| APPLICATION FORM  |
| --- |
|  |
| Personal Details of Principal Member |
| Title:  |
| Name:  |
| Surname: |
| Date of birth: dd/mm/yyyy  | ID number:  |
| Marital status:  |
| Postal Address:  |
| Contact number (C): 00268  | (H): | (W): |
| Employer:  | Occupation: |
| Email address:  |

**DEPENDANT DETAILS
*Codes: Dependant (D#)***

| Code | First name | Surname | Gender | Relationship | ID number |
| --- | --- | --- | --- | --- | --- |
|  |  | **Spouse** |  |  |
| D1 |  |  |  |  |  |
|  |  | **Children** |  |  |
| D2 |  |  |  |  |  |
| D3 |  |  |  |  |  |
| D4 |  |  |  |  |  |
| D5. |  |  |  |  |  |
| D6 |  |  |  |  |  |
| D7 |  |  |  |  |  |
| D8 |  |  |  |  |  |
| D9. |  |  |  |  |  |
| D10 |  |  |  |  |  |

**SELECT THE PLAN
*Mark ‘X’ next to the plan you are selecting***

| **Silver Plan** |  | **Gold Entry** |  | **Gold Plan** |  | **Gold Plus Plan** |  |
| --- | --- | --- | --- | --- | --- | --- | --- |

**NEXT OF KIN**

| First name | Surname | Relationship | Contact |
| --- | --- | --- | --- |
|  |  |  |  |

**MEDICAL HISTORY OF PRINCIPAL MEMBER AND DEPENDANTS
*Codes: Principal member (PM) / Dependant (D#)
Mark ‘X’ on selection***

| **CONDITIONS** | **PM** | **D1** | **D2** | **D3** | **D4** | **D5** | **D6** | **D7** | **D8** | **D9** | **D10** | **DETAILS** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Abnormal Pap Smear |  |  |  |  |  |  |  |  |  |  |  |  |
| ADD/ADHD |  |  |  |  |  |  |  |  |  |  |  |  |
| Alcohol abuse |  |  |  |  |  |  |  |  |  |  |  |  |
| Alcohol or Drug Dependence |  |  |  |  |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |  |  |  |  |
| Amenorrhea /Menstrual Irregularities |  |  |  |  |  |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |  |  |  |
| AutoImmune Disorder |  |  |  |  |  |  |  |  |  |  |  |  |
| Anaesthesia Reactions |  |  |  |  |  |  |  |  |  |  |  |  |
| Back Problems |  |  |  |  |  |  |  |  |  |  |  |  |
| Bleeding tendency |  |  |  |  |  |  |  |  |  |  |  |  |
| Chronic Conditions |  |  |  |  |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |  |  |  |  |
| Colitis |  |  |  |  |  |  |  |  |  |  |  |  |
| Concussion / Head Injury |  |  |  |  |  |  |  |  |  |  |  |  |
| Cough (chronic) |  |  |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes Type I or II |  |  |  |  |  |  |  |  |  |  |  |  |
| Disability/ Handicap |  |  |  |  |  |  |  |  |  |  |  |  |
| Ear Trouble/ Hearing Loss |  |  |  |  |  |  |  |  |  |  |  |  |
| Eating Disorder |  |  |  |  |  |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |  |  |  |  |  |
| Gallbladder Disease / Trouble |  |  |  |  |  |  |  |  |  |  |  |  |
| Headaches / Migraines |  |  |  |  |  |  |  |  |  |  |  |  |
| Heart Disease /Heart Problem / Murmur |  |  |  |  |  |  |  |  |  |  |  |  |
| Hepatitis |  |  |  |  |  |  |  |  |  |  |  |  |
| Hernia / Rupture |  |  |  |  |  |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |  |  |  |  |  |
| High cholesterol |  |  |  |  |  |  |  |  |  |  |  |  |
| Joint Disorder/ Issues |  |  |  |  |  |  |  |  |  |  |  |  |
| Kidney Infection/ Stones |  |  |  |  |  |  |  |  |  |  |  |  |
| Liver disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Long term medications |  |  |  |  |  |  |  |  |  |  |  |  |
| Mental/emotional illness |  |  |  |  |  |  |  |  |  |  |  |  |
| Mononucleosis |  |  |  |  |  |  |  |  |  |  |  |  |
| Phlebitis (blood clots) |  |  |  |  |  |  |  |  |  |  |  |  |
| Porphyria |  |  |  |  |  |  |  |  |  |  |  |  |
| Previous operations |  |  |  |  |  |  |  |  |  |  |  |  |
| Seizure disorder |  |  |  |  |  |  |  |  |  |  |  |  |
| Sexually Transmitted Disease (STD) |  |  |  |  |  |  |  |  |  |  |  |  |
| Sickle Cell Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Sinus Trouble |  |  |  |  |  |  |  |  |  |  |  |  |
| Skin Problems |  |  |  |  |  |  |  |  |  |  |  |  |
| Smoker |  |  |  |  |  |  |  |  |  |  |  |  |
| Spleen removed |  |  |  |  |  |  |  |  |  |  |  |  |
| Stomach or Intestinal Problem |  |  |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |  |  |
| Suicide attempt |  |  |  |  |  |  |  |  |  |  |  |  |
| Thyroid disorder |  |  |  |  |  |  |  |  |  |  |  |  |

**DOCUMENTS REQUIRED TO BE SUBMITTED WITH THE APPLICATION FOR APPROVAL**

* ID copies of Primary Member and Dependants
* Birth certificates for minor beneficiaries
* Marriage certificate of spouse
* Passport size pictures for all beneficiaries

I, in my capacity as the applicant’s employer/ applicant confirm that the applicant is employed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and commenced work as at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date). We further warrant that the members contributions will be deducted from payroll and paid directly to Mpilwenhle periodically, and in warrant that contributions are being deducted in accordance with the appropriate contributions table. We undertake that we will inform Mpilwenhle 30 days prior in the event the member leaves the company or resigns. I am aware that my membership can only be terminated at the end of the year unless it is due to a loss of income or resignation from employment, death where I will submit proof of such.

**Signature of applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Employer representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***\*Email this application and documents required to: info@swazihmo.co.sz***