PREMIER HEALTH INSURANCE

Your bridge to premier healthcare

PREMIER MICRO HEALTH PLAN

MEMBER APPLICATION FORM

(PLEASE FILL IN CAPITAL LETTERS)

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

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

PRINCIPAL MEMBER #1

SURNAME:	OTHER NAMES:	PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD | MM | YEAR	SEX: MALE [ ] FEMALE [ ]	
STAFF ID:	TEL.(S):	
INSTITUTION		
DISTRICT	REGION	
POSTAL ADDRESS E-MAIL:	RESIDENTIAL ADDRESS	OFFICIAL USE
NHIS REG. NO.:	MEDICAL HISTORY #:	MANDATE NUMBER

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:		
NHIS REG. NO.:	MEDICAL HISTORY #:	OFFICIAL USE

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:		
NHIS REG. NO.:	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:		
NHIS REG. NO.:	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:		
NHIS REG. NO.:	MEDICAL HISTORY #:	OFFICIAL USE

DEPENDENT #6

SURNAME:	OTHER NAMES:	PASSPORT SIZED PHOTOGRAPH
DATE OF BIRTH: DD | MM | YEAR	RELATIONSHIP: SPOUSE [ ] SON [ ] DAUGHTER [ ]	
SEX: MALE [ ] FEMALE [ ]	TEL.(S):	
E-MAIL:		
NHIS REG. NO.:	MEDICAL HISTORY #:	OFFICIAL USE

PREMIUM (GHC)

TOTAL LIVES:		MONTHLY PREMIUM:	

DECLARATION

I hereby declare that the information given herein about me and my dependents are true, and the annual insurance premium should be processed on monthly basis as stated with an annual automatic renewal.

NAME: ____

SIGNATURE: ______________________________________ DATE: ________________________________

FOR OFFICIAL USE ONLY:

POLICY STARTS ON:	POLICY ENDS ON:	ANNUAL PREMIUM:

AGENT (IF ANY):