Application Form

THE NORTHERN MEDICAL AID SOCIETY

northern Alliance

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 **Cover.** 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 section 7 on behalf of all persons included in this application for cover.

Please tick which of the following applies to **you**

Agent (if applicable):

Apply to join a **New Group Plan** ☐ Apply to join an **Existing Group Plan** ☐ Apply to join as an **Individual** ☐

Company/Group Name: No.

1. Your Personal Details (Principal Member)

Surname: Title:

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

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

Industry:

Occupation:

Nationality:

Country of Residence:

Residential Address:

Correspondence Address:

Home Telephone: Business Telephone:

Mobile: Fax:

Email: Email Option 2:

2. Dependant's details

Please note children to be included under this plan must be under 18 years of age or under 25 years of age if they are in full time education and are fully dependent upon **You**.

Dependant 1

Surname:

First Name(s): Sex: M/F

Contact Tel #: Title: I.D/Passport No.

Relationship to Applicant: Date of birth: day month year

Occupation:

Nationality:

Dependant 2

Surname:

First Name(s): Sex: M/F

Other Initials: Title: I.D/Passport No.

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 No.

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 No.

Relationship to Applicant: Date of birth: day month year

Occupation:

Nationality:

3. Commencement date

Subject to the **Plan Rules**, the commencement date of **Your Cover** will be the date on which this application is accepted in writing by **Us**.

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

Northern Alliance: 10N ☐ 20N ☐ 30N ☐

NMAS: Standard ☐ Superior ☐ Superior + ☐ Superior ++ ☐

5. Medical Practitioner Details

Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application.

Please use a separate sheet if this space is insufficient.

6. Your Bank Details

Name of bank:

Branch:

Account name:

Bank account #:

7. Medical Questionnaire

Please answer the following questions by ticking Yes or No. Where You have ticked Yes, please provide full details below.

	Yes	No
1. Has your weight, the weight of your spouse or any of your adult dependants applying for cover changed by more than 5kgs in the past year?		
2. Are you or any of your dependants using any routinely prescribed medication?		
3. Has any parent or sibling or any proposed member wanting cover, ever suffered from porphyria, cancer, mental illness, retinitis pigmentosa, diabetes, stroke, chest pain, high cholesterol or any other hereditary disorder or condition?		
4. Are you or any proposed members pregnant or planning on falling pregnant?		
5. Do you or any proposed members smoke, if yes, how many per day? ...../day.		
6. Have you or any of the proposed members received medical advice for the reduction of alcohol consumption?		
7. Have you or any proposed members (i) suffered from or (ii) been treated for (iii) currently suffered from medical conditions relating to any of the following:		
a) **The Central & / or Peripheral Nervous System** e.g. brain, spinal cord, disc injuries or conditions, growth disorder, stroke, multiple sclerosis, Parkinson's disease, Motor Neurones disease, Epilepsy, etc?		
b) **Eye & Hearing Disorders** e.g. Glaucoma, Cataracts, Retinitis, Uveitis, Hearing impairment, Meieres disease. etc?		
c) **Cardiovascular Disorders** 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?		
d) **Respiratory Disorders** e.g. Chronic Obstructive Airways Disease (Emphysema, Asthma, Bronchiectasis, Chronic Bronchitis), Pleurisy, Tubercolosis, Bronchitis, Pneumonia, etc?		
e) **Gastrol-intestinal Disorders** e.g. Peptic /Duodenal ulcer, Hiatus hernia, Ulcerative Colitis, Divertculitis, Pancreatitis, changes in bowel habits, Liver disorders, Spleen, etc?		
f) **Kidney or Urinary Tract Disorders** e.g. Polycystic Kidneys, Glomerular Nephritis, blood in urine, Prostatism, Renal failure, Dialysis, complications of bilharzia, etc?		
g) **Gynaecology** e.g. Ovarian Cysts, Uterine disorders e.g. fibroids, endometriosis, Hysterectomy, Cervical Polyps, disorders of the Fallopian tubes, etc?		
h) **Breast Abnormalities** e.g. benign or malignant growths e.g. Fibro - adenosis, mastitis, etc?		
i) **Endocrine Disorders** e.g. Hypo / Hyperglycaemia (Diabetes), Hypo / Hyperthyroidism, Phaeochromocytoma, Pituitary Gland Disorders, etc?		
j) **Autoimmune Disorders** e.g. Systemic Lupus Erythrematosis, Scleroderma, HIV, etc?		
k) **Musculoskeletal** e.g. Rheumatism, Arthritis, Osteoporosis, Tendonitis, disorders of the skeletal structure, physical disability, etc?		
l) **Specialist Dental** e.g. Orthodontic, Peridontal, Maxillo Facial, etc?		
m) **Injuries**		
n) **Any other**		

Please use this space to provide any details pertaining to section 7 as well as any other additional information that maybe material. Use a separate sheet of paper if there is insufficient space:

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

Age restriction for joining is **64 years** attained.

12 months waiting period applies for Maternity and General Wellness check benefits.

6 months waiting period applies for Dental and Optical benefits.

24 months waiting period applies for Orthodontics benefit.

Subscriptions are due in full by the 1st of every month. Cover / claims are suspended while subscriptions remain unpaid.

Please obtain and read a copy of the Rules & Benefits of Northern Alliance / Northern Medical Aid Society. (Available on the website www.alliancehealth.co.zw) or email clientservices@healthzim.com

(For Northern Alliance applications only) Pre-existing and all related medical conditions will be excluded from benefit / claim unless you have chosen to have a loading.

(For Northern Medical Aid Society applications only) Pre-existing and all related medical conditions will be excluded from benefit / claim unless specifically agreed in writing by The Society.

Northern Alliance and Northern Medical Aid reserve the right to decline any application.

Please note: Your application will not be automatically accepted. It is subject to assessment and Board approval.

8. 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 Northern Alliance / Northern Medical Aid Society has the right to invalidate the **Cover**.

I authorize the medical practitioners named in section 5, including any other physician or medical practitioner who has attended me or anyone else applying for cover in this application form, to provide the Northern Alliance / Northern Medical Aid Society administrators with the information they may need in connection with applying for cover and any treatment related to a claim.

I and all the people applying for cover on this application form confirm that we agree to all the Terms and Conditions set out in the **Management Rules & Schedule of Benefits.**

Signature of Applicant: _____ Date: day ____ month ____ year ____

OFFICE USE ONLY

Northern Alliance / NMAS Representative's Name:_____ Signature:_____ Date:_____

Accepted ☐ Declined ☐ Loading_____

Signed_____

Underwriting

Alliance Health Lifestyle Questionnaire 2015

Alliance health

Date: / / Name:_____Signature: _____

Please complete this questionnaire selecting the most appropriate answer for each question.

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

☐ 3 to 4 times a week ☐ 1 to 2 times a month ☐ 1 to 2 times a week ☐ Not at all

Which types of physical exercise do you enjoy?

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:*

1 2 3 4 5 6 7 8 9 10

Do you take any medication for anxiety and/or depression?

CURRENT WEIGHT AND HEIGHT

Weight:_____ kgs Height:____cm BMI_____ **Frame Size:** Large Medium Small **Waist Size:**

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

1 2 3 4 5 6 7 8 9 10

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
☐ 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 relax or to help you to sleep?*

☐ Never ☐ Rarely – a few times a year ☐ Sometimes (Monthly) ☐ On a weekly basis ☐ On a daily basis

WELLNESS TESTS: *How often do you undergo a thorough physical 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

How often do you have a mammogram?

☐ Never ☐ Every few years ☐ Every year

How often do you examine your breasts for lumps?

☐ Almost never ☐ Every few months ☐ Every month

Men

How often do you undergo a prostrate test/examination?

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

How often do you examine your testicles for lumps?

☐ Almost never ☐ Every few months ☐ Every month