Jubilee
INSURANCE

MEDICAL INSURANCE

GROUP MEMBERSHIP APPLICATION

JUBILEE HEALTH INSURANCE LIMITED
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DIRECTIONS:

*Please answer all questions in **BLOCK** letters.*

- *Please attach a passport size colour photograph of yourself and each member of your family proposed for insurance on the photo sheet page provided.*
- *Kindly complete all questions in full. Incomplete application forms cannot be processed.*

YOUR PERSONAL DETAILS

(a) Name of your employer

(b) Title Member's First Name

(c) Member's surname Other names

(d) Date of birth D D / M M / Y Y Blood Group

(e) ID or passport number Gender: Male ☐ Female ☐

(f) Occupation *If more than one, state all*

(g) Postal address

(h) Physical location of place of work *Building/Street*

(i) Physical home address *Residence/Area/House No.*

(j) Telephone - Office Personal Mobile

(k) Personal Email

SCHEDULE

To be completed if member's family is covered for Medical Insurance

Names in full	Date of birth (day/month/year)	Identity card no. / Birth certificate no. / Birth notification no.	Blood Group	Relationship to member
1.				
2.				
3.				
4.				
5.				

CONFIDENTIAL MEDICAL HISTORY

Please ensure that you have fully disclosed any known or suspected conditions and symptoms experienced by anybody included in this application. In completing the questions please make sure you answer each question fully and accurately. Failure to disclose material facts could affect payment of claims.

(a) Do you or any member of your family proposed for this insurance already hold Life, Personal Accident or Medical Insurance policies? Yes ☐ No ☐

If Yes, please state name of insurers and policy numbers

(b) Have you or any member of your family proposed for this insurance had medical and surgical or other form of health treatment during the past three years? Yes ☐ No ☐

(c) Have you or any member of your family proposed for this insurance suffered at any time from or become aware of any tendency to infection of the chest, heart, spine, glands, bones or joints, digestive organs, kidneys, bladder or other organs? Yes ☐ No ☐

(d) Have you or any member of your family proposed for this insurance suffered at any time from rheumatism, diabetes, gastric or duodenal ulceration, paralysis, gout, asthma, blood spitting, hernia, rheumatic fever, tuberculosis or from any nervous disease? Yes ☐ No ☐

(e) Have you or any member of your family proposed for this insurance suffered from any complaint which may necessitate a surgical operation or for which you reasonably anticipate the necessity of treatment? Yes ☐ No ☐

(f) Have you or any member of your family proposed for this insurance suffered from chronic/long term medical, optical or dental condition or is there any other known disability, abnormality or recurrent illness or injury? Yes ☐ No ☐

(g) Have any of your immediate relatives (child, father, mother, sister or brother) suffered from rheumatism, gout, kidney related problem, high blood pressure, cancer, diabetes, heart disease, asthma, epilepsy, blood disorder or any chronic illness? Yes ☐ No ☐

(h) Are you or any member of your family proposed for insurance now under observation or taking treatment or medication for any disease or disorder? Yes ☐ No ☐

(i) Do you or any member of your family proposed for insurance currently pursue or intend to pursue any profession, occupation, sport or hobby which is hazardous? Yes ☐ No ☐

Please state the name and address of your medical doctor/physician or hospital

Note: If the answer is YES to any question above please provide full details below

Name and relationship to the applicant	Relevant question	Medical condition	Consultations given and treatments received (with date)	Name of the treating doctor or hospital and their telephone number or address	Needs for future treatment or consultation

DECLARATION OF MAIN MEMBER

I, on behalf of myself and the members of my family proposed for insurance, hereby declare that I have not withheld or misstated any particular material fact. I understand that any misstatement or non disclosure of any material information in this form will jeopardize my membership.I hereby authorise the hospitals/medical practitioners who have treated me or any of my dependants to disclose to Jubilee Health Insurance Limited or their representative the records relating to such current or previous hospitalisation/medical treatment and allow Jubilee Health Insurance Limited to receive extracts from such records and undertake to assist in obtaining such information.

Signature of Member_____ Date _____

Signature/Stamp of Employer _____ Date _____