SPECIALTY EMERGENCY SERVICES

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"Giving healthcare a human touch"

A Your Personal Details

Please complete the following details for yourself as the main applicant

Title:(Mr, Mrs, Miss, Other)			
Surname:			
First Name(s):			
Date Of Birth:		Sex at Birth:	M F (tick as appropriate)
Nationality:		Passport No:	
Occupation:			
Residential Address			
		Postcode	
Postal Address			
		Postcode:	
Telephone No:		Mobile No:	
Email:(home)		Email:(Other)	
Next of Kin Name:		Relationship:	
Next of Kin Address:		Mobile No:	

Do you and/or any family member participate in any competitive sporting activities ☐ Yes ☐ No

If Yes, please give full details of any sporting activities you participate in, and how often:

Competitive sporting Activities include (but are not limited to): parachuting; gliding; paragliding; parascending; scuba diving; hang-gliding; bungee jumping; polo; motor rallying and motor-cycle racing, flying other than as a passenger in commercial aircraft, Equestrian Events, or any other high risk activity.

Have you previously held a policy, or do you currently hold a policy with Specialty Emergency Services ☐ Yes ☐ No

Previous/Current policy No: Date of Expiry of Policy:

Have you previous been insured, or are currently insured, with another health insurer? ☐ Yes ☐ No

Name of Insurer:

Were you excluded from any benefits as a result of a pre-existing medical condition/chronic illness: ☐ Yes ☐ No

Notes:

B Health Plan Applied For

☐ Tanzanite ☐ Amethyst ☐ Sapphire ☐ Silver ☐ Gold ☐ Gold+ ☐ Platinum

OPTIONS: ☐ Pregnancy (Gold only) ☐ Sports Cover

Frequency of Premium Payment: ☐ 1) Annually ☐ 2) 6 Monthly

C Family Members

Please enter the names and details of all dependents for whom cover is required. You may include your partner and children, up to age 18 (or up to age 25 if in full-time education - proof will be required). Children aged 18 or over who are not in full-time education must make their own application for cover.

	Surname	First Names	Occupation	Passport No	Date of Birth	Sex at Birth
Main Member						
Spouse						
Child 1						
Child 2						
Child 3						
Child 4						

D Health Declaration

Specialty Emergency Services are not obliged to provide cover for any pre-existing or past conditions for which you have previously received medication, advice or treatment or experienced symptoms, whether the condition has been diagnosed or not, at any time before the start of your cover. A related condition is any disease, illness or injury that is caused by a pre-existing condition or result from the same underlying cause as a pre-existing condition.

If we choose to accept pre-existing or past conditions then we may apply special terms, exclusions or loading at our discretion.

If you require treatment of any pre-existing or related condition that you have omitted to declare on this application form or you omit to disclose full details surrounding, we are not obligated to pay any associated claims.

Specialty Emergency Services withhold the right to refuse membership or apply special terms, exclusions or loading for any new application or renewal..

Please therefore take the greatest care to ensure that this application form is completed fully and accurately.

If you are uncertain about whether any particular fact needs to be disclosed, you should include it.

If after completing your application form, any changes occur that may affect the information provided by you in this form, such as a change in your state of health or the state of health of any of your dependents, must tell us in writing about the change. Specialty Emergency Services reserve the right to decline or accept your application with special terms, exclusions or loading on receipt of any further health information.

PLEASE NOTE: If you fail to disclose all current and previous medical conditions at each new application or renewal your Specialty Emergency Services membership will be void.

E Medical History

This section asks for health and medical details, past and present, about person named in section C. Please complete every question for every individual.

If you answer Yes to a question, please give full details in section F on the next page. If you are unsure whether any details are relevant, you must include them.

Within the last four years, have you or anyone to be covered under the membership:

- Seen a GP or other health care professional
- Received Treatment
- Experienced Symptoms

	Main Member		Spouse		Child 1		Child 2		Child 3		Child 4	
Name												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Heart or cardiovascular disorders: e.g Coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers, cholesterol.												
2. Glandular disorders: e.g Diabetes, thyroid, hormonal problems.												
3. Breathing or Respiratory disorders: e.g												
Asthma, bronchitis, shortness of breath, chest infections, colds, flu.												
4. Ear, Nose, Throat or Eye problems: e.g Hay fever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections.												
5. Stomach, Intestines, Liver or Gallbladder: e.g Ulcer, colitis, repeated indigestion, irritable bowel, change in bowl habits, hepatitis, piles, rectal bleeding.												
6.Cancer, Tumors, Growths, Cysts or Moles that itch or bleed												
7. Skin Problems: e.g Eczema, rashes, psoriasis, and acne.												
8. Brain or Nervous system disorders: e.g stroke, migraines, repeated headaches, MS, epilepsy, nerve pains, fits												
9. Muscle or Skeletal problems: e.g Arthritis, cartilage and ligament problems back and neck problems, sprains, joint replacements, gout, sciatica.												
10. Urinary problems: e.g Bladder, kidney or prostate problems, urinary infections, incontinence.												
11. Blood disorders: e.g Anemia, hepatitis, HIV, abnormal blood tests												
12. Reproductive system disorders: e.g Pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause.												
13.Dental problems: e.g Wisdom, teeth, abscess, gingivitis.												
14.Allergies												
15.Psychological disorders: e.g. Depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety.												
16.Auto-immune disorders: e.g. HIV, sjorgens syndrome, lupus, multiple sclerosis, rheumatoid arthritis.												

Please also answer the following questions:

	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
17.Are you or any prospective member taking chronic any medicines, prescribed or otherwise?												
18. Are you or any prospective member receiving any treatment of any kind?												

F Additional Information

If you have answered YES to any questions, please give full details below. Please continue on a separate sheet if necessary.

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and Contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and Contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and Contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and Contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and Contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and Contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Please give details of the doctor who is most familiar with the medical history of each person named in this application

Name of Doctor:		Tel	
Email:		Length of time treating applicant:	
Name of Doctor:		Tel	
Email:		Length of time treating applicant:	
Name of Doctor:		Tel	
Email:		Length of time treating applicant:	
Name of Doctor:		Tel	
Email:		Length of time treating applicant:	
Name of Doctor:		Tel	
Email:		Length of time treating applicant:	
Name of Doctor:		Tel	
Email:		Length of time treating applicant:	

G Disclosure by Applicant

I have made a full and complete disclosure about the medical history of each person included in this application and fully understand that pre-existing conditions shall not be covered by this policy.

To the best of my knowledge and belief each person included in this application 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 cover to be cancelled or curtailed and I have not withheld any material facts. I understand that non-disclosure or misinterpretation of material fact will entitle the underwriters to void this policy.

Signed	
Date	

H Legal Declaration

I hereby apply for cover on behalf of all the persons named in this application form for the Specialty Emergency Services health plan specified above. I declare that I have read and understood the Health Plan Terms and Conditions, and that I am aware that cover shall be provided in accordance with the Terms and Conditions, and that pre-existing conditions shall not be covered by this Health Plan.

I also understand that I must notify Specialty Emergency Services of any changes in the details contained in this application form, including a change in the state of health of any person named in it or contact information.

I authorize any doctor who has ever treated or advised any persons named in this application to provide Specialty Emergency Services with information they may require in connection with treatment related to any claim under the above plan.

I and all those named in this application, understand that in order to assess my claim, Specialty Emergency Services may need to obtain details of my medical history.

I and all those named in this application, hereby authorize any physician, healthcare professional, hospital, clinic and other healthcare institution to disclose to Specialty Emergency Services, to the extent allowed by applicable law, any information concerning the medical history, services, supplies or treatment provided to anyone listed on this application. I understand that Specialty Emergency Services may rely on this information to administer my policy and claims and to determine policy coverage according to applicable laws and regulations.

I understand that Specialty Emergency Services will hold and process my personal data for the purpose of processing my Health Plan, Processing any claims submitted under my Health Plan and providing other related services, which may include sharing my personal data with doctors and other medical professionals involved in my treatment or care (or the treatment or care of the persons insured on my policy). I understand that this may include the transfer of personal data to countries outside Zambia and in signing this form I consent to such transfer and use.

I understand that on the receipt of my Health Plan documents, if I am not entirely satisfied, I can cancel this application and receive a full refund of the premium I have paid minus an administration fee, provided that I did not submit any claim and that I return my documents to the company within 30 days of the start of the plan.

I declare that I have been provided with a copy of the cover Terms and Conditions which I have read myself and on behalf of the persons insured on my policy. I understand that this Health Plan starts from the date of the cover and therefore no refund of premium will be allowed after 30 days if this cover is cancelled.

I understand that an excess is payable for each claim I make on my Health Plan Policy, and that Specialty Emergency Services have the right to Load the excess.

I declare that to the best of my knowledge and belief, all the information I have given in this application form is true and complete and that I have confirmed the family details with the respective family members, and that, in the event of fraud or suspected fraud my Health Policy will be voided immediately by Specialty Emergency Services, and my personal data may be disclosed to other parties, including but not limited to, the appropriate law enforcement agencies.

I understand that Specialty Emergency Services will give me reasonable notice on renewal and premiums may vary each year.

I understand that Specialty Emergency Services cannot be liable if my cover lapsed should the Credit/Debit card be declined and I do not respond to requests for alternative methods of payment.

I agree that I will inform Specialty Emergency Services if any of the details given in this application form change.

Signature of Applicant:		Date:	

For Office Use Only

Application Approved?		If not reason why	
Exclusions:			
Group Name:			
Subscription Fee:		Receipt No:	
Membership No:			
Policy Start date:		Renewal date:	