RESOLUTION INSURANCE

Number

Group Additional Member Form

(DO NOT STAPLE)
Attach 2 recent colour passport photos for **each** member of the family with the full name printed on the back.

Application for registration of additional dependants.
Adult dependants 19 years and above should complete a similar separate form unless where proof of full time student status is provided. (Student status only accepted up to the age of 25 years)
All questions are **mandatory** (if not applicable kindly indicate so)

(**Note**: Please complete all sections in Block letters and **BLACK** ink)

A: PRINCIPAL MEMBER DETAILS

Membership No. | ID No. | PP No.

Title | First Name | Middle Name | Surname

Full Name

B: DETAILS OF DEPENDANTS

	FULL NAME	Date of Birth	Gender	Relationship	Weight (kgs)	Height (ft)
2		D D M M Y Y	M F			
3		D D M M Y Y	M F			
4		D D M M Y Y	M F			

For dependants above 18 years of age kindly indicate identification/passport number below, sequence to match as above.

1. ID/PP No. | 2. ID/PP No. | 3. ID/PP No.

DEPENDANT CONTACT DETAILS (Over 18 years)

Name | Relationship

Number | Postal Code | Town

Postal Address

Code | Number | Code | Number

Telephone No. | Mobile No.

Employer/Group Name | Email Add.

C: DETAILS OF PREVIOUS MEDICAL COVER

Name of Scheme/Plan - Principal Applicant

From D D M M Y Y | To D D M M Y Y

E: MEDICAL HISTORY

Have you or any of your dependants ever had (been diagnosed and/or treated for) any of the following medical conditions?
Kindly answer **YES** or **NO** to all the questions below. Answers are required for each applicant. (Ask a Doctor for assistance if needed)
***Note**: if the answer is YES to any of the questions which follow, you will be required to provide full details of the medical condition. Resolution Insurance Company Limited may request you to provide a medical report, without which your application may be delayed.*

Numbering of dependants should match the sequence as under section B.				
Medical Condition		No. 1	No. 2	No. 3
1.	Cancer, growths or tumors whether benign or malignant	Y/N	Y/N	Y/N
2.	Cardiovascular (heart and blood vessels) disorders including High Blood pressure, heart disease, Deep Venous Thrombosis (DVT), congenital heart disease, chest pain, coronary artery disease/ischaemic heart disease, valvular heart disease, arrhythmias, varicose veins, coronary artery stenting, peripheral artery disease, aneurysm, angina, palpitations, rheumatic fever and any other	Y/N	Y/N	Y/N

Numbering of dependants should match the sequence as under section B.				
Medical Condition		No. 1	No. 2	No. 3
3.	Respiratory and Ear Nose and Throat (ENT) Disorders including asthma, tuberculosis, hearing & speech impairment, adenoids, cleft lip & palate, tonsils, nose injuries, nose bleeding, sinus, cigarette smoking bronchitis, allergic rhinitis, chronic obstructive pulmonary disease, and any other	Y/N	Y/N	Y/N
4.	Endocrine disorders including high cholesterol, diabetes, thyroid abnormalities, obesity, hormonal imbalances, diabetic coma and any other	Y/N	Y/N	Y/N
5.	Eye related disorders including glaucoma, blindness, cataracts, retinitis pigmentosa, lens implants, laser surgery, retinoblastoma and any other	Y/N	Y/N	Y/N
6.	Gastro-intestinal, disorders including peptic ulcer disease, heartburn, reflux, dyspepsia, haemorrhoids, pancreatis, gall bladder disease, hepatitis, hernias, anal fissures, rectal bleeding, endoscopy	Y/N	Y/N	Y/N
7.	Gynaecological & Obstetric disorders including caesarian section, fibroids, ovarian cysts, infertility, pelvic inflammatory disease, menstrual irregularities, abnormal pap smear, hormonal treatment, miscarriages, endometriosis, laparascopic surgery and any other	Y/N	Y/N	Y/N
8.	If pregnant, indicate expected date of delivery D D M M Y Y	Y/N	Y/N	Y/N
9.	Genitourinary disorders including enlarged prostate, kidney failure, dialysis, kidney stones, bladder disorders, pyelonephritis, syphilis, gonorrhea, chlamydia, genital herpes and any other	Y/N	Y/N	Y/N
10.	Musculoskeletal disorders including arthritis, gout, back problems, physical disabilities, joint problems, sporting injuries, osteoporosis, scoliosis, kyphosis and any other	Y/N	Y/N	Y/N
11.	Neurological & psychological disorders including epilepsy, mental disabilities, paralysis, schizophrenia, depression, bipolar disorder, panic attack, personality disorder, anxiety, attention deficit disorder, post traumatic stress disorder, attempted suicide, anorexia nervosa, bulimia, alcohol or drug dependency/addiction and any other	Y/N	Y/N	Y/N
12.	Blood & connective tissue disorder including leukemia, HIV & AIDS, Systemic Lupus Erythematosus (SLE) and any other	Y/N	Y/N	Y/N
13.	Congenital/inherited/hereditary disorders including birth defects, sickle cell disease, umbilical hernia and any other	Y/N	Y/N	Y/N
14.	Skin disorders including eczema keloids, warts, acne, moles, melanoma, skin cancer, hypertrophic scars, burns and any other	Y/N	Y/N	Y/N
15.	Has any close blood relative (excluding dependants) ever been diagnosed with heart disease, high cholesterol, diabetes or any other hereditary disease?	Y/N	Y/N	Y/N

*If you answered yes to any of the questions above please supply **full details** on a separate sheet.*

State name, specialty and phone number of your medical practitioner to whom reference may be made.

Name _____ Telephone No. | | | | | | | | | | |

DECLARATION

- I hereby apply for myself and my dependants to be registered on the Resolution Insurance Company Limited Medical Scheme (the "Scheme"). I understand that any mis-statement or the non-disclosure of any material information in this form will entitle the scheme to repudiate claims, suspend, cancel and or terminate membership.
- I warrant that the answers in this form are true, correct and complete and I acknowledge that such answers are all material.
- I hereby authorize the hospital, medical or dental practitioners who have treated me or any of my dependants to disclose to the Scheme the records relating to such current or previous hospitalizations / medical treatment / test or examinations and to allow the Company to receive extracts from such records and undertake to assist in obtaining such information.
- I further authorize and instruct the Scheme and any hospital concerned to give information relating to myself and my dependants to the Medical Care Managers appointed by the Scheme for purposes of ensuring that the members of the Scheme receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources.
- I understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary including the results of such medical examinations and tests that they may require me or my dependants to undertake.
- I hereby authorize the scheme to institute proceedings against third parties in recovery of costs and expenses incurred or paid by the scheme under the terms hereof due to acts of negligence by such third parties and in circumstances where expenses so paid were instead due from a third party.
- I undertake to participate fully in the recovery proceedings so instituted.

Signature of Principal Member: ..... Dated this DD **Day of** MM **20** YY

RESOLUTION INSURANCE

RESOLUTION INSURANCE COMPANY LIMITED

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Protecting what *you* value