Nationwide Medical Insurance
P.M.B. 108, Airport, Accra- Ghana
Tel: 0302-226892
Call Center: 0800 222 222

Attach a passport size photograph here

Principal Membership Application Form

Please print/write all information in CAPITAL LETTERS

COMPANY NAME:		
STAFF ID No: (where applicable)		
BENEFIT OPTION (Please tick √ one)		
Privilege (PRV) ☐ Premier Plus(PRP) ☐ Premier (PRE) ☐ Executive (EXE) ☐ Essential (ESS) ☐		
PARTICULARS OF APPLICANT Title (Mr, Mrs, Dr, Rev etc):		
Surname	**First Name**	**Other Name(s)**
DATE OF BIRTH (dd / mm / yyyy)	**GENDER/SEX** (Please tick one only): Male ☐	Female ☐
MARITAL STATUS (Please tick √ one only)		
Single ☐ Married ☐ Divorced ☐ Widowed ☐		
CONTACT		
POSTAL ADDRESS:		
MOB. NO 1:	MOB. NO 2:	NHIS NO.
E-MAIL:		

HEALTH PROFILE (please tick √ if you have any of the conditions below)

Pre - Existing Conditions

☐ **Angina**	☐ **Gall bladder disease**
☐ **Autoimmune Disease**	☐ **Gout**
☐ **Back, Neck, Joint problems**	☐ **Hernia**
☐ **Cancer / Tumours / Myeloma**	☐ **Hypertension**
☐ **Cardiovascular Disease (Hearth attack / Hearth Disease)**	☐ **Intestinal fibrosis**
☐ **Chronic Bronchitis**	☐ **Kidney Disorders Gastrointestinal Disorders**
☐ **Chronic Respiratory Conditions**	☐ **Leukemia**
☐ **Congenital Heart Abnormalities**	☐ **Liver Disorders**
☐ **Cystic Fibrosis**	☐ **Lung disease**
☐ **Diabetes**	☐ **Musculoskeletal Disorders**
☐ **Disorder of the digestive system**	☐ **Nephritis**
☐ **Embolism**	☐ **Pregnant**
☐ **Emphysema**	☐ **Other conditions**
☐ **Endocrine disorder**	
☐ **Fibroid**	

If you ticked for any condition above, please provide more details here:

NOTE:

1. Please complete all fields of this form.
2. The Scheme shall not be liable for undeclared pre-existing conditions.
3. Submission of this form does not constitute acceptance of the application. The Scheme shall issue membership cards for applications that are successfully considered.

I .....declare that to the best of my knowledge the information given about myself is true. I have read the notes to this application and understand that this forms part of a contract with Nationwide Medical Insurance, i understand that no liability shall be accepted for any conditions that originated before the date of commencement of the policy, or the date of acceptance of this application, unless the condition is disclosed on this application form and accepted by Nationwide Medical Insurance.

Signature of Principal Member: _____ **Date:** _____

COMPANY AUTHORIZATION

Name _____ **Signature:** _____

Stamp **Date:** _____