DIASPORA MEDS

DIASPORA PLAN MEMBERSHIP
APPLICATION FORM

THIS APPLICATION WILL NOT BE PROCESSED IF IT IS NOT COMPLETED IN FULL
IF SUBSCRIPTIONS ARE NOT PAID IN ADVANCE BY THE 1st OF EVERY MONTH, BENEFITS WILL BE SUSPENDED

How did you get to know about us?

☐ Print Adverts ☐ Referral ☐ Website ☐ Exhibition ☐ Radio ☐ Social Media   Other? Specify ______

SECTION I: EMPLOYER ACCOUNT HOLDER'S DETAILS

Employer's name: ______

Subsidiary/Division's name: ______

Cover Commencement Date: dd/mm/yyyy   Authorised Signatory: ______

SECTION II: MEMBER DETAILS *(Complete all fields)*

Title: ◯ Mr ◯ Mrs ◯ Ms ◯ Prof ◯ Dr ◯ Eng ◯ Rev ◯ Past

Surname: ______   First Name(s): ______

ID Number: ______   Date of Birth: dd/mm/yyyy   EC Number: ______

Residential address: ______

Business Tel: ______   Home Tel: ______

Mobile: ______   Email address: ______

Next of Kin Full Name: ______

Next of Kin Email address: ______   Next of Kin Mobile: ______

SECTION III: PLEASE TICK WHICH PLAN YOU WISH TO BE REGISTERED

◯ Manuka ◯ Lavender ◯ Clover ◯ Sage

SECTION IV: DETAILS OF YOUR GENERAL PRACTITIONER

Name of General Practitioner: ______

Address: ______   Contact Number: ______

SECTION V: DEPENDANTS' INFORMATION (Attach copies of ID, Valid Passport or Birth Certificate for all members on this form)

Surname	First Name(s)	Date of Birth	Gender	Relationship	ID Number	Mobile Number
		dd/mm/yyyy				
		dd/mm/yyyy				
		dd/mm/yyyy				
		dd/mm/yyyy				
		dd/mm/yyyy				
		dd/mm/yyyy				
		dd/mm/yyyy				

SECTION VI: BANKING DETAILS

Account Name: ______   Name of Bank: ______

Account Number: ______   Branch: ______   Branch Code: ______

REGISTERED SUPPLIER SAZ ZWS ISO 9001

CELLMED HEALTH MEDICAL FUND

SECTION VII: ANY OTHER INFORMATION

Details:

SECTION VIII: DETAILS OF PREVIOUS MEDICAL FUNDER (Attach certificate of membership)

Medical Funder	Membership Number	Date of Joining	Date of Termination
		dd/mm/yyyy	dd/mm/yyyy

SECTION IX: CHRONIC DISEASE CONDITION

Full Name	Condition	Treatment Administered	Name of Doctor	Doctor's Tel

MEDICAL HISTORY

It is most important that the following questions be answered as thoroughly as possible, by encircling the specific condition. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit.

Organ(s) / Condition	Examples of Conditions
Heart & Vascular System	☐ High blood pressure ☐ High cholesterol ☐ Angina ☐ Heart attack / failure
Lungs	☐ Asthma ☐ Emphysema ☐ Chronic bronchitis ☐ TB ☐ Pneumonia
Digestive System, Gall Bladder & Liver	☐ Peptic Ulcers ☐ Reflux ☐ Constipation ☐ Gallstones ☐ Jaundice ☐ Hepatitis
Nervous System	☐ Epilepsy ☐ Degenerative Diseases - Alzheimer's, Parkinson's ☐ Stroke
Bone, Muscle & Joints	☐ Arthritis ☐ Rheumatism ☐ Gout ☐ Osteoporosis ☐ Knee or neck problems
Urinary Tract	☐ Dialysis ☐ Kidney transplant ☐ Kidney stones ☐ Chronic incontinence
Gynaecological System	☐ Menopause ☐ Female hormone replacement ☐ Breast/ovarian tumours
Male Genital System	☐ Prostate problems (Hypertrophy / Cancer or infections) ☐ Hernias-groin
Gland / Hormonal	☐ Over / Under active thyroid ☐ Diabetes mellitus ☐ Addison disease
Blood	☐ Anaemia ☐ Bleeding disorders ☐ Leukaemia ☐ Hodgkin's disease
Ear, Nose & Throat	☐ Allergies (Rhinitis, Sinusitis) ☐ Deafness hearing aids ☐ Otitis-tonsilitis
Eyes	☐ De-generative disease (Glaucoma, Cataracts) Poor vision ☐ Artificial eyes
Emotional / Psychological Problems	☐ Depression ☐ Bipolar disorder ☐ Alcoholism ☐ Drug abuse
Infectious / Tropical Diseases	☐ Sexually Transmitted Diseases ☐ Genital warts ☐ HIV / AIDS ☐ Hepatitis
Skin Disorders	☐ Acne ☐ Eczema ☐ Psoriasis ☐ Shingles ☐ Kaposi sarcoma tumours
Teeth & Gums	☐ Impacted teeth ☐ Previous / Current orthodontic treatment ☐ Braces
Cancer	☐ Cysts ☐ Growths ☐ Tumours of any kind of any organ
Pregnancy	Are you or any of your dependants pregnant? ○ Yes ○ No If yes - how many weeks? ☐
Any Other (Specify)	

PAST SURGICAL HISTORY AND OBSTETRIC HISTORY (FEMALES)

Give details of any surgery done in the past 5 years. Please use a separate sheet if this space is insufficient.

CELLMED HEALTH MEDICAL FUND

FAMILY HISTORY

Give details of family members both maternal and paternal with chronic illness e.g. Diabetes Mellitus, High Blood Pressure and Cancer. Please use a separate sheet if this space is insufficient.

SECTION X: LIFESTYLE HISTORY

A: Pastimes, Hobbies, Activities and Pursuits
Please detail in the space below any activities that you, or any individuals listed in this application participate in on a regular basis (or more than three times in 12 months) which may be considered to be hazardous, dangerous or place you at greater risk of injury in comparison to the activities of your everyday life.

B: Body Mass Index
Please furnish us with the following details for all applicants: Height (cm) Weight (kg)

	Height (cm)	Weight (kg)	(This column is for office use only)
Principal			
Dependant full name:			
Dependant full name:			
Dependant full name:			
Dependant full name:			
Dependant full name:			

C: Physical Activity
In the last 12 months, how frequently have you participated in some kind of physical exercise.

Name	Frequency				(This column is for office use only)
	3 to 4 times a week	1 to 2 times a week	1 to 2 times a month	Not at all	
Full name:	◯	◯	◯	◯	
Full name:	◯	◯	◯	◯	
Full name:	◯	◯	◯	◯	
Full name:	◯	◯	◯	◯	

D: Stress
(i) 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
Full name:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Full name:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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

Full name:	◯ Yes	◯ No
Full name:	◯ Yes	◯ No

(iii) How frequently do you use medication to calm your nerves, or to help you to sleep? *(Tick the appropriate box)*

◯ Never ◯ Rarely ◯ Sometimes (Monthly) ◯ Weekly basis ◯ Daily basis

E: 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
Full name:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Full name:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

F: Use Of Alcohol
(i) What is your average consumption of alcohol on a weekly basis? (drinks/number of units)

	Non-Drinker	1-4	5-8	9-12	More than 12
Full name:	◯	◯	◯	◯	◯
Full name:	◯	◯	◯	◯	◯

(ii) How many days did you drink alcohol on a weekly basis (average over the last 3 months)

	Non-Drinker	1-4	5-8	9-12	More than 12
Full name:	◯	◯	◯	◯	◯
Full name:	◯	◯	◯	◯	◯

G: Use of Cigarettes *(Tick the appropriate box)*

I have never smoked	I quit smoking less than 10 years ago	I smoke 5 to 10 cigarettes a day	I smoke 11 to 20 cigarettes a day	I smoke more than 20 a day
◯	◯	◯	◯	◯

H: Wellness Tests: How often do you undergo a thorough physical medical examination? *(Tick the appropriate box)*

Almost never	Every few years	Every 2 years	Every year	On a daily basis
◯	◯	◯	◯	◯

I: Women/ Men: How often do you have a PAP smear? How often do you undergo a prostrate test/examination? *(Tick the appropriate box)*

Women PAP smear/Mammogram	◯ Almost never	◯ Every 2 years	◯ Every year
Men - Prostate examination	◯ Almost never	◯ Every 2 years	◯ Every year

DECLARATION

I certify that the information given above was submitted wilfully and is correct. I agree that should my application be accepted, I will abide by the rules, benefits and regulations set by CellMed Health Medical Fund (CellMed); details of which is available on request. Signing of this contract signifies the basis of contract between CellMed and myself.

I hereby consent and authorise CellMed Health Medical Fund to collect biometrics for all beneficiaries specified in this membership application. This collection is essential for verification, claims submission and validation processes.

Member Signature: SIGN HERE

Date: dd/mm/yyyy

FOR OFFICIAL USE ONLY

APPLICATION RECEIVED:

Date: dd/mm/yyyy

Reviewed by:

Signature SIGN HERE

APPROVAL

Outcome of Application: ◯ Approved ◯ Rejected ◯ Requested more Information

Additional comments: