Office Use
Membership No.

BUDGET HEALTH
Medical Aid Society

26 East Road, Belgravia
Harare
P.O. Box A1260
Avondale

Email: membership@budgethealth.co.zw
Website: www.budgethealth.co.zw
+263242705158
+263783073156

Application Form

Please complete all relevant sections

Personal Details

Company Name:	
Principal Member:	
Postal Address:	
Home Address:	
Email Address:	Phone:
Date of Birth: d d m m y y y y	Sex: Male ☐ Female ☐
Marital Status: Married ☐ Divorced ☐ Widowed ☐ Single ☐	
Weight: Kg	Height cm
I.D Number:	
Occupation:	

Electronic Data

Bank: Branch Code:	
Account Name:	Account Number:
Have you been a member of any Medical Aid in the past Yes No	Start Date: End Date
Society: Number	Scheme:

NB: If yes please attach a certificate of membership from your previous medical aid society.
Budget Health reserves the right to waiver or impose waiting periods against a certificate of membership.

Package Applied for

Platinum ☐		Bronze ☐		
Gold ☐		Copper ☐		
Silver ☐		Iron ☐	Other	……..

Please Enter below Details of all dependents to be included in this Application for Membership

Surname	First Names	DOB	Sex	I.D Number	Weight/ height	Relation to P/Member

Medical History

(To be completed by all applicants) (Pre-existing conditions are excluded from foreign travel emergency)

Please read carefully and complete all the required information by placing a tick in the correct box. If the answer to any of the questions is YES, please provide details in the space provided below in respect of the member or dependents applicable. Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of your membership of benefits.

Are you, your spouse or any of your dependents experiencing or have experienced any of the following?

	Tick Yes	No
1. **Heart (cardiac) Diseases:** heart attack, rheumatic fever, congenital heart abnormalities, angina, embolism, high blood pressure	☐	☐
2. **Circulatory Disorders:** varicose veins/ thrombosis, blood disorders (e.g., anaemia, leukemia)	☐	☐
3. **Diseases of the Liver:** jaundice, gall bladder diseases, liver cirrhosis	☐	☐
4. **Disease of the Airway / Lungs:** Asthma, chronic bronchitis, tuberculosis, emphysema, cystic fibrosis, interstitial fibros of any cause.	☐	☐
5. **Disease of the digestive system:** gastric/ duodenal ulcers, hiatus hernia, severe recurring diarrhoea	☐	☐
6. **Disease of the bladder/ kidney:** kidney stone, congenital kidney disorder, nephritis, bladder infections	☐	☐
7. **Neurological Disorders:** Migraine, stroke, epilepsy		
8. **Diseases of the bone:** joints and muscles, rheumatic arthritis, gout, back. neck. joint problems	☐	☐
9. **Endocrine Disorders:** diabetes mellitus, thyroid disease (e.g.; goitre)		
10. **Mental Health Disorders:** Psychotic disorders (e.g., schizophrenia) mood disorder, anxiety disorder (e.g., panic disorders)	☐	☐
11. Any condition not mentioned above		
12. Are you currently taking medication for any permanent or recurring condition? If so please detail name, dosage & frequency	☐	☐
13. Is there any illness or factor not mentioned on this questionnaire that might affect your health in the next 12 months		
14. Are you pregnant? If so what is the expected date of delivery	☐	☐
15. If you have ticked YES for any of the above, please complete the section below. Please note all important information must be disclosed. The following section is for details of 1-14.		

Quest No:	Name	Date	Please supply full details of disorder, date, duration of treatment and medication if any

If there is insufficient space above, please attach a separate sheet with additional information

NB: If you or your family suffer from any chronic illness, (i.e., diabetes, asthma, etc.) Section 15 above must be completed

Declaration by applicant on behalf of self and all their dependents (please read carefully)

I declare that any false information in the above questionnaire, or the non-disclosure of any material information will render the membership entirely null and void.

1. I understand that any condition for which I or any of my dependents have received medical advice or treatment in the previous 3 months may be excluded from benefits offered under the scheme.
2. I understand that I or any of my dependents may be required to obtain a medical report or undergo a medical examination to provide further information on any of the conditions declared above.
3. I authorize Budget Health to have unrestricted access to my medical records but require their confidentiality to be maintained.
4. I have completed the medical history for myself and all my dependents declared in this application.
5. I declare that if I do not declare existing conditions I will bear the costs associated with treatment of such existing conditions.

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Principal Member's Signature Date

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Operations Manager signature authorizing cover and date of commencement Date of commencement