**GROUP HEALTH INSURANCE EMPLOYEE**

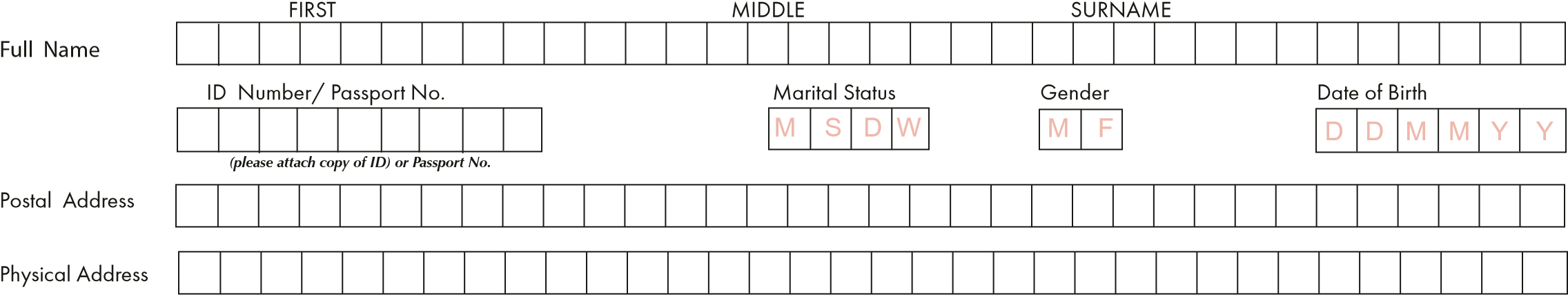
**APPLICATION FORM**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***For Office use Only:***   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | D | D | M | M | Y | Y |   Policy Date  Membership Number |

Please complete in full in BLOCK letters. Attach two recent COLOUR passport photographs for each proposed insured, print the name and sign on the back of each.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  | (Home) |  |  |  |  |  |  |  |  |  |  |  |  |  |

# PERSONAL PARTICULARS



E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CODE NUMBER CODE NUMBER

Telephone Number (Work)



# PARTICULARS OF OCCUPATION

Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Employment

Postal Address P.O. Box RAMA/Mutuelle No.

Specific Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PARTICULARS OF DEPENDANTS

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full name** | | **Date of Birth** | | | | | | **Gender** | | **Relationship** | **Living with you** | |
| (01) |  |  |  |  |  |  |  | M | F | Spouse | Y | N |
| (02) |  |  |  |  |  |  |  | M | F |  | Y | N |
| (03) |  |  |  |  |  |  |  | M | F |  | Y | N |
| (04) |  |  |  |  |  |  |  | M | F |  | Y | N |
| (05) |  |  |  |  |  |  |  | M | F |  | Y | N |
| (06) |  |  |  |  |  |  |  | M | F |  | Y | N |
| (07) |  |  |  |  |  |  |  | M | F |  | Y | N |

Name of previous medical insurer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Period of insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Continued overleaf*

# Medical history of applicant and dependants



|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **All questions must be answered**  **(blank spaces on lines are not acceptable)** | | | **Member 00** | | **Dependant**  **01**  **(Spouse)** | **Dependant 02** | **Dependant 03** | **Dependant 04** | **Dependant 05** | **Dependant 06** | **Dependant 07** |
| 1a) | Are you or your dependants presently suffering from any physical defect or illness whatsoever even in slight form? | | |  | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| YES NO |  |
|  |
| b) | If so, is such illness or physical defect likely to necessitate an operation? Please give details. | | | YES NO |  | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| 2) | Have you consulted your doctor OR what illness accidents or operations have you or your dependants had in the past, no matter how trivial? State YES or NO. If YES, please specify (add an additional sheet if necessary) and state date of last consultation. | | | YES NO |  | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
|  |
|  |
| 3) | Please state if you or your dependants at any time have been subject to any chronic/recurring illness e.g asthma, diabetes, hypertension, convulsions/ epilepsy gastric or duodenal ulcers, gallstones, heart disease, neurological disease, psychiatric illness, rheumatic fever, kidney disease, back pain/spinal  disease, sinusitis, recurrent tonsillitis, arthritis, fibroids, menstrual disorders, cancer, others (please specify) | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| 4a) | State any allergies | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| b) | Do you or your dependants smoke? | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| 5) | Are you or your dependants currently using medication for medical or other reasons? If so, please specify. | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| 6) | Are there any other circumstances in your current or past medical history not mentioned above, which may result in hospitalisation in future? | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| 7) | Female members only  i) Has any member of your family ever delivered a child through caesarean operation. | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
|  | ii) Is any member currently pregnant? | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| 8) | State name, address and phone number of your medical practitioner to whom reference may be made. | | | YES  NO | | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO | YES  NO |
| **Please provide details of positive (YES) answer to questions 1 to 8** | | | | | | | | | | | | |
| Question No. | | Dependants No. | Details | | | | | | | | | |
|  |  | | | | | | | | | |
|  |  | | | | | | | | | |

**Beneficiary details**

Name of beneficiary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number/ Passport No. (pls. attach copy of ID/ Passport No.) \_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Declaration

I hereby apply to join the above-mentioned plan. I understand that any misstatement or the non-diclosure of any material information in this form will jeopardise my membership. I warrant that the answers in this form are true, correct and complete and I acknowledge that such answers are all material. I hereby authorise the hospital, medical or dental practitioners who have treated me or any of my dependants to disclose to the Company the records relating to such current or previous hospitalisations / medical treatment and to allow the Company to receive extracts from such records and undertake to assist in obtaining such information.

I confirm that I have explained to the client all the general Dated this Day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ conditions and exclusions of this cover.

Member’s Signature. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Human Resource Manager Signature & Stamp

**UAP Old Mutual Insurance Uganda**

Plot 3-5 New Portbell Road | UAP Nakawa Business Park| P. O. Box 7185 Kampala, Uganda | Toll Free: 0800132700 | Tel: +256414332700

Email: medicaluic@uap-group.com | Website: www.uapoldmutual.com