Ultra-Med Health Care
caring for you always.

Application for New Membership

- New Application to complete this form
- Read terms & conditions
- Where appropriate mark your selection with a ✔
- Where not applicable put N/A

Please complete this application in BLACK INK using CAPITALS.

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

Date of Birth: Male/Female:

Home Address:

Postcode:

ID/Passport Number

Telephone (Mobile):

Company Name

Telephone (Work):

Email Address:

Name of Next of Kin

Telephone Number of Kin

PRINCIPAL MEMBER DETAILS

*Please note: cover is subject to acceptance by General & Medical and payment of the appropriate premium. Whilst we will try to begin cover on the date indicated it cannot be guaranteed. There may be some circumstances where we have agreed to hold cover but you should note that we will not back date applications/cover.

PARTNER AND DEPENDANTS DETAILS

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

If you wish to add more dependents please give details on a separate sheet and attach.

SELECTING YOUR PLAN

Please tick which scheme you are applying for.

☐ **Starter** ☐ **Essential** ☐ **Essential** Plus ☐ **Comprehensive** ☐ **Comprehensive** Plus ☐ **Premium** ☐ **Premium** Plus

GENERAL TERMS AND CONDITIONS

1. The general waiting period for accessing basic medical care is 3 months.
2. 9 months waiting period applies to all new policies. However, in the relationship of husband and wife, where the husbands' policy had been running for a period of more than 9 months, the 9 months waiting period shall not be applied to the wife's' policy. In such cases the wife only has to wait for 3 months before she can access benefits under her policy.
3. 12 months initial waiting period shall be applied to optical costs (lenses, glasses frames and other associated costs) and 3 year waiting period shall apply thereafter.
4. 6 months waiting period shall apply for dental care.
5. 12 months waiting period shall apply for all foreign specialist care.
6. The Starter product covers in-patient costs only. However, policy holders under this plan will be allowed access to network doctors (GPs).
7. The maximum of 12 visits per annum shall be allowable for specialist consultants for all policies.
8. Pre-existing conditions: policyholders shall not denied cover because of pre-existing medical conditions. However, a **2 year** waiting period shall be imposed on all the pre-existing medical conditions.

TERMS AND CONDITIONS for STUDENTS LEVEL

1. The period of cover will end upon the occurrence of either one of the following events: **(a)** At the end of the academic year **(b)** Upon termination of the studies by either the student or the university **(c)** Termination of contract of cover between the university and Ultra-Med Health Care, whichever is to occur first.

2. Start date is effective at the first day of the semester and runs until the last day of the 6 months after inception

3. Declaration of Medical History – students will be required to declare the medical history. Such information will not be used to deny the student cover, but will help the Fund to make arrangements for suitable health and care facilities for the student.

Exclusions

Ultra-Med will not cover the following: **(a)** Injuries/sickness/ disability arising from attempted suicide **(b)** Sickness arising from drug addiction and abuse of addictive substances **(c)** Sickness/disability from participation in illegal activities **(d)** Policyholders that fail to disclose material information or misrepresent information **(e)** Fraudulent claims.

PRE-EXISTING CONDITIONS

Do you or any of your dependents 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 ☐
Other (specify) .....

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	

PREVIOUS MEDICAL AID

Name of Level	Membership Number	Start Date								End Date							
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	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 dependents 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.

Applicant's Signature

D	D	M	M	Y	Y	Y	Y