Ultra-Med Health Care
caring for you always.

AMMENDMENT FORM

Full Name: Mr/Mrs/Miss/Ms/Dr:

Date of Birth: Male/Female:

Membership Number

Start Date

[Tick where applicable]

I wish to **ADD** ☐ **/ TERMINATE** ☐ **/ AMEND** ☐ my membership / beneficiary of the under mentioned

Full Name: Mr/Mrs/Miss/Ms/Dr:	Date of Birth:	ID/Passport Number	
			M F
			M F
			M F
			M F

If changing packages please indicate

Current Package **New Package**

PRE-EXISTING CONDITIONS

Do you or any of your dependants suffer from any of the following medical conditions? If yes, tick the appropriate box and provide details below. (Attach extra sheet if required)

List of Pre-existing Conditions

1 Abdominal disease ☐
2 Arthritis ☐
3 Asthma ☐
4 Cardio and vascular conditions ☐
5 Cancer ☐
7 Disorder of the ear, nose or eye ☐
8 Orthodontics ☐
9 High blood pressure ☐
10 Renal/kidney disease ☐

Name of Beneficiary	Condition & Date Diagnosed	Currently on Treatment		Date of Last Treatment								Attending Doctor
		YES	NO	D	D	M	M	Y	Y	Y	Y	
		YES	NO	D	D	M	M	Y	Y	Y	Y	
		YES	NO	D	D	M	M	Y	Y	Y	Y	
		YES	NO	D	D	M	M	Y	Y	Y	Y	

I declare that the information provided in this form is true and signing this application form, forms the basis of a contract accurate. Should my application for membership be accepted, between myself and Ultra-Med Health. I agree to abide by the Rules and Regulations by Ultra-Med Health Care.

I certify that none of my dependants or myself suffer from any condition(s) not stated on the form. I hereby authorize Ultra-Med Health to access my medical record from any health service provider for any reason whatsoever.

D D M M Y Y Y Y