RESOLUTION INSURANCE

Number:

Individual Member Application Form

This form is to be completed with details of the Principal Member, Spouse and Children under 18 years.
Adult dependants 19 years and above should complete a similar separate form.
All questions are **mandatory** (if not applicable kindly indicate so)
All applicants above 18 years must provide a copy of identification (National ID or Passport)

Please complete all sections in Block Letters and **BLACK** ink.

(DO NOT STAPLE), Attach 2 recent colour passport photos for **each** member of the family with the full name printed on the back.

A. DETAILS OF PRINCIPAL MEMBER

First Name (In full) | Middle Name

Surname | Title | Marital Status M S D W

ID No. | PP No. | Gender M F | D.O.B. D D M M Y Y Y Y | Blood Grp.

Employer | NHIF No.

Occupation

B. CONTACT DETAILS (Please give current & accurate details to enable updates to you continuously & consistently)

Telephone (H) Code | Number

Telephone (W) Code | Number

Mobile No.

Alternative Mobile No.

E-mail Address

Postal Address Number | Postal Code | Town

Residential Address (Estate)

Hse/Flat No. | Road | Town

SPOUSE

First Name | Middle Name | Surname

ID No. | PP No. | Gender M F | D.O.B. D D M M Y Y Y Y

Employer | NHIF No.

Email Address | Tel No.

NEXT OF KIN

Person to be notified in case of emergency and cover status while member is hospitalized

Name

Postal Address Number | Postal Code | Town

Telephone Code | Number | Alternative Telephone No.

Relationship to Principal Member

BENEFICIARY

Person designated to receive funds as per cover benefits in the unfortunate event of loss of life

Name

Postal Address Number | Postal Code | Town

Telephone Code | Number | Alternative Telephone No.

Relationship to Principal Member

My Health, My Life, My Resolution

C. FAMILY MEMBERS DETAILS

Note: A selection for dental or optical is an addition to an outpatient plan, and **MUST** include the inpatient plan. However, one may choose an inpatient plan on its own.
For details of plans available, please see the latest product guide

Plan selection for Principal Applicant (Member No. 1)

Plan Selection (Indicate plan name as appropriate) Total For Plan(s) Selected	Inpatient	Outpatient
	Auxiliary Services	
Height: Weight (Kg)	Allergies:	

Plan selection for spouse and dependants (Details of height and weight are only necessary for applicants/dependants over 18)

Surname			First Name		Middle Name	
Member No.	Date of Birth	D D M M Y Y Y Y	Relationship to Member		Allergies	
2.	Height		Blood Group			
	Weight (Kg)		Gender	M F		
Plan Selection (Indicate plan name as appropriate)			Inpatient		Outpatient	
Total For Plan Selected			Auxiliary Services			

Surname			First Name		Middle Name	
Member No.	Date of Birth	D D M M Y Y Y Y	Relationship to Member		Allergies	
3.	Height		Blood Group			
	Weight (Kg)		Gender	M F		
Plan Selection (Indicate plan name as appropriate)			Inpatient		Outpatient	
Total For Plan Selected			Auxiliary Services			

Surname			First Name		Middle Name	
Member No.	Date of Birth	D D M M Y Y Y Y	Relationship to Member		Allergies	
4.	Height		Blood Group			
	Weight (Kg)		Gender	M F		
Plan Selection (Indicate plan name as appropriate)			Inpatient		Outpatient	
Total For Plan Selected			Auxiliary Services			

Surname			First Name		Middle Name	
Member No.	Date of Birth	D D M M Y Y Y Y	Relationship to Member		Allergies	
5.	Height		Blood Group			
	Weight (Kg)		Gender	M F		
Plan Selection (Indicate plan name as appropriate)			Inpatient		Outpatient	
Total For Plan Selected			Auxiliary Services			

Surname			First Name		Middle Name	
Member No.	Date of Birth	D D M M Y Y Y Y	Relationship to Member		Allergies	
6.	Height		Blood Group			
	Weight (Kg)		Gender	M F		
Plan Selection (Indicate plan name as appropriate)			Inpatient		Outpatient	
Total For Plan Selected			Auxiliary Services			

Grand Total premium for service/plan selected for all family members...

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 Continued overleaf

D. DETAILS OF PREVIOUS MEDICAL COVER

1. Name of Scheme/Plan - Principal Applicant

From: D D M M Y Y To: D D M M Y Y

2. Name of Scheme/Plan - Spouse

From: D D M M Y Y To: D D M M Y Y

Have you or any of your dependants ever been declined, loaded or had exclusions applied by a medical scheme?

YES	NO

If 'yes' please provide details (A separate report can be attached to this application) ....

E. MEDICAL HISTORY OF APPLICANT AND DEPENDANTS

Have you or any of your dependants ever had (been diagnosed and/or treated for) any of the following medical conditions?
Kindly answer **YES** or **NO** to all the questions below. Answers are required for each applicant. (Ask a Doctor for assistance if needed)
Note: If the answer is YES to any of the questions which follow, you will be required to provide details of the medical condition. Resolution Insurance Limited may request you to provide a medical report, without which your application may be delayed

Numbering of dependants should match the sequence as under section C with the principal member being No. 1.

	Medical Condition	No. 1	No. 2	No. 3	No. 4	No. 5	No. 6
1.	Blood Group (if known)						
2.	Cancer, growths or tumors whether benign or malignant	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3.	Cardiovascular(heart and blood vessels) disorders including High blood pressure, heart disease, Deep Venous Thrombosis (DVT), congenital heart disease, chest pain, coronary artery disease/ischaemic heart disease, valvular heart disease, arrhythmias, varicose veins, coronary artery stenting, peripheral arterial disease, aneurysm, angina, palpitations, rheumatic fever and any other.	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4.	Respiratory and Ear Nose and Throat (ENT) Disorders including asthma, tuberculosis, hearing & speech impairment, adenoids, cleft lip & palate, tonsils, nose injuries, nose bleeding, sinus problems, cigarette smoking, bronchitis, allergic rhinitis, chronic obstructive pulmonary disease, and any other.	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5.	Endocrine disorders including high cholesterol, diabetes, thyroid abnormalities, obesity, hormonal imbalances, diabetic coma and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
6.	Eye related disorders including glaucoma, blindness, cataracts, retinitis pigmentosa, lens implants, laser surgery, retinoblastoma and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
7.	Gastro-intestinal disorders including peptic ulcer disease, heartburn, relux, dyspepsia, haemorrhoids, pancreatitis, gall bladder disease, hepatitis, hernias, anal fissures, rectal bleeding, endoscopy, colonoscopy, sigmoidoscopy and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
8.	Gynaecological & Obstetric disorders including caesarian section, fibroids, ovarian cysts, infertility, pelvic inflammatory disease, menstrual irregularities, abnormal pap smear, hormonal treatment, miscarriages, endometriosis, laparascopic surgery and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
9.	If pregnant indicate expected date of delivery D D M M Y Y	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
10.	Genitourinary disorders including enlarged prostate, kidney failure, dialysis, kidney stones, bladder disorders, pyelonephritis, syphillis, gonnorrhoea, chlamydia, genital herpes and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
11.	Musculoskeletal disorders including arthritis, gout, back problems, physical disabilities, joint problems, sporting injuries, osteoporosis, scoliosis, kyphosis and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
12.	Neurological & psychological disorders including epilepsy, mental disabilities, paralysis, schizophrenia, depression, bipolar disorder, panic attack, personality disorder, anxiety, attention deficit disorder, post traumatic stress, attempted suicide, anorex, nervosa/bulimia, alcohol or drug dependency/addiction and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
13.	Blood & connective tissue disorders including leukemia, HIV & AIDS, Systemic Lupus Erythematosus (SLE) and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
14.	Congenital/inherited/hereditary disorders including birth defects, sickle cell disease, umbilical hernia and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
15.	Skin disorders including eczema, keloids, warts, acne, moles, melanoma, skin cancer, hypertrophic scars, burns and any other	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
16.	Has any close blood relative (excluding dependants) ever been diagnosed with heart disease, high cholesterol, diabetes or any other hereditary disease?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

NB: Any misrepresentation or non-disclosure of material or factual information will render all benefits granted by the Scheme null and void. In addition any payment made due to such actions will be recovered from the member by the Scheme.

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If you answered YES to any of the questions above, please supply full details below

Q. No.	Applicant Name	Date	Condition	Treatment / Medicines	Consulting Doctor

(If the space provided is insufficient, please attach additional information to the application)

DETAILS OF FAMILY MEDICAL PRACTITIONER(S)

Please give the name and address of your general practioner as well as any specialist you may recently have consulted.

1. Doctor

Name ____________ Telephone ____________

2. Doctor

Name ____________ Telephone ____________

SURGERY AND HOSPITAL ADMISSIONS

Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past, and/or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future

Applicant Name	Surgical Procedure/ Hospital Admission	Date	Conditions / Diagnosis	Current Condition

F. EXCLUSIONS

1. All expenses associated with Dental services and Optical services unless covered under the plan or purchased separately.
2. All expenses associated with Pre-existing*, Congenital illnesses**, Psychiatric disorders, HIV /AIDS and related conditions unless where covered under the plan.
3. Cancer diagnosed before or within your selected plan's waiting period.
4. Compensation for pain and suffering; loss of income; funeral expenses or claims for damages; expenditure incurred by a member or dependants arising from any illegal or criminal act.
5. Expenses arising from injuries sustained as a result of participation in and not limited to professional sport or hazardous pursuits such as motor racing, skydiving, parachute jumping and bungee jumping.
6. Operations, treatments and/or procedures of own choice for purely cosmetic purposes, obesity, and eating disorders and any complications that may arise thereof
7. Expenses incurred from recuperative or convalescent holidays.
8. All expenses in respect of illness or conditions that were subject to waiting periods when the member joined the Scheme and where the diagnosis for such illness occurred during the waiting period.
9. Purchase of:
    - 9.1. Applicators, toiletries, sunglasses and/or lenses for sunglasses and beauty preparations;
    - 9.2. Patented foods and nutritional supplements including baby foods;
    - 9.3. Contraceptive preparations, remedies and devices;
    - 9.4. Tonics, slimming preparations, appetite suppressants and drugs as advertised to the public for the specific treatment of obesity;
    - 9.5. Sunscreen and sun tanning lotions, soaps and shampoos (medicinal or otherwise);
    - 9.6. Household and biochemical remedies which are not promoted by the medical profession;
    - 9.7. Cosmetic products (medicinal or otherwise); anti-habit forming products; vitamins and multi-vitamins (unless prescribed for documented deficiency);
    - 9.8. Remedies for body building purposes;
    - 9.9. Aphrodisiacs;
    - 9.10. Patent medicines and proprietary preparations; household bandages, cotton wool, dressings and similar aids.
    - 9.11. External prosthesis.
    - 9.12. Crutches and standard wheelchairs, unless under rehabilitation cover.
    - 9.13. Monitoring and assistive devices including Blood Pressure machines, glucometers and thermometers.
10. Investigation and treatment for infertility and impotence.
11. Vaccinations and/or immunizations and other preventive treatments with the exemption of KEPI.
12. Services arising from an accident or event of which the member or dependants has received, or is likely to receive, compensation from any source whatsoever including NHIF and employer liability insurance.
13. Any treatment relating to an accident/illness which occurred while the member was intoxicated or was under the influence of alcohol or drugs (unless prescribed and taken according to the instructions of a medical practitioner).
14. Dialysis of any kind (except for acute renal failure).

My Health, My Life, My Resolution

 Continued overleaf

15. Treatment or services rendered in respect of dependence producing substances.
16. Exercising and/or guidance programmes inclusive of antenatal exercises, special diets and weight control.
17. Kilometers charges and traveling expenses with the exception of ambulance services as per plan benefits.
18. Gold or other precious metal inlays in dentures.
19. Hormonal Replacement Therapy.
20. Examinations or check-ups such as general health examinations not related to diagnosis of sickness or accidental bodily injury unless explicitly agreed in writing by Resolution Health.
21. Accommodation in convalescent or old age homes or similar institutions catering for the aged.
22. Costs associated with Vocational Guidance, Child Guidance, and Marriage Guidance.
23. Cost of alternative therapy including chiropractic, acupuncture, herbal treatment and any complication arising as a result thereof.
24. Laser treatment
25. Illness, injury or disablement directly or indirectly caused by or contributed to by:
    - 25.1. Active participation in Civil war, riots, rebellion, revolution, insurrection or political activity.
    - 25.2. Any declared or undeclared war, invasion, act of foreign enemy, hostilities or war like operations.
    - 25.3. Nuclear fission, ionizing or non-ionizing radiation.
    - 25.4. Operating, learning to operate or serving as a Member of a crew of any aircraft being used for sky-diving, racing, testing or exploration.
    - 25.5. Participation in Naval, Military, Air Force, Paramilitary, Police or Police Reserve service or operations.
    - 25.6. Attempted suicide or self-injury deemed deliberate by Resolution Health.
    - 25.7. The willful non-compliance on the part of the member with Resolution Health's appointed doctors prescribed treatment.
26. Allergy tests.
27. Costs incurred by a member at a Medical Service Provider not approved by Resolution Health.

* A Pre-existing condition refers to a medical condition (whether declared or not) of which a member was aware, or in the company's opinion, ought to have known existed prior to becoming member.

Please note that cover for Pre-existing conditions is subject to medical underwriting and that not all pre-existing conditions will be covered.

** Congenital condition is a genetic, physical or (bio) chemical defect, disease or malformation which may be either hereditary / familial or due to an influence during intra uterine development of the foetus and which may or may not be obvious at birth.

G. DECLARATION

General

1. I, the undersigned member/applicant:

1.1 Hereby apply for myself and my dependants to be registered on the Resolution Insurance Limited Medical Scheme (the "Scheme") and have read, understood and agree to abide by the Rules of the Scheme;

1.2 Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete, whether recorded in writing by me or by my agent/broker/intermediary on my behalf and, should there be any change in the state of health or illness suffered by myself or any of my dependants from the date of signing this application form and the date of acceptance of the risk by the Scheme, notification of such change will be provided to the Scheme in writing with full details of such condition/ailment;

1.3 Understand that the statements and answers provided form the basis of the contracts and any breach of my warranty or non disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null and void and all premiums paid shall be forfeited;

1.4 Understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary including the results of such medical examinations and tests that they may require me or my dependants to undertake;

1.5 Consent to the Scheme addressing any requests for information, tests or examinations directly to any dependant of mine over the age of 21, with the same legal consequences as if the request had been addressed to me in my capacity as a member;

1.6 Acknowledge and accept that the Scheme reserves the right to, without notice, cancel, suspend and or terminate membership to the Scheme if any due premium is not paid on the due date;

1.7 Do hereby undertake to repay the scheme any amounts paid under circumstances where no benefits were payable under the terms and conditions of the scheme and acknowledge that such amounts are recoverable from me.

1.8 Undertake to inform the Scheme within 30 days should material changes occur;

1.9 Undertake to provide an adoption order or official proof that my adopted/foster child is legally placed in my custody.

Authority

2. Accepting that I am curtailing my and my dependants' right to privacy but in order to facilitate the assessment of the risks and the consideration of any claim, I irrevocably authorize:

2.1 The Scheme to obtain from any person, whom I hereby so authorize and direct to give, any information which the Scheme deems necessary,

2.2 I further authorize and instruct the Scheme and any hospital concerned to give information relating to myself and my dependants to the Medical Care Managers appointed by the Scheme for purposes of ensuring that the members of the Scheme receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical

 Continued overleaf

resources.

2.3 I understand and accept that the above authorization constitutes a partial waiver of my and my dependants right to privacy.

2.4 I hereby authorize the scheme to institute proceedings against third parties in recovery of costs and expenses incurred or paid by the scheme under the terms hereof due to acts of negligence by such third parties and in circumstances where expenses so paid were instead due from a third party.

2.5 I undertake to participate fully in the recovery proceedings so instituted.

3. **I declare that:**

3.1 My dependant(s) is/are residing with me,

3.2 I am liable for his/her/their family care,

3.3 The dependant(s) is/are my immediate family,

4. I undertake to repay the Scheme any amount by which claims paid out exceed benefits covered for myself and all my dependants.

5. I have read and understood the terms and conditions governing the scheme, including all the exclusions herein and applicable to the benefits granted and undertake to abide by those terms and conditions.

Dated ____________ **day of** ______MONTH______ / ___YEAR____

Signature of Principal Member ____

AGENT/BROKER DETAILS

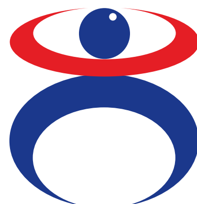
Full name of Agent / Broker | | | | | | | | | | | | | | | | | | | | | | | | | | |

Telephone Contacts | | | | | | | | | | | | | | | | | | | | | | | | | | |

Agent/Broker Declaration

I hereby declare that I explained the benefits of this application and that the applicant is aware of the membership terms and conditions of RESOLUTION INSURANCE LIMITED.

Signature of Agent/Broker ____ **Date:** __________________



RESOLUTION
HEALTH
• EAST AFRICA LIMITED •

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