Nationwide Medical Insurance
P.M.B. 108, Airport, Accra- Ghana
Tel: 0302-251107/ 251108
Call Center: 0800 222 222

Attach a passport size photograph here

Family Care Dependant Application Form

Please print/write all information in CAPITAL LETTERS

PRINCIPAL MEMBER NAME / MEMBER NO.:		
BENEFIT OPTION (Please tick √ one)		
Privilege (PRV) ☐ Premier Plus(PRP) ☐ Premier (PRE) ☐ Executive (EXE) ☐ Essential (ESS) ☐		
PARTICULARS OF APPLICANT		
Title (Mr, Mrs, Dr, Rev etc):		
Surname	**First Name**	**Other Name(s)**
DATE OF BIRTH (dd/mm/yyyy)	**GENDER/SEX** (Please tick one only)	**OCCUPATION**
	Male ☐ Female ☐	
MARITAL STATUS (Please tick √ one only) Single ☐ Married ☐ Divorced ☐ Widowed ☐		
RELATION TO PRINCIPAL MEMBER		
Spouse ☐ Daughter ☐ Son ☐ other: ☐		
CONTACT		
POSTAL ADDRESS:		
MOB. NO 1:	MOB. NO 2:	NHIS NO.
E-MAIL.:		
HEALTH PROFILE (please tick √ as applicable)		

Pre - Existing Conditions (Please Tick ✓ if you have any of the conditions below)

☐ **Diabetes**	☐ **Cardiovascular Disease**
☐ **Spectacles**	☐ **Musculoskeletal Disorders**
☐ **Previous Cs**	☐ **Cancer / Tumours / Myeloma**
☐ **Hypertension**	☐ **Chronic Respiratory Conditions**
☐ **Liver Disorders**	☐ **Kidney Disorders Gastrointestinal Disorders**
☐ **Autoimmune Disease**	☐ **Any Other Conditions**

NOTE:

1. Please complete all fields of this forms.
2. The Scheme shall not be liable for undeclared pre-existing conditions.
3. Submission of this form does not constitute acceptance of the application. The Scheme shall issue membership cards for applications that are successfully considered.

I ....declare that to the best of my knowledge the information given about myself is true. I have read the notes to this application and understand that this forms part of a contract with Nationwide Medical Insurance, I understand that no liability shall be accepted for any conditions that originated before the date of commencement of the policy, or the date of acceptance of this application, unless the condition is disclosed on this application form and accepted by Nationwide Medical Insurance.

Signature of Principal Member: ____________________ **Date:**____________

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Medical Examination Form

To be completed by examining physician

Name of Hospital/ Clinic			
Name of Applicant:			
Age:	Weight:	Height:	BP:
General (weight loss, anemia, jaundice, pedal edema, etc)			
Mouth and Teeth (dental caries, etc)			
Ears, Nose, Throat			
Neck (Thyroid, etc)			
Eyes (Cataract, etc)			
Cardiovascular System (Pulse, heart sounds etc)			
Respiratory System (Breath sounds, etc)			
Abdomen (Liver, spleen, kidneys, hernia, fibroids, etc)			
Central Nervous System (tremors, etc)			
Musculoskeletal system (disabilities, joints, etc)			
Skin			

Lab Investigations (>5 years old)

Full Blood Count		Sickling Test	
Urine Routine Exam		Other (as required):	
FBS (> 18 years old)			
CXR (>18 years old)			

Findings/Conclusion:……………………………………………………………………………………………

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Date:……………………Dr.'s Name:…………………………………Dr.'s Signature…...…………………

Approval by GM: ☐ No (Office Use Only)

☐ Yes Terms:…………………………………………………………………………...

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