Application Form

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 in sections 9, 10 and 11 on behalf of all persons included in this application for cover.

Please tick which of the following applies to you

Intermediary (if applicable):

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

Please note: child dependants 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 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:

Children:

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 01 month year

4. Cover Details

Multimed

Bronze ☐ **Silver** ☐ **Gold** ☐ **Platinum** ☐ **Platinum Plus** ☐

Alliance Health Options

Core ☐ **Core +** ☐ **Comprehensive** ☐ **Comprehensive +** ☐

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

5. Premium Payment Frequency

Annual ☐ **Bi-Annual** ☐ **Quarterly** ☐ **Monthly** ☐

6. Medical Practitioner 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.

7. Your Bank Details*

Name of bank:			
Branch:		Branch Code:	
Account name:			
Bank account #:			

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

8. Dangerous 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.

9. Pre-existing Health Condition(s)

I hereby acknowledge and agree that subject to the Terms and Conditions of membership, the benefits of membership to Alliance Health Options and Multimed may be restricted or completely exclude the costs of treatment of any and all health condition(s) and 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.

*(For Multimed applications only) However, if a period of two years has passed during which we have had no treatment or medication for the condition, and being symptom and advice free, then subject to the Terms and Conditions of cover, we will be covered for those conditions.

Signature: _____ 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.)

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 presribed medication, or received treatment for a period in excess ten(10) days in the last 24 monthsHave you or any of the applicants listed on this enrolment been presribed medication, or received treatment for a period in excess ten(10) days in the last 24 months 6
7. Have 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 Cancer, Porphyria, Mental illness, Retinitis pigmentosa, Diabetes, stroke,Chest Pain, Elevated Cholestrol, Epilepsy,Heart Disease, Asthma and any hereditary disorder or condition 8
9. Are you or any proposed members pregnant or planning on falling pregnant? 9
10. Do You or any propsed 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 e.g. Fibro - adenosis, mastitis, etc? b
    - c. Heart and/Circulatory Conditions e.g. Angina, Acute Myocardial Infarction, Valve Disease / Disorders, Coronary Artery Disease, Rheumatic Fever / Heart Disease, Hypertension (high blood pressure), Cardiac Arrhythmias, Heart Surgery, Bleeding Disorders, Leukaemia, 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 e
    - f. Mental Health e.g. Bi-Polar, Depression, etc? f
    - g. Metabolic or Endocrine Conditions e.g.including diabetes, thyroid disorders, developmental growth disorders,Phaeochromocytoma, Pituitary Gland Disorders, etc? g
    - h. Liver or Pancreatic Conditions h
    - i. e.g. Peptic / Duodenal ulcer, Hiatus hernia, Ulcerative Colitis, Divertculitis, Pancreatitis, changes in bowel habits, Liver disorders, Spleen, etc? i
    - j. Parasitic and Tropical Diseases (including Malaria and Bilharzia) j
    - k. Brain, Neurological and Nerve Conditionse.g. Brain, Spinal Cord, Disc Injuries or Conditions, Growth Disorder,Stroke, Multiple Sclerosis, Parkinson's Disease, Motor Neurones Disease, Epilepsy, etc? k
    - l. Respiiratory Disorders.g. Chronic Obstructive Airways Disease (Emphysema, Asthma, Bronchiectasis, Chronic Bronchitis), Pleurisy, Tubercolosis, Bronchitis, Pneumonia, etc? l
    - m. Musculoskeletal e.g. Rheumatism, Arthritis, Osteoporosis, Tendonitis, Disorders of the Skeletal Structure, Physical Disability, etc?e.g. Rheumatism, Arthritis, Osteoporosis, Tendonitis, Disorders of the Skeletal Structure, Physical Disability, etc? m
    - n. Kidney or Urinary Tract Disorders e.g. Polycystic Kidneys, Glomerular Nephritis, Blood in Urine, Prostatism, Renal failure, Dialysis, complications of Bilharzia, etc? n
    - o. Blood Conditions o

p.	Reproductive Disorders		p
q.	Autoimmune Disorders or Immune Sysytem Disorders e.g. Systemic Lupus Erythrematosis, Sclerderma, HIV,etc?		q
r.	Sight and Hearing Disorders e.g. Glucoma, Cataracts, Retinits, Uveitis, Hearing Impairment, Meieres Disease?		r
s.	Specialised Dentistry (includes orthodontics, periodontal treatment, maxilla facial surgery)		s
t.	Any form of plastic surgery or use of prostheses		t
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 12 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 - Multimed and Alliance Health Options reserve the right to send this completed form to your GP or our Medical Director for verification.

I confirm that I have answered the above questionnaire truthfully and declared all relevant material facts in the space provided overleaf. I understand that if I have not answered the above truthfully and disclosed all material facts, the cover will be invalidated.

Principal Member's Name:_____ **Signature:**_____ **Date:**_____

Please use this space to provide any details pertaining to section 8 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. Declaration

On behalf of all the people applying for cover on this application form, I confirm that the information given in this application form is true and complete.

I confirm that I have declared all material facts which relate to this application for cover. Hence, I agree that if I have not disclosed all material facts, Multimed / Alliance Health Options has the right to invalidate the **Plan**.

I authorize the medical practitioners named in section 6, including any other physician or medical practitioner who has attended me or anyone else applying for cover in this application form, to provide Multimed / Alliance Health Options with the information they may need in connection with any treatment related to a claim under this **Plan**.

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**.

*(For Multimed applications only) Unless the Group Administrator has chosen MHD cover and Multimed has not applied any exclusions of special conditions, I agree that me and any of my dependants applying for cover on this Group **Plan** will not be covered for treatment relating to pre-existing medical conditions or related medical conditions which we first had symptoms of, knew about, or for which treatment was received in the two years prior to the start date of this **Plan.** However, if after a period of two years has passed during which we have had no treatment or medication for the medical conditions, and being symptom and advice free, then subject to the Terms and Conditions of cover, we will be covered for those conditions.

Signature of applicant: Date: day month year