**Central Health Medical Aid**
Lilongwe Area 47/3/138
P.O Box 2739
Lilongwe
**www.centralhealthmw.org**

All Communication to **Managing Director:**
Mobile Number: **+265 (0) 991 802 538**
**+265 (0) 997 134 844**
Email: **info@centralhealthmw.org**

# MEMBERSHIP APPLICATION FORM

## PART A: APPLICANT'S DETAILS

**Member Name:** Mr/Mrs/Ms/Dr/Prof/Rev/H.E _____ **Gender**: Male ☐ Female ☐

Date of Birth: _____ Nationality _____ ID Number _____ Marital Status _____

**Phone Number(s):** _____ Email Address _____

Occupation: Employed ☐ Self Employed ☐ Not Employed ☐

Employer's Name _____ Type of Business _____

Employer Address _____

Department _____ Position _____ Location _____

## PART B: MEDICAL AID PLAN

Bronze: ☐ Silver: ☐ Gold (Executive): ☐ Diamond ( VIP): ☐ Diamond-Plus ( Super VIP): ☐

Emerald ( VVIP): ☐

## PART C: MODE OF PAYMENT

Quarterly ☐ Biannually ☐ Annually ☐

By:

Cash ☐ Cheque ☐ Mobile Transfers ☐ Online Transfer ☐ Standing Order ☐

## PART D: DEPENDANTS

| Surname | First Name | Gender | Date of Birth | Relationship to Member | Doctor/Hospital |
|---|---|---|---|---|---|
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## PART D: CONFIDENTIAL MEDICAL HISTORY

1. Do you or any family member have any other medical/healthcare insurance in force? Yes ☐ No☐

   If Yes, please give details:

   (i) Name of Insurer: _____

   (ii) Sum Insured: _____ (iii) Insurance Period: _____

2. Have medical/health insurance application or policy for you or any family member ever been declined or accepted with special terms? If Yes, please give details:

   (i) Application declined? Yes ☐ No☐

   Reason: _____

   (ii) Special terms to insure required? Yes ☐ No☐

   Reason: _____

   (iii) Renewal cancelled or refused? Yes ☐ No☐

   Reason: _____

## PART F: CONFIDENTIAL MEDICAL HISTORY

| | | Principal Applicant | Dependant One | Dependant Two | Dependant Three | Dependant Four | Dependant Five |
|---|---|---|---|---|---|---|---|
| 1 | **Medication** Are you, your spouse and dependant or any other, currently taking any medication? Please detail the name, dosage and frequency in the medication part G page 3. | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 2 | **Cardiovascular** Chest pain/angina, heart attack, heart failure, heart valve disease, high blood pressure, high cholesterol deep vein thrombosis (DVT), or any other heart or circulatory problems. | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 3 | **Respiratory & Breathing** Difficulty with breathing, tuberculosis (TB), emphysema, chronic bronchitis, asthma, or any other breathing problems. | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 4 | **Bladder & Kidneys** Kidney failure, polycystic kidneys, removal of kidney(nephrectomy), kidney stones, abnormal kidneys, any other kidney problems. | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 5 | **Reproductive & Gynaecological** Endometriosis, infertility, ovarian cysts, fibroids, hysterectomy, abnormal PAP smear, fibro-adonesis of the breast, hormone replacement therapy, prostate infenctions or surgery, prostate enlargement or any other reproductive problems. | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 6 | **Digestive System** Ulcers, pancreatitis, hiatus hernia,colon problems, crohnsdisease ulcerative colitis, gall bladder diseases, liver problems, colonyscopy or endoscopy. | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 7 | **Ear, Nose & Throat** Deafness, nasal surgery, throat surgery. | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 8 | **Other** Are there any other diseases/conditions related to you or your spouse or any other dependant's health that are not disclosed or listed above? | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No | ◯ Yes ◯ No |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 9 | **Dental**<br>Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, or other surgery or any other such surgery or problems. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 10 | **Eyes**<br>Blindness (partial or full), eye surgery, cataracts, glaucoma, retinitis pigmentosa or any other eyelid problems. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 11 | **Endocrine**<br>Diabetes, thyroid surgery or an other glandular problems. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 12 | **Joint Disease**<br>Rheumatoid arthritis, osteo-arthritis or any other joint disease. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 13 | **Musculoskeletal Disorders**<br>Neck, back, knee or shoulder problems or operations, recurrent back pain, osteoporosis, spondylitis or any other bone, skeletal or muscle disorders. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 14 | **Neurological**<br>Epilepsy, stroke (CVA), brain or head injuries, spinal code injuries, paralysis, mental retardation, parkinson's disease, alzheimer's disease or any other neurological disease. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 15 | **Psychological**<br>Psychosis, suicide attempts, bipolar disorders, schizophrenia, counselling or hospitalisation for alcohol or drug abuse or any other psychological conditions. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 16 | **Tumours and Growths**<br>Lymph gland cancer, leukaemia , breast cancer or any other tumours, growths and cancers. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 17 | **Blood**<br>Blood or bleeding disorders, platelet or any other blood clotting disorders, or have you ever had blood transfusion. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 18 | **Skin**<br>Eczema, psoriasis, skin cancer or any other skin disorders. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |
| 19 | **Hereditary Disorders / Family History**<br>Are you aware of any family history of Cancer, High cholesterol, Heart attacks or any other hereditary conditions or predispositions. | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No | ◯ Yes<br>◯ No |

## PART G: CURRENT MEDICATION DETAILS

if you answered YES to Question 1 in the Confidential Medical History Section kindly complete full details below

| Name of Applicant | Condition being Treated | Dosage, Name & frequency of prescribed medication | Date treatment commenced |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |

## PART H: DECLARATION

CERTIFICATION I hereby certify, represent and warrant:

(i) that I have read the above questions or they have been read to me, and I understand them,

(ii) that my responses to the questions are true, accurate and complete in all respects,

(iii) that I am (we are) currently in good health and, except for the conditions and other information disclosed herein, have not been diagnosed with, treated for, and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or financial and employment status, to provide such information to Central Health.

_____

Signature
Name of Applicant:
Date:

**MOST PREFERRED HOSPITAL**

In our quest to provide you with quality medical aid services please kindly list down your three (3) preferred hospitals where you would like to access medical services from time to time.

1 .....

2 .....

3 .....

**FOR OFFICIAL USE ONLY**

**Approved Plan:**

| | | | | | |
|---|---|---|---|---|---|
| Bronze | | Silver | | Gold | |
| Diamond | | Diamond-Plus | | Emerald | |

Reason for Approval: .....

.....

**Approved by** Name .....

Signature: .....

Date of Approval: .....