



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 Membership Application Form

Please print/write all information in CAPITAL LETTERS

BENEFIT OPTION (Please tick ✓ one)		
Privilege (PRV) <input type="checkbox"/>	Premier Plus (PRP) <input type="checkbox"/>	Premier (PRE) <input type="checkbox"/> Executive (EXE) <input type="checkbox"/> Essential (ESS) <input type="checkbox"/>
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 <input type="checkbox"/> Female <input type="checkbox"/>	
MARITAL STATUS (Please tick ✓ one only) Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>		
CONTACT		
POSTAL ADDRESS:		
MOB. NO 1:	MOB. NO 2:	NHIS NO.
E-MAIL:		
HEALTH PROFILE (please tick ✓ if you have any of the conditions below)		
Pre - Existing Conditions		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cardiovascular Disease	
<input type="checkbox"/> Spectacles	<input type="checkbox"/> Musculoskeletal Disorders	
<input type="checkbox"/> Previous Cs	<input type="checkbox"/> Cancer / Tumours / Myeloma	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Chronic Respiratory Conditions	
<input type="checkbox"/> Liver Disorders	<input type="checkbox"/> Kidney Disorders Gastrointestinal Disorders	
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> 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.

Ideclare 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:.....

.....

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

Approval by GM: No

(Office Use Only)

Yes Terms:.....

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