personal data we collect will include data relating to your name, address, email address, IP address, date of birth, nationality, country of residence, occupation, credit card details and medical information. We will process your personal data to allow us to administer your health insurance policy and any associated claims and for actuarial analysis. If you require further information on how we process your data and our lawful bases for doing so, please contact us at admin@healthintergrp.com or refer to our Privacy Policy which can be found on our website.

   I understand that Health International will process my personal data, including medical data in relation to my insurance policy.

IT IS IMPORTANT THAT ALL APPLICANTS HAVE VALID TRAVEL DOCUMENTS.

DECLARATION OF APPLICANT

I agree with the terms and conditions of membership, and I hereby apply for membership.

Applicant Signature _____ Date (DD / MM / YY)_____

www.healthintergrp.com

health INTERNATIONAL

AUTHORISED REPRESENTATIVES OF HEALTH INTERNATIONAL

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