APPLICATION FORM

Please complete in BLOCK CAPITALS and return with passport photograph of each beneficiary to asterhealth.

Applicant's Surname | Othe Names

Address (Not P.O. Box)

Occupation | e-mail: | Tel

Nationality | Date of Birth | Age | Sex

Next of Kin | Relationship

Please complete the following detailsfor all persons to be insured

Spouse's Surname | Other Names

Date of Birth: day | month | year

Names of Children (if applicable)	*Existing Chronic Illness*	Date of Birth	Age	M	F
(1)					
(2)					
(3)					
(4)					

Choice of Hospital *(Please refer to list)*

Are you or your spouse pregnant at the moment? **If so, how many months?**

Have you or any of your immediate family had any of the following?

Asthma		Minor Surgery		Cataract		Sickle Cell Disease		Persistent Chest Pain		Diabetes Mellitus	
Heart Disease		Duodenal Ulcer		Skin Infection		Hypertension		Passing Bloody Urine		Arthritis	
Glaucoma		T.B.		Viral Hepatitis		Persistent Swollen ft.		Epilepsy		Persistent Dizziness	
Herpes Genitals		Goitre		Major Surgery		Hospitalization		Heamorrhoids		HIV/AIDS	

Other significant conditions

SCHEME REQUIRED *(Please tick as required)*

INDIVIDUAL | FAMILY

BASIC | **STANDARD** | **COMPREHENSIVE** | **ULTIMATE**

N.B. ***Please inscribe name at the back of each passport photograph.***

Declaration: I hereby apply to be enroled in the Plan together with the persons to be insured listed above. I declare that to the best of my knowledge on behalf of all persons to be insured under this application that I have read and understood fully the policy exclusions and conditions. It is agreed that this declaration and information given in this application shall form the basis of the contract(S) between the insured Person(s) and the HMO.

Signature of Applicant *(On behalf of all persons to be insured)* | **Date**