APPLICATION FOR TRANSFER ENROLMENT

Individual and Family Membership

Telephone: +263 (0)772 126 129, +263 (0)712 347 880, email enquiries@healthzim.com

Thank you for choosing to transfer to the Alliance Health Options international health plan. You must complete this document in full. Please do not leave any sections blank. You must disclose as much information as you can. Where you would like to include further detailed information, please do so. Medical reports from your doctor may be required to validate any updated information provided in your medical history.

Please ensure that you print clearly in UPPER CASE BLOCK CAPITALS to ensure that your information can be accurately read and adjudicated. All applications are adjudicated by our membership department, and we reserve the right to reject applications for TRANSFER.

When you sign this application, you are confirming that you have read and understood the terms and conditions of membership and that you agree to them. Please ensure that you read and understand these terms and conditions. If you have any questions or queries, please discuss these with your financial or health care advisor.

Advisory Agent	

SECTION 1

If you, or any members of this application have previously been members of an international health plan or private medical insurance, please ensure that you include copies of your most recent membership certificate and where possible copies of your original applications. Please consult with your personal financial or health care advisor.

1. **Please ensure that you include a copy of your most recent membership certificate with this application.**
2. **Unless you are a member of a Multimed, NMAS or Northern Alliance scheme you are required to enclose a copy of your original application form. If you cannot enclose such a copy, then you are required to complete a new application form.**
3. **Unless you are a member of a Multimed, NMAS or Northern Alliance scheme you are also required to enclose a copy of the last two years of your medical records and test results held by your family doctor.**

MAIN APPLICANT

Surname		Title	
First Names			
Occupation			
Previous Plan Provider			
Plan or Scheme Name			
Member Number			
ID Number			

SECTION 2

DEPENDANT MEMBER 1 (spouse or partner*)

Surname		Title		M/F	
First Names					
Member Number/ID Number					

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

DEPENDANT MEMBER 2 (child*)

Surname		Title	M/F
First Names			
ID Number			

*Your child should be your biological child. Where this is not the case please state "adopted" or "foster" and provide evidence

DEPENDANT MEMBER 3 (child*)

Surname		Title	M/F
First Names			
ID Number			

*Your child should be your biological child. Where this is not the case please state "adopted" or "foster" and provide evidence

DEPENDANT MEMBER 4 (child*)

Surname		Title	M/F
First Names			
ID Number			

*Your child should be your biological child. Where this is not the case please state "adopted" or "foster" and provide evidence

SECTION 3 - Please provide us with your bank account details for reimbursement of claims due to you

Bank		Branch	
Account Name			
Account Number		Branch Code	

Signature of Account Holder:

SECTION 4

Please select your health plan by filling in your proposed start date next to the plan of your choice (**one only**)

Plan Name	Basic Benefits Scope*	Start Date
CORE	Hospital + Cancer	/ /
CORE ✚	Specialists & Diagnostics + Hospital + Cancer	/ /
COMPREHENSIVE	Family Doctor + Medication + Dental Treatment + Specialists & Diagnostics + Hospital + Cancer	/ /
COMPREHENSIVE ✚	Complementary Therapy + Routine Healthcare + Maternity + Family Doctor + Medication + Dental Treatment + Specialists & Diagnostics + Hospital + Cancer	/ /

SECTION 5 – Declaration

I hereby confirm that I have the right to apply for the transfer of my membership and that of my dependents and I confirm that I am legally able to act on behalf of the dependents listed on this form. I request Alliance Health to take all necessary steps to transfer my benefits of membership from my existing membership to the benefits of membership to Alliance Health Options.

As such, I hereby authorise Alliance Health to use all of the information that I have ever provided to them as may be required for the adjudication and processing of this application. On behalf of myself and the other applicants listed on this enrolment application form I confirm that all such information supplied is both accurate and complete. I have read, understood and agree to the terms and conditions of membership, as well as the limitations regarding benefits use for pre-existing health conditions. I agree to follow the procedures and protocols of benefits use as set out in the terms and conditions of membership. I authorise the medical practitioners specified in my medical records to provide Alliance Health with full access to all of my medical records and to provide Alliance Health with any information that they may request at any time. I accept any adjudications and decisions taken by the Medical Advisory Board of Alliance Health regarding my medical history as binding as final. I agree that should it transpire at any time that I have not made a full and truthful disclosure of all material facts and required information in this application, that my membership will be cancelled and declared invalid.

Name:

Signature: Date: / /