CELLMED HEALTH
MEDICAL FUND

CELLMED VALUE PLAN MEMBERSHIP APPLICATION FORM

THIS APPLICATION WILL NOT BE PROCESSED IF IT IS NOT COMPLETED IN FULL

IF SUBSCRIPTIONS ARE NOT PAID IN ADVANCE BY THE 1st OF EVERY MONTH, BENEFITS WILL BE SUSPENDED

How did you get to know about us - Print Advert / Referral / Word of Mouth / Exhibition / Radio / Facebook / specify

Robert burns

SECTION I: EMPLOYER ACCOUNT HOLDER'S DETAILS

Employer's Name:	Cover Commencement Date:
Subsidiary's/Division's Name:	Authorised Signatory:

SECTION II: MEMBER DETAILS (This application will not be processed if not completed in full)

Surname:	First Names(s) :				ID Number:	
Title : Mr. / Mrs / Miss	Date Of Birth:	DD	MM	YYYY	EC Number :	Race:
Occupation:	Residential Address:				Contact Details:	
					Bus Tel:	
					Home:	
Name of Next of Kin	E-mail Address and Mobile Number of Next of Kin:				Mobile:	
					Fax:	
					E-mail:	

SECTION III: PLEASE TICK WHICH PLAN YOU WISH TO BE REGISTERED

Value	

SECTION IV: DETAILS OF YOUR GENERAL PRACTITIONER

Name:	Address:	Contact Number:

SECTION V: DEPENDANTS' INFORMATION (Attach copies of ID, Valid Passport or Birth Certificate for all members on this form)

Surname	First Name (s)	Date of Birth	Gender	Relationship	ID Number	Mobile Number

SECTION VI: BANKING DETAILS

Name of Bank:	Branch:
Branch Code:	Account Number:

SECTION VII: ANY OTHER INFORMATION

SECTION VIII: DETAILS OF PREVIOUS MEDICAL FUNDER (Attach certificate of membership)

MEDICAL FUNDER	MEMBERSHIP NUMBER	DATE OF JOINING	DATE OF TERMINATION

SECTION IX: CHRONIC DISEASE CONDITION

If you or your dependants suffer from any chronic condition, please provide details below

Full Name	Condition	Treatment Administered	Name of Doctor	Doctor's Telephone

MEDICAL HISTORY

It is most important that the following questions be answered as thoroughly as possible, by encircling the specific condition.
The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit.

ORGAN(S) / CONDITION	EXAMPLES OF CONDITIONS
Heart & Vascular System	High blood pressure, High cholesterol, Angina, Heart attack / failure
Lungs	Asthma, Emphysema, Chronic bronchitis, TB, Pneumonia
Digestive System, Gall Bladder & Liver	Peptic Ulcers, Reflux, Constipation, Gallstones, Jaundice, Hepatitis
Nervous System	Epilepsy, Degenerative Diseases - Alzheimer's, Parkinson's, Stroke
Bone, Muscle & Joints	Arthritis, Rheumatism, Gout, Osteoporosis, Knee or neck problems
Urinary Tract	Dialysis, Kidney transplant, Kidney stones, Chronic incontinence
Gynaecological System	Menopause, Female hormone replacement, Breast/ovarian tumours
Male Genital System	Prostate problems (Hypertrophy / Cancer or infections), Hernias-groin
Gland / Hormonal	Over / Under active thyroid, Diabetes mellitus, Addison disease
Blood	Anaemia, Bleeding disorders, Leukaemia, Hodgkin's disease
Ear, Nose & Throat	Allergies (Rhinitis, Sinusitis), Deafness hearing aids, Otitis-tonsilitis
Eyes	De-generative disease (Glaucoma, Cataracts) Poor vision, Artificial eyes
Emotional / Psychological Problems	Depression, Bipolar disorder, Alcoholism, Drug abuse
Infectious / Tropical Diseases	Sexually Transmitted Diseases, Genital warts, HIV / AIDS, Hepatitis
Skin Disorders	Acne, Eczema, Psoriasis, Shingles, Kaposi sarcoma tumours
Teeth & Gums	Impacted teeth, Previous / Current orthodontic treatment, Braces
Cancer	Cysts, Growths, Tumours of any kind of any organ
Pregnancy	Are you or any of your dependants pregnant? If yes - how many weeks?
Any Other (Specify)	

SECTION X: DECLARATION

I certify that the information given above was submitted willfully and is correct. I agree that should my application be accepted, I will abide by the rules, benefits and regulations set by CellMed Health Medical Fund (CellMed); details of which is available on request. Signing of this contract signifies the basis of contract between CellMed and myself.

Signature ..... Date .....