



# CELLMED PREMIUM USD 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:  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:  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

Base
  Value
  Care
  Alpha Plus
  Essential Plus
  Vital Plus  
 Prime Plus
  Superior Plus
  Supreme Plus
  Universal Plus
  SportsMed
  Scholar

## 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				

## SECTION VI: BANKING DETAILS

Account Name:  Name of Bank:

Account Number:  Branch:  Branch Code:



**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	<input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Angina <input type="checkbox"/> Heart attack / failure
Lungs	<input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> TB <input type="checkbox"/> Pneumonia
Digestive System, Gall Bladder & Liver	<input type="checkbox"/> Peptic Ulcers <input type="checkbox"/> Reflux <input type="checkbox"/> Constipation <input type="checkbox"/> Gallstones <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis
Nervous System	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Degenerative Diseases - Alzheimer's, Parkinson's <input type="checkbox"/> Stroke
Bone, Muscle & Joints	<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatism <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Knee or neck problems
Urinary Tract	<input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney transplant <input type="checkbox"/> Kidney stones <input type="checkbox"/> Chronic incontinence
Gynaecological System	<input type="checkbox"/> Menopause <input type="checkbox"/> Female hormone replacement <input type="checkbox"/> Breast/ovarian tumours
Male Genital System	<input type="checkbox"/> Prostate problems (Hypertrophy / Cancer or infections) <input type="checkbox"/> Hernias-groin
Gland / Hormonal	<input type="checkbox"/> Over / Under active thyroid <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Addison disease
Blood	<input type="checkbox"/> Anaemia <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Leukaemia <input type="checkbox"/> Hodgkin's disease
Ear, Nose & Throat	<input type="checkbox"/> Allergies (Rhinitis, Sinusitis) <input type="checkbox"/> Deafness hearing aids <input type="checkbox"/> Otitis-tonsillitis
Eyes	<input type="checkbox"/> De-generative disease (Glaucoma, Cataracts) Poor vision <input type="checkbox"/> Artificial eyes
Emotional / Psychological Problems	<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug abuse
Infectious / Tropical Diseases	<input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Genital warts <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Hepatitis
Skin Disorders	<input type="checkbox"/> Acne <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Shingles <input type="checkbox"/> Kaposi sarcoma tumours
Teeth & Gums	<input type="checkbox"/> Impacted teeth <input type="checkbox"/> Previous / Current orthodontic treatment <input type="checkbox"/> Braces
Cancer	<input type="checkbox"/> Cysts <input type="checkbox"/> Growths <input type="checkbox"/> Tumours of any kind of any organ
Pregnancy	Are you or any of your dependants pregnant? <input type="radio"/> Yes <input type="radio"/> No If yes - how many weeks? <input style="width: 40px;" type="text"/>
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.



**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:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Full name:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Full name:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Full name:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**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:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full name:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Full name:	<input type="radio"/> Yes	<input type="radio"/> No
Full name:	<input type="radio"/> Yes	<input type="radio"/> 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: .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full name: .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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: .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full name: .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(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: .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full name: .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Women PAP smear/Mammogram	<input type="radio"/> Almost never	<input type="radio"/> Every 2 years	<input type="radio"/> Every year
Men - Prostate examination	<input type="radio"/> Almost never	<input type="radio"/> Every 2 years	<input type="radio"/> 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:

Reviewed by:

Signature

**APPROVAL**

Outcome of Application:

Approved

Rejected

Requested more Information

Additional comments:

