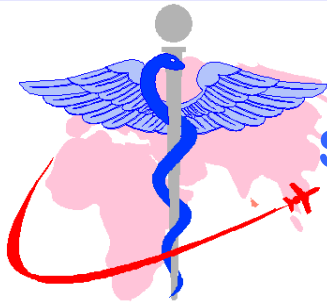


MEDTOUR APPLICATION



Specialty Emergency Services Med Rescue

P.O.Box 31500, Lusaka, Zambia
The Grove, Kafue Road, Lusaka
Tel:(2601) 273302 - 7
Fax: (2601) 273181 / 273301
E-mail: med@zamnet.zm

MedBronze MedSilver MedGold Individual Group
 Annual Short-term Others Family From _____ to _____

	Surname	First Names	Date of Birth	Passport No.	Occupation
Principal Member					
Spouse					
Child 1					
Child 2					
Child 3					
Child 4 (extra)					
Residential address			Telephone no. (home):		
			Fax no.:		
			Cell No:		
Postal address:			Telephone no. (work):		
			Fax no.:		
			Radio call sign / e-mail:		
Next of kin name:			Relationship:		
Next of kin address:			Telephone no. (home):		
			Telephone no.(work)		
			Fax no.:		

Please mark with an X if you compete/ participate in anyone of the following activities:

Flying Motor X Hunting Equestrian Events Other

Do you have any other health plan? Are you covered by a specific or annual travel insurance policy?

Please give details _____

Have you received treatment for any disease, sickness or chronic illness in the last 12 months? yes No

If so kindly have the form filled in by your medical practitioner

Declaration by medical practitioner: (if applicable)

I hereby declare that the above persons have received the following treatment during the last 12 months

Medical condition	_____

Treatment	_____

Signed	_____

Declaration by applicant:

To the best of my knowledge and belief all persons enrolled are in good physical health and free from physical defect or infirmity except where the condition has been disclosed herein on the medical questionnaire.
 I am not aware of any reason for the above health plan to be cancelled or curtailed and I have not withheld any material facts.
 I understand that non-disclosure or misinterpretation of a material fact will entitle SES to void this medical plan.
 I declare that I have been provided with a copy of the terms & conditions and have read myself and on behalf of those for whom I seek to enrol on your health plan.
 I understand that this health plan starts from the date of issue of the health plan and therefore no refund of subscriptions will be allowed if this health plan is cancelled.

Signed _____ Date _____

For office use only

Subscription fee: _____ Receipt No.: _____ Membership No.: _____

HEALTH DECLARATION Please answer yes or no to each of the following questions:-

*** Delete Yes or No as appropriate**

1. Have any persons named in this application ever:-

A. undergone a surgical operation?	Yes / No*	C. Been advised to have any medical tests or investigations	Yes / No*
B. Been a patient in a hospital, clinic or sanatorium	Yes / No*	D. Been tested HIV Positive	Yes / No*

2. Have any persons in this application ever suffered from, been diagnosed with, treated or perscribed drugs for:-

A. conditions of the eyes, ears, nose or throat?	Yes / No*	H. Any genito - urinary or renal conditions?	Yes / No*
B. Any nervous or mental conditions, fainting, blackouts or fits?	Yes / No*	I. Any stomach, liver, or bowel conditions?	Yes / No*
C. Any high blood pressure, heart or circulatory conditions?	Yes / No*	J. Any cysts, tumour or cancer?	Yes / No*
D. Diabetes?	Yes / No*	K. Any skin conditions?	Yes / No*
E. Any rheumatic or arthritic conditions?	Yes / No*	L. Any gynaecological conditions?	Yes / No*
F. Any spine, bone, muscle or joint conditions?	Yes / No*	M. Any physical defect, infirmity or congenital illness?	Yes / No*
G. Any Asthma, respiratory, or allergic conditions?	Yes / No*	N. Any other type of disease, injury or medical conditions?	Yes / No*

3. Are any of the persons named in this application aware of any symptoms present which may give rise to a claim?

Yes / No*

4. Are any persons named in this application currently taking any drugs or medication?

Yes / No*

If you have answered YES to any of the above questions, please give full details about each condition by answering the following questions in as much detail as possible

Question No:			
State the name of the person who suffered the illness / injury:			
State the name and address of the treating physician:			
State the date(s) on which the illness / injury occurred:			
Give full details of the treatment / tests performed and the results:			
When did you last suffer from symptoms or receive treatment relating to this condition?			
Is there any foreseeable need for further consultation or treatment for this condition? If yes please Give details.			

We cannot accept your application if this health declaration is incomplete. If we need to contact you for further information, please give us a personal contact number we can use

Telephone		Fax	
		e-mail	

PLEASE STATE THE NAME, ADDRESS AND CONTACT NUMBER OF YOUR FAMILY DOCTOR:-

Declaration

I hereby apply for enrollment under the Health Plan. I declare that I have read and understood the Health Plan rules and that I am aware that plan shall be provided in accordance with the Rules, and that pre-existing conditions as defined in the Rules shall not be covered by this Health Plan

I understand that upon receipt of my Health Plan documents, if I am not entirely satisfied, I can cancel this application and receive a full refund of the subscription I have paid, (provided that I do not submit any claim), if I return my documents to the company limited within 30 days of the start of the plan.

I authorise the doctor named above and any other physician or medical practitioner who has attended me and any of my dependants included under this plan to provide the company with the information they may need in connection with treatment related to any claim under this plan.

I declare that the information given in this application is true and complete.

If I have applied for a travel health plan I declare that at the time of purchasing this health plan or at the time of booking any future trip(s), I am aware of no reason why any journey or trip should be cancelled or curtailed or expense be incurred.

I understand that the company will give me 4 weeks of notice of renewal and that subscriptions may vary each year.

I understand that the company cannot be liable if my subscription is lapsed should the credit / Debit card be declined and I do not respond to requests for alternative methods of payment.

Signature of Applicant	Date
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PLEASE ENSURE YOU HAVE GIVEN AN ANSWER TO EVERY QUESTION. AN INCOMPLETE FORM WILL DELAY YOUR APPLICATION



MedTour: Insurance Details

Medical Insurance

Group Contract Details

Medical Insurance	
Member number	
Policy Type	
Group Name	
Group Number	
Certificate number	
Start Date	
Renewal Date	

Telephone No.	
Fax No	
Cell no.	
e-mail address	
Contact Person	

Individuals covered

	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
Member Surname	0	0	0	0	0	0
Member Name	0	0	0	0	0	0
Member Number						
Product Purchased						
Start Date						
Renewal date						

Endorsement	
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Gaurentee of Payment

Company Details

Company Name	
Telephone Number	
Fax Number	
e-mail address	

Address	
Postal Address	

Authorised Contact Person

Name	Position	Telephone Home	Telephone work	Cell Number	e-mail Address

Maximum Amount	
Date until valid	

Remark:	
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MEDTOUR APPLICATION FORM

Name of Group:

Postal Address:

Physical Address:

Telephone:

Fax:

e-mail:

Other:

Authorized

Contact Persons

Position

Address

Telephone

.....
.....
.....
.....
.....
.....
.....
.....
.....

Payment per employee:monthlyquarterlyannually

Guarantee of Payment:Company/CorporateBank
(please tick where applicable)

Maximum Amount of GOP US\$.....

Note: Premiums paid are transferable

It is understood that the services provided by Specialty Emergency Services only become available in terms of MedTour on receipt of a completed application form for each member and the first payment

Signed at: On

By: Signature:

