MEDICAL ENROLMENT FORM.

Please complete the following information as fully in block letters.

NAME

DETAILS

Date of birth: Day…… / Month…….. / ……

Sex: ☑ Male Female **Blood group:** ,kmnmm

Business address:

Residential address:

Next of Kin:

Telephone numbers **- Home:**

- Mobile:

- Office:

☑ **Please indicate the package:**

Group Life Domestic ☐

DEPENDANTS DETAILS

Please complete the following for your dependants. If there are more than 5 dependants then please complete a separate form for the others:

	First name Surname	dd/mmm/yr	Sex
1			
2			
3			
4			
5			
6			

MEDICAL DECLARATION (for self and Dependants)

Please indicate by ticking if you or any members of your immediate family have suffered /are suffering from any of the following:

	SELF	DEPENDANTS					
		1	2	3	4	5	6
Diabetes							
Cancer							
Hypertension							
Sickle Cell Disease							
Bronchitis or Asthma							
Rheumatic fever							
Malaria							
Tuberculosis							
Hepatitis B							
Any STDs							
Any Allergies							
Any serious injury							
Any operation in the last 5 years							

If the answer to any of the above is **YES**, please give details.

……

……

SERVICE AGREEMENT

Case Medcare hereby agrees to provide and the Client hereby agrees to utilize the medical services of the Hospital at its above address.

Case Medcare hereby warrants that it will diligently provide such services to the Client to the best of its ability using accepted scientific methods as and when required to do so by the Client.

The Client hereby undertakes to pay for any additional services rendered to him which exceed the financial limits of the contractual terms.

The Client hereby understands that membership fees are not redeemable 60 days after inception of cover. If termination, for whatever reason occurs within 60 days, membership fees are refundable, less the cost of treatment received by the Client during that period plus an administrative charge of 5% of the membership fee.

Signed by the Client: ..... Date: .....

Signed & Stamped by;
Case Medcare

..... Date: .....