SERENICARE INDIVIDUAL HEALTH INSURANCE COVER APPLICATION FORM

Please complete this form using BLOCK Letters. It is important that you provide ALL the information requested to facilitate prompt processing of your application. Any blank spaces will be taken to mean that you have nothing to disclose.

1. Applicant details for Beneficiary

SECTION A: Principal Member

Option Chosen:

Mr. | Mrs. | Ms. | Miss. | Other | Surname:

First Name: | Other Names

Date of Birth: D D M M Y Y Y Y | Gender: Male: Female: | Nationality:

National ID/Passport No: | Tax Identification Number

Postal Address: | Code: | Town:

Physical Address*:

Country of Residence:

Mobile Number*: | Other Phone Number:

Email Address*:

Occupation*, *please state if student*: | Employer:

2. Dependants' details

	Full name	Date of Birth	Gender		Relationship	Option/Category Chosen
(01)			M	F	Spouse	
(02)			M	F		
(03)			M	F		
(04)			M	F		
(05)			M	F		
(06)			M	F		
(07)			M	F		

Name of current/previous health insurer _____

Expiry date: _____

3. Last Expense

Name of next of kin	ID Number	Relationship

Continued overleaf

4. Medical history of applicant and dependents

Have you had any of the following medical conditions? (Ask your doctor for any assistance if needed).
If there is a yes to any of the questions asked, kindly obtain a medical report from your attending doctor or discharge summary from hospital and forward together with your application form under confidential cover. This information is essential in processing your application. Please note that no liability will be accepted for any medical conditions which originated before the date of enrolment or which was foreseeable at the time of application unless such medical condition has been declared to and accepted by UAP Old Mutual Insurance in writing. If in doubt you should still disclose the medical condition.

QUESTIONS		**MEMBERS** *(Only "Yes" or "No" are acceptable answers for each)*									
Dependant Code		00	01	02	03	04	05	06	07	08	09
A	**Cardiovascular Conditions**										
	High Blood Pressure										
	Heart Disease										
	High Cholesterol levels										
B	**Respiratory**										
	Asthma										
	Chronic obstructive airway disease										
	Sinus Disease										
C	**Endocrine**										
	Thyroid Disease										
	Diabetes Mellitus										
D	**Neurological**										
	Paralysis										
	Epilepsy										
E	**Blood Disorders**										
	Sickle Cell										
	Disease Leukemia										
F	**Musculoskeletal**										
	Arthritis										
	Gout										
	Chronic back pain/slipped disc										
G	**Gastrointestinal**										
	Liver Disease										
	Stomach and Duodenal Ulcers										
H	Surgical Operations										
I	Hospitalised (within the last seven years)										
J	On Regular Medication										
K	Cancer										
L	**Genito-Urinary**										
	Pelvic Inflammatory disease (female)										
	Fibroids (Female)										
	Enlargement of the prostate (male)										
M	**Pregnancy (Female)**										
	History of Caesarian										
	Section Pregnant Member										
N	Other medical conditions or disabilities not mentioned Above										

Details of positive (yes answers to questions *i, j, k, l, m* and *n* or any other. If this space is insufficient append an additional sheet.

Continued overleaf

5. FAMILY DOCTOR'S INFORMATION

Doctor's name:	Speciality:
Email Address:	Mobile:
Postal address:	Tel No.:
Clinic physical address:	Code:

6. COVER PLAN AND PREMIUM (UGX)

Option Chosen	Premium	Comprehensive	Classic	Essential
INPATIENT PER FAMILY	100,000,000	60,000,000	30,000,000	15,000,000
Premium for all members proposed				

OUTPATIENT PER PERSON	5,000,000	3,000,000	2,000,000	1,500,000
Premium for all members proposed				

MATERNITY PER FAMILY	4,000,000	3,000,000	2,500,000	1,500,000
Premium per family				

7. LEVIES

Training levy	(0.5%)
Stamp Duty	(UGX 35,000)
Total premium payable (premium is payable upfront or through premium financing)	

8. DECLARATION

This membership application form is part of the contract with UAP Old Mutual Group

A. I declare that all the persons named in the application form are members of my immediate family for whose membership I am responsible

B. I hereby apply to join the above mentioned health insurance plan

C. I understand that any mis-statement or non-disclosure of any material information in this form will jeopardize my membership.

D. I warrant that the answers in this form are true, correct, and complete and I acknowledge that such answers are all material

E. I hereby authorize the hospital, medical or dental practioners who have treated me or any of mu dependents to disclose to UAP Old Mutual Group the records relating to such current or previous hospitalizations/medical treatment and allow the company to receive extracts from such records and undertake to assist in obtain such information.

F. I have read, understood and agree with the cover options, exclusions, terms and conditions as stipulated in the product brochure and benefit schedules

G. I have appointed _____ as my Agent/Broker for this policy.

H. Desired start date:_____

SIGNATURE OF THE PRINCIPAL MEMBER (POLICY HOLDER)

SIGNATURE _____DATE_____

AGENT/BROKER DECLARATION

I CONFIRM THAT I HAVE EXPLAINED TO THE CLIENT THE BENEFIT STRUCTURE, GENERAL CONDITIONS AND EXCLUSIONS OF THIS COVER

AGENT'S / BROKER'S NAME_____

Tel. No _____ Mobile_____

Email Address _____

Authorized Signature & STAMP _____ Date_____