



OLDMUTUAL

GROUP HEALTH INSURANCE EMPLOYEE APPLICATION FORM

For Office use Only:

Policy Date

D	D	M	M	Y	Y
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Membership Number

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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.

PERSONAL PARTICULARS

								(Home)											
FIRST				MIDDLE				SURNAME											
Full Name																			
ID Number/ Passport No.																			
(please attach copy of ID) or Passport No.																			
Marital Status																			
M S D W																			
Gender																			
M F																			
Date of Birth																			
D D M M Y Y																			
Postal Address																			
Physical Address																			
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 <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b)	If so, is such illness or physical defect likely to necessitate an operation? Please give details.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
4a)	State any allergies	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b)	Do you or your dependants smoke?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
5)	Are you or your dependants currently using medication for medical or other reasons? If so, please specify.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
6)	Are there any other circumstances in your current or past medical history not mentioned above, which may result in hospitalisation in future?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
7)	Female members only i) Has any member of your family ever delivered a child through caesarean operation.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
	ii) Is any member currently pregnant?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
8)	State name, address and phone number of your medical practitioner to whom reference may be made.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Please provide details of postive (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-disclosure 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 conditions and exclusions of this cover.

Dated this Day of _____ 20_____

Member's Signature. _____

Human Resource Manager Signature & Stamp

UAP Old Mutual Insurance Uganda

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