



ACACIA HEALTH INSURANCE

#5 Asoye Lane, East Legon Accra Ghana.

Tel: 0302 543738, 0302 543734

MEMBER APPLICATION FORM

FIRST	
MIDDLE	
SURNAME	

PHOTO

WHITE
BACKGROUND

Please Staple
Ends

Date of Birth

D	D	M	M	Y	Y
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Gender

M	F
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Nationality

Number of Dependents

BENEFIT (Please Tick)

SUPER CARE PLUS

☐

SUPER CARE

☐

PREMIER CARE

☐

UNI CARE

☐

LIFE CARE

☐

EMPLOYER'S NAME

HOW MANY FAMILY MEMBERS USE OPTICAL

POSTAL ADDRESS (Personal)

RESIDENTIAL ADDRESS

Email :

Mob:

BRANCH

POSITION

MEDICAL HISTORY (Please Underline or Circle the appropriate Medical Condition applicable to you)

1.Allergies	12.Cystic Fibrosis	23.HIV positive	34.Leukemia	45.Severe recurrent diarrhoea
2.Anemia	13.Depression or Psychiatric disorder	24.Heart attack	35.Life insurance rejected	46.Smoking
3.Angina	14.Diabetes Mellitus	25.Heart disease	36.Liver condition	47.Spectacles or contact lenses
4.Any medication for any condition	15.Disorder of the digestive system	26.Hepatitis	37.Lung disease	48.Stroke
5.Asthma	16.Embolism	27.Hepatitis B	38.Malaise	49.Thrombosis
6.Back Neck Joint Problems	17.Emphysema	28.Hernia	39.Malignant cancer	50.Thyroid disorder
7.Benign cancer	18.Endocrine disorder	29.High Blood Pressure	40.Migraine	51.Tuberculosis
8.Bladder Infections	19.Epilepsy	30.High Cholesterol Level	41.Nephritis	52.Ulcers
9.Chronic Bronchitis	20.Fibroid	31.Intestinal Fibrosis	42.Pregnancy	53.Varicose Veins
10.Congenital Heart Abnormalities	21.Gall bladder disease	32.Jaundice	43.Rheumatic Arthritis	54.No specific risks
11.Congenital kidney disorder	22.Gout	33.Kidney stone	44.Rheumatic Fever	55.Others- Please State

DECLARATION

APPLICANT,
I HEREBY DECLARE THAT THE INFORMATION
I HAVE GIVEN ABOUT ME AND MY DEPENDENTS IS TRUE.

Signature

Date:

HUMAN RESOURCE MANAGER,
I HEREBY CONFIRM THAT THE DETAILS GIVEN
BY THE APPLICANT IS TRUE

Signature

Date: