

**PREMIER CORPORATE PLAN**  
**MEMBER APPLICATION FORM**  
(PLEASE FILL IN CAPITAL LETTERS)

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**MEDICAL HISTORY** (Please note the Number against Medical Condition applicable to you (dependent) and fill in appropriate box)

1. Allergies	12. Depression or Psychiatric disorder	25. Hepatitis	40. Pregnancy
2. Anemia	13. Diabetes Mellitus	26. Hepatitis B	41. Rheumatic Arthritis
3. Angina	14. Disorder of the digestive system	27. Hernia	42. Rheumatic Fever
4. Asthma	15. Embolism	28. High Blood Pressure	43. Smoking
5. Back Neck Joint Problems	16. Emphysema	29. High Cholesterol Level	44. Spectacles or contact lenses
6. Benign cancer	17. Endocrine disorder	30. Intestinal Fibrosis	45. Stroke
7. Bladder Infections	18. Epilepsy	31. Jaundice	46. Thrombosis
8. Chronic Bronchitis	19. Fibroid	32. Kidney stone	47. Thyroid disorder
9. Congenital Heart Abnormalities	20. Gall bladder disease	33. Leukemia	48. Tuberculosis
10. Congenital kidney disorder	21. Gout	34. Liver condition	49. Ulcers
11. Cystic Fibrosis	22. HIV positive	35. Lung disease	50. Varicose Veins
	23. Heart attack	36. Malaise	51. No specific risks
	24. Heart disease	37. Malignant cancer	52. Others - Please State
		38. Migraine	
		39. Nephritis	

<b>NAME OF COMPANY:</b>	
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**PRINCIPAL MEMBER**

SURNAME:		OTHER NAMES:		PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD   MM   YEAR		RELATIONSHIP: PRINCIPAL MEMBER [ ] DEPENDANT [ ] STAFF [ ]		
SEX: MALE [ ] FEMALE [ ]		TEL.(S):		
POSTAL ADDRESS		RESIDENTIAL ADDRESS		
E-MAIL:				
BENEFIT OPTION: <input type="radio"/> PREMIER REGULAR <input type="radio"/> PREMIER MERCURY		MEDICAL HISTORY #:		
<input type="radio"/> PREMIER PLATINUM <input type="radio"/> PREMIER PLATINUM PLUS				

**DEPENDENT #1**

SURNAME:		OTHER NAMES:		PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD   MM   YEAR		RELATIONSHIP: SPOUSE [ ] SON [ ] DAUGHTER [ ]		
SEX: MALE [ ] FEMALE [ ]		TEL.(S):		
E-MAIL:				
MEDICAL HISTORY #:				

**DEPENDENT #2**

SURNAME:		OTHER NAMES:		PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD   MM   YEAR		RELATIONSHIP: SPOUSE [ ] SON [ ] DAUGHTER [ ]		
SEX: MALE [ ] FEMALE [ ]		TEL.(S):		
E-MAIL:				
MEDICAL HISTORY #:				

**DEPENDENT #3**

SURNAME:	OTHER NAMES:	PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD   MM   YEAR	RELATIONSHIP: SPOUSE [ ] SON [ ] DAUGHTER [ ]	
SEX: MALE [ ] FEMALE [ ]	TEL.(S):	
E-MAIL:		
MEDICAL HISTORY #:		OFFICIAL USE

**DEPENDENT #4**

SURNAME:	OTHER NAMES:	PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD   MM   YEAR	RELATIONSHIP: SPOUSE [ ] SON [ ] DAUGHTER [ ]	
SEX: MALE [ ] FEMALE [ ]	TEL.(S):	
E-MAIL:		
MEDICAL HISTORY #:		OFFICIAL USE

**DEPENDENT #5**

SURNAME:	OTHER NAMES:	PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD   MM   YEAR	RELATIONSHIP: SPOUSE [ ] SON [ ] DAUGHTER [ ]	
SEX: MALE [ ] FEMALE [ ]	TEL.(S):	
E-MAIL:		
MEDICAL HISTORY #:		OFFICIAL USE

**DECLARATION**

<p><b>APPLICANT</b> I hereby declare that the information I have given about me and my dependents is true.</p> <p>SIGNATURE: _____</p> <p>DATE: _____</p>
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<p><b>HUMAN RESOURCE MANAGER</b> I hereby confirm that the details given by the applicant is true and (s)he is a legitimate staff of our company.</p> <p>SIGNATURE (STAMP): _____</p> <p>DATE: _____</p>
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**FOR OFFICIAL USE ONLY:**

POLICY STARTS ON:	POLICY ENDS ON: