

**INDIVIDUAL APPLICATION FORM**

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| **NAME OF PRINCIPLE** |  |

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| **MEMBER DETAILS** |
| **SURNAME**  |  | **FIRST NAME** |  |
| **OTHER NAME** |  | **AGE** |  |
| **DATE OF BIRTH** |  | **POSTAL ADDRESS** |  |
| **MARITAL STATUS** |  | **OCCUPATION** |  |
| **EMAIL ADDRESS** |  | **HEIGHT** |  |
| **RESIDENTIAL ADDRESS** |  | **WEIGHT**  |  |
| **ALLERGIES** |  | **BLOOD GROUP** |  |

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| **ENTER BELOW DETAILS OF THE SPOUSE(01) AND DEPENDANTS WHERE APPLICABLE** |
| **SURNAME**  | **FIRSTNAME** | **GENDER** | **DATE OF BIRTH** | **ALLERGIES** | **CATEGORIES** |
| 1 |  |  |  |  |  | SPOUSE |
| 2 |  |  |  |  |  | DEPENDANT  |
| 3 |  |  |  |  |  | DEPENDANT |
| 4 |  |  |  |  |  | DEPENDANT |
| 5 |  |  |  |  |  | DEPENDANT |
| 6 |  |  |  |  |  | DEPENDANT |
| 7 |  |  |  |  |  | DEPENDANT |
| 8 |  |  |  |  |  | DEPENDANT |

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| **MEDICAL DICLARATION** |
| NOTE: **FOR MEMBERSHIP TO BE CONSIDERED, THIS DECLARATION MUST BE COMPLETED IN FULL AND ALL QUESTIONS ANSWERED**IF THE ANSWER IS YES TO ANY OF THE QUESTIONS WHICH FOLLOW, KINDLY OBTAIN A MEDICAL REPORT FROM YOUR ATTENDING DOCTORS & ADDRESS OR FORWARD IT TOGETHER WITH YOUR APPLICATION FORM UNDER CONFIDENTIAL COVER TO THE UNDERWRITER OR EMAIL ADDRESS: underwriter.ug@aar-insurance.com WITHOUT WHICH YOUR APPLICATION MAY BE DELAYED. |

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| **QUESTIONS** | **M** | **01** | **02** | **03** | **04** | **05** | **06** |
| **a** | **Cardiovascular** | Please put yes or no |
|  | High Blood Pressure |  |  |  |  |  |  |  |
|  | Heart Disease |  |  |  |  |  |  |  |
| **b** | **Respiratory** | Please put yes or no |
|  | Asthma |  |  |  |  |  |  |  |
|  | Tuberculosis |  |  |  |  |  |  |  |
| **c** | **Endocrine** | Please put yes or no |
|  | Thyroid Disease |  |  |  |  |  |  |  |
|  | Diabetes |  |  |  |  |  |  |  |

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| **d** | **Neurological** | Please put yes or no |
|  | Paralysis |  |  |  |  |  |  |  |
|  | Epilepsy |  |  |  |  |  |  |  |
| **e** | **Musculo Skeletal** | Please put yes or no |
|  | Arthritis |  |  |  |  |  |  |  |
|  | Gout |  |  |  |  |  |  |  |
|  | Slipped Disc |  |  |  |  |  |  |  |
| **f** | **Blood Disorders** | Please put yes or no |
|  | Sickle Cell Anaemia |  |  |  |  |  |  |  |
|  | Leukaemia |  |  |  |  |  |  |  |
|  | HIV/AIDS |  |  |  |  |  |  |  |
| **g** | **Genito - Urinary** | Please put yes or no |
|  | Pelvic Inflammatory Disease(Female) |  |  |  |  |  |  |  |
|  | Fibroids (Female) |  |  |  |  |  |  |  |
|  | Enlargement of the Prostate (Male) |  |  |  |  |  |  |  |
| **h** | **Gastro - Intestinal** | Please put yes or no |
|  | Duodenal or Stomach Ulcers |  |  |  |  |  |  |  |
|  | Liver Disease |  |  |  |  |  |  |  |
|  |  | Please put yes or no |
| **i** | PREVIOUS SURGICAL OPERATIONS |  |  |  |  |  |  |  |
| **j** | OTHER MEDICAL CONDITIONS OR DISABILITIES (Not specifically covered) |  |  |  |  |  |  |  |

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| **k** | **Have you been hospitalised within the last 3 years?** |
| YES |  | (Give reason) |
| NO |  |  |
| **l** | **Are you on any regular prescribed medication?** |
| YES |  | (Type of medication) |
| NO |  |  |
| **m** | **Have you been screened or tested for any condition in the last three years?** |
| YES |  | (Condition: Year: (Please attach copies of any records)) |
| NO |  |  |
| **n** | **Are you a member of any rescue or medical insurance organization?** |
| YES |  | (Give details) |
| NO |  |  |
| **o** | **Have you had a pap smear (screening test for cervical cancer) in the last 1 year?** |
| YES |  |
| NO |
| **p** | **Have you had a PSA (screening test for prostate cancer) done?** |
| YES |  |
| NO |
| **q** | **Other than those declared above do you have any particular Health concerns you wish to inform AAR about?** |
| YES |  | (Give details) |
| NO |  |  |

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| M | MAIN MEMBER |  |
| 01 | SPOUSE |  |
| 02 | DEPENDANT |  |
| 03 | DEPENDANT |  |
| 04 | DEPENDANT |  |
| 05 | DEPENDANT |  |
| 06 | DEPENDANT |  |
| 07 | DEPENDANT |  |

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| **This is a signed declaration that this information is true and that AAR have the express authority to access any medical information from any source as required from time to time.****I hereby consent to authorise AAR to receive/disclose to my employer any and all information, reports, records and or details relating to me including such medical or other information that would otherwise be confidential for the administration of the medical scheme****Failure to disclose correct information will mean what may have been coverable becomes automatically excluded for both in-patient and out-patient cover** |

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| **DATE OF SUBMISSION** | **SIGNATURE/ NAMES** |
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