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

# Individual Application Form

Please complete all relevant sections

## Personal Details

| | | | |
|---|---|---|---|
| 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: | | | |

## Nostro Banking Details

| | | | |
|---|---|---|---|
| Bank Name: | | Branch Code: | |
| Account Name: | | Account Number: | |

## Previous Membership

| | | | | | |
|---|---|---|---|---|---|
| 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:

| | | |
|---|---|---|
| CARE **80** ☐ | CARE **50** ☐ | CARE **30** ☐ |
| CARE **20** ☐ | CARE **10** ☐ | CARE **5** ☐ |
| | | 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 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |

## 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 | Tick No |
|---|---|---|
| 1. **Heart** (cardiac**) Diseases:** heart attack, rheumatic fever, congenital heart abnormalities, angina, embolism, high blood pressure | ☐ | ☐ |
| 2. **Circulatory:** 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 conditions:** Migraine, stroke, epilepsy | ☐ | ☐ |
| 8. **Diseases of the bone:** joints and muscles, rheumatic arthritis, gout, back. neck. joint problems | ☐ | ☐ |
| 9. **Endocrine conditions:** diabetes mellitus, thyroid disease (e.g.; goitre) | ☐ | ☐ |
| 10. **Mental Health conditions:** Psychotic conditions (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. Are you pregnant? If so what is the expected date of delivery**……** | ☐ | ☐ |
| 14. 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. | | |

| Question Number: | Name of Dependent | Date | Please supply full details of condition, 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 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.
2. I authorize Budget Health to have unrestricted access to my medical records but require their confidentiality to be maintained.
3. I have completed the medical history for myself and all my dependents declared in this application.
4. I declare that if I do not declare existing conditions I will bear the costs associated with treatment of such existing conditions.

Principal Member's Signature ..... Date .....

Operations Manager signature authorizing cover ..... Date of commencement .....