RC: 413934

songhai

HEALTH TRUST LIMITED

...always there when you need us.

ENROLMENT FORM

"Liability of SONGHAI Health Trust Limited does not commence until this application is accepted, premium received and policy issued. Please NOTE that benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and if you are in any doubt as to whether any facts are material, you should disclose them. This applies even if medical advice has not been sought. A material fact is one that is likely to affect the assessment of this application".

Please tick as appropriate: **Individual** ☐ **Family** ☐

Company Name: _____ **Nature of Business:** _____

If you're applying as a corporate entity, please insert the name of the company above.

1. PERSONAL DETAILS (Principal)

Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Occupation: _____

Genotype: _____ Blood Group: _____

Residential Address: _____

_____

Phone: _____ E-mail: _____

Name & Number of Next of Kin: _____

Preferred Hospital: _____

Contact details of the preferred Hospital (Address/Telephone/E-mail): _____

_____

2. SPOUSE DETAILS

Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____ Blood Group: _____ Genotype: _____

Residential Address: _____

Phone: _____ E-mail: _____

Preferred Hospital: _____

Contact details of the preferred Hospital (Address/Telephone/E-mail): _____

_____

3. DEPENDANT 1 (below 21 years)

Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____ Blood Group: _____ Genotype: _____

Residential Address: _____

_____

Preferred Hospital: _____

Contact details of the preferred Hospital (Address/Telephone/E-mail): _____

_____

4. DEPENDANT 2 (below 21 years)

Surname:_____ **First Name:** _____

Date of Birth:_____ **Gender:**_____ **Blood Group:** _____ **Genotype:**_____

Residential Address:_____

_____

Preferred Hospital: _____

Contact details of the preferred Hospital (Address/Telephone/E-mail): _____

_____

5. DEPENDANT 3 (below 21 years)

Surname:_____ **First Name:** _____

Date of Birth:_____ **Gender:**_____ **Blood Group:** _____ **Genotype:**_____

Residential Address:_____

_____

Preferred Hospital: _____

Contact details of the preferred Hospital (Address/Telephone/E-mail): _____

_____

6. DEPENDANT 4 (below 21 years)

Surname:_____ **First Name:** _____

Date of Birth:_____ **Gender:**_____ **Blood Group:** _____ **Genotype:**_____

Residential Address:_____

_____

Preferred Hospital: _____

Contact details of the preferred Hospital (Address/Telephone/E-mail): _____

_____

Kindly request extra form to register extra dependant(s)

7. CATEGORY OF MEDICAL COVER (Please tick one box only)

SHTL Gold Plus ☐ **SHTL Gold** ☐ **SHTL Silver** ☐ **SHTL Classic** ☐ **SHTL Standard** ☐

8. COMMENCEMENT DATE:

dd	mm	yyyy

(Date you want to commence)

9. METHOD OF PAYMENT:

(i) **Cheque** ☐

(ii) **Bank Draft** ☐

(iii) **Mobile Banking Transfer** ☐

(iv) **SHTL Mobile App** ☐

(v) **Internet Banking** ☐

(Please tick one box only)

	Principal		Spouse		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
a. Do you smoke?												
b. Has any person named in this form been admitted to a hospital or nursing home or had any medical test done in the last 2 years?												
c. Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 1 year?												
d. Has any application for life, accident, health or any other insurance been refused or had special terms applied? If yes, give details												
e. Does any person named in this form anticipate the need or has been recommended to undergo any medical test or investigations in the foreseeable future? If yes, give details												

Has any person named in this form ever suffered or is suffering from any disease or condition stated below?

		Principal		Spouse		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	High Blood pressure or circulatory disorders If yes underline												
2.	Stroke or Paralysis If yes underline												
3.	Heart disease												
4.	Fainting, blackout, dizziness, seizures, fits, etc. If yes underline												
5.	Stomach ulcer, hepatitis, gall bladder disease, intestinal or bowel disorders. If yes underline												
6.	Asthma, persistent cough, breathlessness or other respiratory disorders. If yes underline												
7.	Kidney, Bladder, Prostate or Genito-urinary disorders. If yes underline												
8.	Gynecological or hormone disorders. If yes underline												
9.	Diabetes, High Cholesterol or other blood disorders If yes underline												
10.	Musculo-skeletal disorders												

Medical condition Cont'd

		Principal		Spouse		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11.	Tumour growth, cancer or glandular diseases. If yes underline												
12.	Diseases or disorders of the eyes, ears, nose and throat. If yes underline												
13.	Mental disorders												
14.	Any diseases, disorders or conditions which are long-lasting or recurrent. If yes underline												
15.	Management for drug or substance abuse.												
16.	Any other illnesses, disabilities or defects that have not been mentioned above												

If your answer to Question 16 above is YES, please provide details: _____

_____

_____

11. DECLARATION

I hereby declare that the information given in this form is complete and true. I am aware that if I give false or misleading information deliberately, my enrollment may be rejected, or maybe terminated back to the date of this application. I am also aware that if I leave out important information in this form, my enrollment may be rejected. I am also aware that I must give true and complete information about my dependant(s) (spouse and children) otherwise, their enrollment may be rejected or terminated back to the date of this application.

I understand and agree that any dispute between myself (including any of my enrolled family members) and Songhai Health Trust must be subject to final and binding arbitration. I also understand that disputes that I may have with Songhai Health Trust involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration.

My signature below indicates that I understand and agree with the terms of this Agreement.

_____ _____

SIGNATURE OF APPLICANT DATE