Gilead Medical & Dental Centre

THIRD-PARTY CORPORATE REGISTRATION FORM (HEALTH INSURANCE COMPANY)

INFORMATION OF ORGANISATION

Name of Organisation

Address / Location

Region

Postal Address

Official Email

Landline

Mobile No.

Health Insurance Company Representative

Name

Position

Type of Business

Please attach a copy of certificate of incorporation or registration (whichever is applicable)

Ownership Category *(please tick where applicable)*

☐ Government ☐ NGO ☐ Quasi-Government ☐ Private

Member Registration Requirements

- List of members indicating their Organisation and Health Insurance plan.
  (Please indicate Primary Insured, Primary Dependants, Secondary Dependants)
- List of the Health Insurance Plans and their Benefit Packages.
- Sample of Health Insurance Company's member ID Cards
- Health Insurance Company shall submit an update of member information as and when necessary.

Medical Service and Payment Condition

Please see list of our services:

- General Outpatient Services
- Corporate Wellness Services
- Specialist Care: *Physician Specialist, Gynaecology & Obstetrics (Antenatal Care), Cardiology, Men's Clinic, Paediatrics, ENT, Neurosurgery, Clinical Psychology, Orthopaedic, Dermatology, Dietetics*
- General & Specialist Eye Care and Optical Services
- General & Specialist Dental Care
- Orthodontics
- Pharmaceutical Services
- Diagnostics Services - Lab, Ultrascan, ECG, CTG.

Below are the specific group amounts.

- **Private Health Insurance Company (National) is GH¢ 2,000.00**
- **Private Health Insurance Company (International) is GH¢10,000.00**

1) Claims payment period by the Health Insurance Company is thirty (30) days after medical bills have been submitted.

2) Gilead Medical & Dental Centre shall be given two weeks prior notice of names withdrawn from the organization's list.
   It shall be the responsibility of the Health Insurance Company to retrieve the health insurance ID cards from affected staff and their dependants.

3) Where the service received is not covered by the clients` collective agreement, the client shall make an internal arrangement for the recovery of amount paid on behalf of member or his/her dependants.

Payment Details

☐ Cash ☐ Cheque No. _____

Amount GH¢ _____

Amount in words _____

Acceptance

We the undersigned having considered the terms and conditions of Gilead Medical & Dental Centre's offer do hereby unreservedly accept. Dated: _____ day of _____ / _____
day *month* *year*

Name _____

Position _____

Signature & Stamp _____