MEMBERSHIP APPLICATION FORM

Policy ID / Membership Number

IMPORTANT PLEASE READ: To avoid delays in processing your application:
• Answer **ALL** questions **IN FULL** • Use **BLOCK CAPITALS** • Provide **COMPLIANCE DOCUMENTS**

AGENT / BROKER:

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 you must disclose it. All information provided by you is treated in the strictest confidence. As the principal, you are required to answer all questions in full and sign the declaration on behalf of all persons included in this application.

SECTION 1 - MEMBERSHIP PLAN APPLIED FOR

Diamond Plan ☐ Optional Excess: Nil ☐ USD250 ☐ USD500 ☐ USD1000 ☐

Emerald Plan ☐ Garnet Evac Plus ☐ Have you selected a Link-on Plan? If so, please specify:

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

Required Compliance Documents as soon as possible to avoid delays in processing your application.

Surname Title:

First Name(s)

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

Nationality: ID / Passport No:

Residential Address:

Country of Residence:

Occupation: Marital Status:

Position Held within Company: ☐ Owner ☐ Director ☐ Shareholder ☐ Employee

Company Name: Nature of Business:

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:

Residential Address:

Country of Residence: Occupation:

Relationship to Applicant: Nature of Business:

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

NOT a direct family member or a person who appears on this application form.

Surname		Title:	
First Name(s)		Relationship to Applicant:	
Email:		Telephone No:	

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 - 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 8 - 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 **CHRONIC** (long term) or **ACUTE** medications? **If yes, please detail the name, dosage and frequency.**	☐ 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

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

SECTION 8 - CONFIDENTIAL MEDICAL HISTORY (CONTINUED)
FULL DISCLOSURE IS NECESSARY TO PREVENT FUTURE INVALIDATION OF MEMBERSHIP

		Principal Applicant	Dependant One	Dependant Two	Dependant Three	Dependant Four	Dependant Five
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
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	**Medical Imaging / Scans** Have you, your spouse or any dependants ever had an MRI or CT scan? If yes, please give details in Section 9.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13	**Musculoskeletal Disorders** Neck, back, knee or shoulder problems or operations, including arthroscopes on any major joints. Recurrent back pain, osteoporosis, ankylosing spondylitis, bunions or any other bone skeletal or muscle disorders? Broken / fractured bones that have required internal / external fixations and screws / plates that may require removal in the future.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14	**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
15	**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
16	**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
17	**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
18	**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
19	**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
20	**Hospitalisation** Have you, your spouse or any dependants ever been hospitalised, including day cases, childbirth or a c-section. If yes, please give details in Section 9.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
21	**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

SECTION 8 - CONFIDENTIAL MEDICAL HISTORY (CONTINUED)
FULL DISCLOSURE IS NECESSARY TO PREVENT FUTURE INVALIDATION OF MEMBERSHIP

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

		Principal Applicant	Dependant One	Dependant Two	Dependant Three	Dependant Four	Dependant Five
22	**Other** For any medical conditions / diseases not listed in questions 1 - 21, please provide full details in the Medical History section in Section 9.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
23	**Pregnancy** Are you, your spouse, or any other dependants currently pregnant or previously had a c-section? If yes, please advise expected date of delivery in Section 9.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
24	**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
25	**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 Section 9 provided on this page.

SECTION 9 - ADDITIONAL MEDICAL HISTORY INFORMATION

If you answered **YES** to any question in the confidential medical history, Section 8, 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 9 - ADDITIONAL MEDICAL HISTORY INFORMATION (CONTINUED)

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 dependent regularly involved in any hazardous sport, pastime or occupation?

- ☐ Professional Hunter — Name / s:
- ☐ Short Term Hunter/Recreational — Name / s:
- ☐ Safari Guide — Name / s:
- ☐ Safari Videographer / Photographer — Name / s:
- ☐ Pilot — Name / s:
- ☐ Endurance / Off Road / Bush Motorbiking — Name / s:
- ☐ BMX — Name / s:
- ☐ Motocross — Name / s:
- ☐ Karting — Name / s:
- ☐ Other — Occupation / Sport / Pastime?: — Name / s:

If you have indicated participation in any of the above activities, you will be required to complete the relevant **RISK ASSESSMENT** form. This will be forwarded to you.

Please note that certain hazardous sports, occupations and pastimes are excluded from cover, Clause 8.43 of the Terms & Conditions. Some examples, but not limited to: Racing of any kind (other than on foot); skydiving; microlighting; bungee jumping, recreational water sports, scuba diving, mountain climbing and quad biking.

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.)

SECTION 10 - LIFESTYLE QUESTIONNAIRE (CONTINUED)

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. WEEKLY CONSUMPTION
NAME OF APPLICANT	☐ Tobacco ☐ E-Cigarettes	AVG. WEEKLY 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 - REQUIRED MANDATORY COMPLIANCE DOCUMENTS

Kindly refer to the **COMPLIANCE REGULATIONS** from your Health International Regional Office or Agent / Broker for full details on the documents required for individuals. These documents are required as a one-time submission. Timely submission of these documents will help to avoid delays in processing your application.

SECTION 13 - 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 may 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 only use your data for the purpose for which it was collected and when the law allows us to. We will only grant access to or share your data where we are required or entitled to do so by law under lawful data processing. This is within our firm or other firms associated with us, our authorised partners, your broker if you have appointed one, third party service providers such as insurers, assistance companies and claims administration providers. 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.
10. On behalf of myself, the principal applicant and for each person included on this application, I consent to Health International disclosing my personal data to related entities of Health International, their staff members outside of Sub-Saharan Africa, the insurer, other insurers and reinsurers, medical assistance providers, law enforcement agencies, investigators, lawyers, assessors, advisors and the agent of any of those, insurance brokers, insurance agents or other intermediaries, my employer or the covered member's employer for the purposes of providing claims assistance, emergency assistance or the administration of the health insurance policy.
11. **I understand and will meet my obligations under the COMPLIANCE REGULATIONS as advised by authorised representatives of Health International**.

IT IS IMPORTANT THAT ALL APPLICANTS HAVE VALID TRAVEL DOCUMENTS.

DECLARATION OF APPLICANT

☐ I confirm that I have been provided with a copy of the Terms & Conditions (either in hard copy, soft copy or via access to the website) and that I have read, understood, and agree to be bound by them. I acknowledge that the Terms & Conditions may be updated from time to time and that I will be notified of any changes, in writing, via the Important Changes document, at the time of my policy renewal. It is my responsibility to review the latest version available.

Principal Applicant Signature* : _____ Date (DD / MM / YY) _____

**** IMPORTANT: This application form must be signed by the PRINCIPAL APPLICANT. No other signature will be accepted.***

AUTHORISED REPRESENTATIVES OF HEALTH INTERNATIONAL

STRATTON AGENCIES (PVT) LTD t/a TRILOGY BENEFITS GROUP, REGIONAL HEAD OFFICE, HARARE, ZIMBABWE

Registration No. 827/1982

No. 23 Kenilworth Road,
Newlands, HARARE, Zimbabwe
P O Box BW 269, Borrowdale
Harare, Zimbabwe

Tel: +263 (0) 86 7700 8964
+263 (0) 772 443 902
+263 (0) 772 443 909
marketing@healthintergrp.com

TRILOGY BENEFITS GROUP

AIR HEALTH INTERNATIONAL (PTY) LTD, JOHANNESBURG, SOUTH AFRICA

Registration No. 96/16923/07

67 Voortrekker Avenue,
Edenvale, 1609
Johannesburg, South Africa

Tel: +27 (0) 11 452 2152

info@airhealthinternational.co.za

Air health INTERNATIONAL

HEALTH INTERNATIONAL ZAMBIA LTD, LUSAKA, ZAMBIA

Registration No. 61450

Suite B15, First Floor, Block B,
Green City, Stand No. 2374,
Kelvin Siwale Road, Lusaka, Zambia

Post Net Box 325
Private Bag E 10, Lusaka, Zambia

Tel: +260 (0) 211 263 570

zambia@healthintergrp.com

health INTERNATIONAL ZAMBIA LIMITED

EXPACARE INSURANCE COMPANY (MAURITIUS) LIMITED, PORT LOUIS, MAURITIUS

Registration No. 23670/5472

Suite 335, 3rd Floor, Barkly Wharf,
Caudan Waterfront,
Port Louis 11306, Mauritius

Tel: +230 (0) 214 1841

compliance@expacareinsurance.com

expacare INSURANCE