UNIVERSITY OF MALAWI MEDICAL SCHEME (UNIMED)

STAFF REGISTRATION FORM

(For office use only)

Membership Number

SECTION A - COLLEGE DETAILS

COLLEGE _____

ADDRESS _____

_____

_____

TELEPHONE _____

FAX _____

SECTION B – MEMBER DETAILS

Payroll Number

TITLE _____

SURNAME _____

FIRST NAME(S) _____

GENDER MALE ☐ FEMALE ☐

NATIONALITY _____

ADDRESS _____

_____

_____

CELLPHONE NUMBER _____ EMAIL _____

(Attach **TWO COLOUR** passport size photographs for you and each dependant with name and signature at the back. The photos should preferably have a white background)

DATE OF BIRTH _____

MARITAL STATUS SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

DATE OF APPLICATION _____/_____/_____

PROPOSED DATE OF JOINING _____/_____/_____

SECTION C – DEPENDANTS TO BE COVERED

SURNAME	FIRSTNAME	RELATIONSHIP TO MEMBER	DATE OF BIRTH	COVER

SECTION D – PREVIOUS MEDICAL INSURANCE/ SCHEME MEMBERSHIP

(Supply details of previous Medical Insurance membership and attach proof of previous membership)

	DATE JOINED	DATE LEFT	NAME OF PREVIOUS COVER
1.	_____/_____/_____	_____/_____/_____	_____
2.	_____/_____/_____	_____/_____/_____	_____
3.	_____/_____/_____	_____/_____/_____	_____

SECTION E – CHOICE OF COVER

(Tick where appropriate)

COMPREHENSIVE ☐ STANDARD ☐

SECTION F: DECLARATION BY PRINCIPAL MEMBER

In this declaration, the singular shall imply the plural.

1. I the undersigned, hereby register myself and my dependants to join as a member of the scheme
2. I agree to be bound and to abide by the rules, standard terms, conditions and any rules ordinarily used by the scheme for types of benefits for which I have been registered.
3. I authorise my employer to deduct from my salary, any amount due in terms of the membership and remit the same to the scheme.
4. I declare that no material fact has been withheld, misstated or concealed by me and that I will disclose all material facts prior to acceptance of the risk and I agree that any misstatements and/or omission of any material information will render my membership null and void, and in such event all monies paid in respect thereof shall be forfeited.
5. I acknowledge that in the event of any modification or variation of this standard form, the scheme will regard this form as being invalid and of no force and effect.

SIGNATURE _____ DATE: _____ 20_____

ANNEXURE B: MEDICAL INFORMATION

Supply full details on questions. Where an answer to a question is "yes" provide details in the space provided below.
All questions pertain to applicant and all dependants

		Have you/your spouse or any one of your dependants ever experienced any of the following? Please TICK the relevant box	Answer	
			Yes	No
1	Cardio Vascular	Chest pain/angina, heart attack, heart failure, heart valve disease, rheumatic fever, high blood pressure (hypertension), High cholesterol, heart murmurs, circulatory problems/disorders, varicose veins, deep vein thrombosis (DVT), or any other heart or circulatory problems		
2	Respiratory & Breathing	Asthma, difficulty with breathing, bronchospasm, tuberculosis (TB), coughing up blood, emphysema, pneumonia, cystic fibrosis, pthisis, chronic bronchitis, shortness of breath, any other breathing problems		
3	Bladder & Kidneys	Blood in urine, kidney failure, polycystic kidneys, kidney or bladder infections, removal of kidney (nephrectomy), kidney stones, abnormal kidney or urine tests or any other kidney problems		
4	Reproductive & Gynae	Endometriosis, infertility, ovarian cysts, hysterectomy, abnormal PAP smear, laser treatment, cervix and breast biopsies, fibro-adenosis of the breast, laparoscopies, hormone replacement therapy, prostate infections or surgery, prostate enlargement or any other reproductive problems		
5	Digestive system	Duodenal ulcers, gastric ulcers, peptic ulcers, hiatus hernia, colon problems, crohn's disease, ulcerative colitis, gall bladder problems, liver problems or any other digestive problems		
6	Ear, Nose & Throat	Deafness, ear infections,, sinus problems, nasal surgery, throat surgery		
7	Dental	Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, or any other such surgery.		
8	Eyes	Blindness (partial or full), eye surgery, lens implant, cataracts, glaucoma, renitis pigmentosa, retinal detachment, impaired vision, or any other eyesight problems		
9	Endocrine	Diabetes mellitus or insipidus, underactive thyroid, overactive thyroid, thyroid surgery, Cushing's syndrome, Addison's disease, pituitary gland, gland problems or any other glandular problems		
10	Back & Muscles	Neck or back problems or operations, recurrent back pain, osteoporosis, ankylosing spondylitis, rheumatoid arthritis, osteo-arthritis, or any other bone or skeletal disorders.		
11	Neurological	Epilepsy, stroke (CVA), migraine, brain or head injuries, spinal cord injuries, paralysis, multiple sclerosis, mental retardation, narcolepsy, motor neuron disease, Parkinson's disease, Alzheimer's disease, or any other neurological problems		
12	Psychological	Depression, anxiety, psychosis, suicide attempts, bipolar disorders, manic depression, "Stress", schizophrenia, tourete's syndrome, anorexia nervosa, received advice, counseling or hospitalization for alcohol or drug abuse, attention deficit disorders, bulimia or any other psychological disorders.		
13	Tumours & Growths	Benign or malignant growths or lumps or tumors including melanoma, lymph gland cancer, leukemia, breast cancer or any other tumours, growths and cancers.		
14	Blood	Blood or bleeding disorders, e.g. hemophilia, Christmas factor deficiency, platelet or any other blood clotting disorders.		
15	Skin	Eczema, acne, dermatovositis, psoriasis, scleroderma, or any other skin disorders		
16	Sexually transmitted diseases	Advice, treatment or counseling for any of the following: HIV/AIDS, syphilis, gonorrhea, herpes, genital ulcers, pelvic infectious disease, genital warts, hepatitis B or any other sexually transmitted disease or disorder.		
17	Hospitalization	Have you, your spouse or any dependants ever been hospitalized? If yes, how frequently?		
18	Treatment & Surgery	Are you, your spouse or any dependants expecting any medical or dental advice, treatment, or are you planning any such treatment within the next three to six months?		
19	Dangerous pastimes	Are you, your spouse, or any dependants participating in any hazardous sport or occupations e.g. motor or motorbike or motorboat racing, dragster racing, bungee jumping, skydiving, scuba diving, or any other hazardous pursuits?		
20	Pregnancy	Are you, your spouse, or any dependants currently pregnant? Should the answer be yes, when is the expected date of delivery? (yyyy/mm/dd)		
21	Other	Are there any other factors related to you or your beneficiaries' health that is not disclosed above?		
22	Planned treatment	During the last 12 months, have you, your spouse or any dependants had any special dentistry treatment or are you planning any such treatment within the next six months?		

Question number	Name of person suffering from condition	Nature and duration of condition or symptoms. Date of diagnosis and duration of treatment	Dates symptoms were last experienced	Exact dates of treatment/hospitalisation	Medication/treatment and monthly cost thereof

For official use only

…….
Membership approved

…….
Date