Member Application Form

METROPOLITAN HEALTH INSURANCE GHANA

Metropolitan House, 81 Tabon Link North Ridge Crescent, Accra-North, Ghana
PO Box AN 12408, Accra-North, Ghana

Please select only one option: (Indicate with an "X" in chosen block)

OPTION ☐ **Champagne** ☐ **Burgundy** ☐ **Turquoise** ☐ **Orange** ☐ **Beige**

Principal Member

Title Mrs. **Gender** Male ☐ Female ■ **Employer**

Surname

Maiden name

Registered First name

Initial(s)

Employee/Payroll no.

Weight KG **Height** M

Pensioner Y N **Smoking** Y N

Marital status Single ☐ Married ■ Divorced ☐ Widowed ☐ **Date of birth** (yyyy mm dd)

Form of identification Voter's ID ■ Passport ☐ Driver's Licence ☐ **Number**

Principal Member Address

Postal address

Town/city **Postal Code**

Residential address

Town/city **Postal Code**

Email address

Tel no. (h) (w) **Cellphone no.**

Please note: ONE telephone number is compulsory

Spouse / Partner details

Title Mr. **Initial(s)** **Cellphone no.**

Surname **Date of birth** (yyyy mm dd)

Maiden name **Gender** Male ■ Female ☐

Registered First name **Weight** KG

Dependants

(Complete special dependant form for mother, father, adopted/foster child, brother, sister or other relatives. Also complete special dependant form for children over the age of 21 years.)

Please use a seperate page if you have more than six dependants.

1. **Surname** | **ID no.**
   First names | **Date of birth** (yyyy mm dd) | **Gender** M ■ F □
   Initial(s) | **Relation**

2. **Surname** | **ID no.**
   First names | **Date of birth** (yyyy mm dd) | **Gender** M ■ F □
   Initial(s) | **Relation**

3. **Surname** | **ID no.**
   First names | **Date of birth** (yyyy mm dd) | **Gender** M □ F ■
   Initial(s) | **Relation**

4. **Surname** | **ID no.**
   First names | **Date of birth** (yyyy mm dd) | **Gender** M □ F ■
   Initial(s) | **Relation**

5. **Surname** | **ID no.**
   First names | **Date of birth** (yyyy mm dd) | **Gender** M □ F ■
   Initial(s) | **Relation**

6. **Surname** | **ID no.**
   First names | **Date of birth** (yyyy mm dd) | **Gender** M □ F ■
   Initial(s) | **Relation**

Medical History of Main Member and Dependants

Any previous or current treatment for a disorder or condition must be marked as YES. Answer all questions by selecting YES or NO. Where the answer is Yes, please give full details. A doctor's report may be requested in some cases.

Please circle the specific condition

EXAMPLE

Condition	Yes	No
Birth defects & inherited disorders - Spina Bifida, injuries, Heart Disorders or other.		

Condition	Yes	No
1. **Birth defects & inherited disorders** - Spina Bifida, injuries, Heart Disorders or other.	☐	■
2. **Dermatological** - Acne, Eczema, Pemphigus, Psoriasis, Fungal infections or other.	☐	■
3. **Musculo-Skeletal** - Osteo-arthritis, Rheumatoid arthritis, Osteo-sarcoma, Gout, Osteoporosis, Lupus Erythematosus or other.	☐	■
4. **Ear, Nose and Throat** - Deafness/Hearing impairment, Allergic Rhinitus, Recurrent Throat Infections, Vertigo, Chronic Sinusitis, Meniere's Disease or other.	■	☐
5. **Respiratory disorders** - Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis, Bronchiectasis or other.	☐	■
6. **Gastro-Intestinal** - Hiatus Hernia, Chronic Peptic Ulcer, Crohn's disease, Oesophageal reflux, Spastic Colon, Ulcerative Colitis, Malabsorbtion Syndrome or other.	☐	■
7. **Urological Disorders** - Chronic Renal Failure, Kidney Stones, Chronic Pyelonephritis or Prostatic Hypertrophy, Neurogenic bladder, Urinary incontinence, Urinary retention or other.	☐	■
8. **Neurological** - Cerebro Vascular Accident, Neuropathy, Epilepsy, Multiple Sclerosis, Neuralgia, Migraine, Parkinson's disease, Myasthenia Gravis, Stroke, Alzheimer's, Narcolepsy or other	☐	■
9. **Psychiatric** - Anxiety, Depression, Bipolar Mood Disorder, Schizophrenia, Sleep disorders, Attnetion Deficit Hyperactivity disorder, Neurosis, Obsessive-Compulsive disorder or other.	☐	■
10. **Metabolic disorders** - Lipid Disorders, Porphyria or other.	☐	■
11. **Cardiovascular** - Hypertension, Hypotension, Dysrrhythmias, Cardiac Failure, Hypercholesterolaemia, Aneurysm, Angina, Ischaemic Heart Disease, Peripheral Vascular or other	☐	■
12. **Liver and Pancreas Disorders** - Hepatitus, Cirrhosis, Gallstones, Pancreatitis, Chronic Cholecystitis or other.	☐	■
13. **Blood Disorders** - Anaemia, Leukemia, Haemophilia, Clotting Disorders, Thrombocytopenia or other.	☐	■
14. **Endocrine Disorders** - Diabetes Insipidus, Hypothyroidism, Hyperthyroidism, Addison's Disease, Cushing's Syndrome, Diabetes, Mellitus, Hypoglycemia or other.	■	☐
15. **Infections** - HIV, Hepatitus or any sexually transmitted disease	☐	■
16. **Cancer** - any form	☐	■
17. **Gynaecologist system** - Infertility, Endometriosis, Ovarian Cysts, Menopause, Menstrual disorders, Mastalgia or other.	☐	■
18. **Eye Disorders** - Impaired vision, Glaucoma, Retinopathy, other	■	☐
19. **Have/are you being compensated for any disability?**	☐	■
20. **Are you pregnant or do you suspect you are?**	☐	☐
21. **Any previous surgery?**	■	☐
22. **Any exclusions on previous medical aid?**	☐	■

Any other conditions *(Please use a seperate page if more than two conditions)*

If YES to any of the previous questions please complete the section below, and fill in the applicable condition number:
(Please use a seperate page if more information applies to relevant questions)

Condition No. ☐☐ **Patient** ☐ **Doctor** ☐

Treatment ☐ **Last Date of Treatment** (yyyy mm dd) ☐☐☐☐☐☐☐☐

Condition No. ☐☐ **Patient** ☐ **Doctor** ☐

Treatment ☐ **Last Date of Treatment** (yyyy mm dd) ☐☐☐☐☐☐☐☐

Condition No. 1 4 **Patient** ☐ **Doctor** ☐

Treatment ☐ **Last Date of Treatment** (yyyy mm dd) ☐☐☐☐☐☐☐☐

Current Chronic Medication *(Please use a seperate page if more than three chronic medications are used)*

Initials ☐ **Registered First Name** ☐

Surname ☐ **Medicine** ☐

Duration of use **From** (yyyy mm dd) ☐☐☐☐☐☐☐☐ **To** (yyyy mm dd) ☐☐☐☐☐☐☐☐

Initials ☐ **Registered First Name** ☐

Surname ☐ **Medicine** COLESTOP/ LOSARTAN POTASSIUM/ NIFECARD XL/ SELEVITE

Duration of use **From** (yyyy mm dd) ☐☐☐☐☐☐☐☐ **To** (yyyy mm dd) ☐☐☐☐☐☐☐☐

Initials ☐ **Registered First Name** ☐

Surname ☐ **Medicine** ☐

Duration of use **From** (yyyy mm dd) ☐☐☐☐☐☐☐☐ **To** (yyyy mm dd) ☐☐☐☐☐☐☐☐

Statement by Employer concerning Main Member

I, _____ (responsible officer)

of _____ (name of employer)

hereby state that the applicant is a certified staff member of the company and a participating member under:

OPTION ☐ Champagne ☐ Burgundy ☐ Turquoise ☐ Orange ☐ Beige

Payment by debit order (Individual members only)

I hereby agree to arrange with a financial institution to pay my annual contribution to this Health Plan as well as to update my stop order with every premium increase.

Annual Contribution _____ . _____

Name of account holder _____

Current ☐ Transmission ☐ Savings ☐

Name of bank/ building society _____

Branch name _____

Account no. _____

Branch code _____

Date of first deduction (yyyy mm dd) _____

Signature of Account Holder _____

Date _____

Statement by Main Member

I, _____ hereby state that:

(a) Should I be enrolled as a member of The Scheme, I will subject myself to the rules of The Scheme. The information herein is completed true to the best of my knowledge and conviction. No relevant information has been omitted. If after my admission to The Scheme, it is found that my statement or information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to The Scheme all payments which The Scheme have made on my behalf and to relinquish any claim to any benefits on the part of The Scheme.

(b) Should there by any deterioration or change in my state of health or in that of any of my dependants before the date or event to be set by The Scheme for the commencement of membership or the date of acceptance of this application by The Scheme; or the date of receipt of the first contribution, (whichever date is the latest), The Scheme will be entitled to reconsider the application and propose new terms of admission or declare the membership null and void.

(c) Any monies paid to The Scheme in terms of this membership, before The Scheme is informed of the change, shall be forfeited and benefits paid by The Scheme, shall immediately be refunded to The Scheme.

(d) I am bound now, and in the future, if we (myself and my dependants) are accepted as members, to give The Scheme all such information and evidence to The Scheme as they require from time to time. I authorise the attending medical practitioner or any other provider, to provide The Scheme with such information as it may require, hereby waiving the provisions of any law or regulation restricting the giving of such information.

(e) I undertake to pay any other amount due to The Scheme, on default. I hereby authorise my employer to deduct the due amount from my salary or any other monies due by me.

(f) In the event of voluntary resignation from The Scheme, I agree to give The Scheme one calender month notice, which must be received by The Scheme in writing by no later than the 7th of the month.

(g) I agree to call The Scheme client services with regards to any queries and pre-authorise any treatment as required by The Scheme.

Signature of Applicant _____

Date _____