Application Form

Alliance | health

Please read through the following before completing this application form in BLOCK CAPITALS. You must disclose all material facts. Failure to do so may invalidate the plan. A material fact is one which is likely to influence the assessment and acceptance of Your application for cover. If **You** are in any doubt whether a fact is material it should be disclosed. As the **Principal Member**, **You** should answer all the questions in full and sign the declaration on behalf of all persons included in this application for cover.

For Office use:

Intermediary:

Apply to join a **new Group** ☐ Apply to join an **existing Group** ☐ Apply to join as an **Individual / Family** ☐

Company/Group Name: No.

1. Your Personal Details (Principal Member)

Surname: Title:

First Name(s): I.D/Passport No.

Marital Status: Sex: M/F Date of Birth: day month year

Industry:

Occupation:

Nationality:

Country of Residence:

Residential Address:

Correspondence Address:

Contact Details

Home Telephone: Business Telephone:

Mobile: Fax:

Email: Email Option 2:

2. Dependant's Details

Dependant 1 (spouse or partner) *your spouse or partner should be able to act on your behalf in a legal capacity. Otherwise please complete separate applications.

Surname:

First Name(s): Sex: M/F

Contact Tel #: Title: I.D/Passport #

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Please note: Each child dependant should be your biological child. Where this is not the case please state "adopted" or "foster" and provide evidence. They must be under 18 years or under 25 years of age if they are in full time education and are fully dependent upon **You**.

Dependant 2

Surname:

First Name(s): Sex: M/F

Other Initials: Title: I.D/Passport #

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 3

Surname:

First Name(s): Sex: M/F

Other Initials: Title: I.D/Passport #

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 4

Surname:

First Name(s): Sex: M/F

Other Initials: Title: I.D/Passport #

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

3. Commencement Date:

Subject to the **Plan Agreement**, the commencement date of **Your Plan** must be first of the month.

Please note the commencement date cannot be more than 30 days from the date of completion of this application by **You**. Under no circumstances will we backdate cover.

Commencement Date: day month year

4. Cover Details

Please refer to the Table of Benefits for the particular benefits applicable to each plan

Alliance Options Select

Select 1 ☐ Select 2 ☐ Select 3 ☐ Select 4 ☐

Alliance Health Options

Core ☐ Core + ☐ Comprehensive ☐ Comprehensive + ☐

Multimed

Bronze ☐ Silver ☐ Gold ☐ Platinum ☐ Platinum Plus ☐

5. Payment Frequency

Annual ☐ Bi-Annual ☐ Quarterly ☐ Monthly ☐

6. Your Bank Details*

Bank Name:			
Branch:		**Branch Code:**	
Account Name:			
Bank Account #:			

*** Without this information, your claims will not be paid.**

7. Your Medical Practitioner's Details

Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner** and all other medical professionals whose advice you may have sought prior to this application, and in respect of **anyone else included in this application.**

Please use a separate sheet if this space is insufficient.

8. Pastimes, Hobbies, Activities and Pursuits

Please detail in the space below any activities that you, or any individuals listed in this application participate in on a regular basis (or more than three times in 12 months) which may be considered to be hazardous, dangerous or place you at greater risk of injury in comparison to the activities of your everyday life.

Please use a separate sheet if this space is insufficient.

9. Body Mass Index

Please furnish us with the following details for all applicants:

	Height (cm)	**Weight (kg)**	**(This column for office use)**
Principal			
Spouse (Dependant 1)			
Child (Dependant 2)			
Child (Dependant 3)			
Child (Dependant 4)			
Child (Dependant 5)			
Underwriter name: _____		**Date:** _____	

10. Medical History Questionnaire

(To be completed by the Principal Member on behalf of all family members applying for cover. If you answer **YES** to any of the questions below, please provide full details in the space provided overleaf - including dates.)

		Yes	No
1.	Have **You**, or anyone else applying for cover in this application form, ever been admitted to **Hospital** or other similar establishment?	1	
2.	Have you, or any of the other applicants listed on this enrolment application, ever undergone SURGERY?	2	
3.	Have you, or any of the other applicants listed on this enrolment application, ever received advice from a medical professional concerning improvements to be made to your diet and exercise habits?	3	
4.	Has your weight, or the weight of any other applicant listed on this enrolment application, changed by 5kgs or more in the last 12 months?	4	
5.	Have you, or any of the other applicants listed on this enrolment application, ever received advice from a medical professional for the reduction of alcohol consumption?	5	
6.	Have you or any of the applicants listed on this enrolment been prescribed medication, or received treatment for a period in excess ten (10) days in the last 24 months?	6	
7.	Are you, or any of the other applicants listed on this enrolment application, currently taking any prescribed medication?	7	
8.	Have any members of your family(and your spouse's/partners) immediate family ever been diagnosed with Asthma, Cancer, Porphyria, Mental Illness, Retinitis Pigmentosa, Diabetes, Epilepsy, Stroke, Chest Pain, Elevated Cholesterol, Heart Disease, or any hereditary disorder or condition? (please specify on the next page)	8	
9.	Are you or any proposed members pregnant or planning on falling pregnant?	9	
10.	Do You or any proposed members smoke, if yes how many per day? _____	10	
11.	Have you, or any of the other applicants listed on this enrolment application, ever experienced symptoms of, or received treatment or advice for any of the following:		
a.	Cancer	a	
b.	Breast Abnormalities e.g. benign or malignant growths, fibro-adenosis, mastitis, etc	b	
c.	Heart and/Circulatory Conditions e.g. angina, heart attack, valve disease/disorders, coronary artery disease, rheumatic fever, heart disease, hypertension (high blood pressure), cardiac arrhythmias, heart surgery, bleeding disorders, leukemia, high cholesterol, etc.?	c	
d.	Gynaecological Conditions e.g. ovarian cysts, uterine disorders e.g. fibroids, endometriosis, hysterectomy, cervical polyps, disorders of the fallopian tubes, etc?	d	
e.	Dermatological Conditions, including moles.	e	
f.	Mental Health e.g. bi-polar, depression, anxiety etc?	f	
g.	Metabolic or Endocrine Conditions e.g. including insulin resistance, diabetes, thyroid disorders, developmental growth disorders, phaeochromocytoma, pituitary gland disorders, etc?	g	
h.	Liver or Pancreatic Conditions e.g. peptic/duodenal ulcer, hiatus hernia, ulcerative colitis, divertculitis, pancreatitis, changes in bowel habits, liver disorders, spleen, etc?	h	
i.	Parasitic and Tropical Diseases (including malaria and bilharzia)	i	
j.	Brain, Neurological and Nerve Conditionse.g. brain, spinal chord, disc injuries or conditions, growth disorders, multiple sclerosis, parkinson's disease, motor neurone disorders, epilepsy, etc?	j	
k.	Respiratory Disorders e.g. asthma, bronchiectasis, chronic obstructive airways disease, emphysema, chronic bronchitis, pleurisy, tubercolosis, pneumonia, etc?	k	
l.	Musculoskeletal e.g. any disorders of the skeletal structure, arthritis, osteoporosis, rheumatism, tendonitis, physical disability, etc?	l	
m.	Kidney or Urinary Tract Disorders e.g. polycystic kidneys, glomerular nephritis, blood in urine, prostatism, renal failure, dialysis, complications of Bilharzia, etc?	m	
n.	Blood Conditions	n	
o.	Reproductive Disorders	o	
p.	Autoimmune Disorders or Immune System Disorders e.g. systemic lupus erythrematosis, sclerderma, HIV, etc.	p	
q.	Sight & Hearing Disorders e.g. cataracts, glaucoma, retinits, uveitis, hearing impairment, meieres disease	q	
r.	Specialised Dentistry (includes orthodontics, periodontal treatment, maxilla facial surgery)	r	
s.	Any form of plastic surgery or use of prostheses	s	

		YES	NO
12.	Do you or any of the other applicants registered on this enrolment application form have any **foreseeable** need to consult with a medical practitioner or any healthcare professional concerning health care treatment in the next twelve months?		12
13.	Do you or any of the other applicants registered on this enrolment application form suffer from or display any symptoms of ill-health, medical disorders or conditions?		13
14.	Are you aware of any factors concerning your health and wellbeing, and that of the other applicants on this form which might reasonably be considered to constitute an additional risk for treatment?		14

Important Information - Alliance Health reserves the right to send this completed form to your GP or our Medical Director for verification.

Please use this space to provide any details pertaining to section 10 as well as any additional information related to material facts. For every condition in the previous table for which you have indicated YES, please could you provide further details in the space below including dates of injuries and treatments, the names, dosages and frequency and start dates of prescribed medication, and the results of relevant diagnostic tests. Use a separate sheet of paper if there is insufficient space:

11. Lifestyle Questionnaire

ADULT 1 (Principal Member)	ADULT 2
Frame Size: Large Medium Small	**Frame Size:** Large Medium Small
Waist Size: _____cm	**Waist Size:** _____cm

PHYSICAL ACTIVITY: In the last 12 months, how frequently have you participated in some kind of physical exercise?

Adult 1	3 to 4 times a week	1 to 2 times a week	1 to 2 times a monthly	Not at all
Adult 2	3 to 4 times a week	1 to 2 times a week	1 to 2 times a monthly	Not at all

STRESS: Please rate your stress level on a scale of 1 to 10, with 1 being very low stress and 10 being very high stress:

Adult 1 1 2 3 4 5 6 7 8 9 10

Adult 2 1 2 3 4 5 6 7 8 9 10

FITNESS: Please rate your current level of fitness on a scale of 1 to 10, with 1 being least fit and 10 most fit:

Adult 1 1 2 3 4 5 6 7 8 9 10

Adult 2 1 2 3 4 5 6 7 8 9 10

Do you take any medication for anxiety and/or depression? Adult 1 **YES / NO** Adult 2 **YES / NO**

(Please indicate answer for Adult 1 and Adult 2 by writing A1 / A2 in the applicable box)

USE OF ALCOHOL: What is your average consumption of alcohol on a weekly basis? (drinks/number of units)

☐ Non Drinker ☐ 1 to 4 ☐ 5 - 8 ☐ 9 - 12 ☐ More than 12

On how many days did you drink alcohol on a weekly basis (average over the last 3 months)

☐ Non Drinker ☐ Once or twice ☐ Two to three days ☐ Four to seven days

USE OF CIGARETTES:

☐ I have never smoked
☐ I quit smoking more than 10 years ago
☐ I quit smoking less than 10 years ago
☐ I smoke less than 5 cigarettes a day
☐ I smoke 5 to 10 cigarettes a day
☐ I smoke 11 to 20 cigarettes a day
☐ I smoke more than 20 a day

USE OF MEDICATION: How frequently do you use medication to calm your nerves, or to help you to sleep?

☐ Never ☐ Rarely ☐ Sometimes (Monthly) ☐ On a weekly basis ☐ On a daily basis

WELLNESS TESTS: How often do you undergo a thorough physical medical examination?

☐ Almost never ☐ Every few years ☐ Every 2 years ☐ Every year

Women

How often do you have a PAP smear?

☐ Almost never ☐ Every 2 years
☐ Every few years ☐ Every year/Annually

How often do you have a mammogram?

☐ Never ☐ Every few years ☐ Annually

How often do you examine your breasts for lumps?

☐ Almost never ☐ Every few months ☐ Monthly

Men

How often do you undergo a prostrate test/examination?

☐ Almost never ☐ Every year/Annually
☐ Every few years ☐ Every few months

How often do you examine your testicles for lumps?

☐ Almost never ☐ Every few months ☐ Monthly

12. Declarations

On behalf of all the people applying for cover on this application form, I confirm that I have answered the all of the questions in this enroll form completely and truthfully and that I have declared all relevant material facts in the space provided. I understand that if I have not answered the above truthfully and disclosed all material facts, then Alliance Health has the right to invalidate this agreement.

I hereby acknowledge and agree that subject to the Terms and Conditions of membership, the benefits of my membership to may completely exclude the costs of treatment of any and all health condition(s), and/or any complications thereof, which had first presented symptoms, or for which treatment has been sought or received prior to the join date specified in Section 3 of this application.

I authorize the medical practitioners named in section 7, including any other physician or medical practitioner who has attended me or anyone else applying for cover in this application form, to provide Alliance Health with the information they may need in connection with any treatment related to a claim under this **Plan**.

I also authorize Alliance Health to furnish the aforementioned medical practitioners with our membership certificates where necessary.

I and all the people applying for cover on this application form confirm that we have read, understood and agree to all the Terms and Conditions set out in the **Plan Agreement**.

Signature: _____ Date: _____