PRUDENTIAL

PRUDENTIAL LIFE ASSURANCE ZAMBIA LIMITED
HEALTH DIVISION

EMPLOYEE'S PROPOSAL FORM FOR CORPORATE MEDICAL ASSURANCE POLICY

Company
HR Stamp

HR Name:.....

HR Signature:.....

Date:.....

EMPLOYEE'S PROPOSAL FORM

PLEASE ENSURE THAT ALL RELEVANT SECTIONS ARE COMPLETED

(IF INSUFFICIENT SPACE, PLEASE ATTACH SEPARATE SHEET WITH ADDITIONAL INFORMATION)

1. PERSONAL DETAILS

EMPLOYEE SURNAME

EMPLOYEE OTHER NAMES

NRC/PASSPORT NO: DOB

OCCUPATION SEX

POSTAL ADDRESS

PROFILE PLAN EMPLOYMENT START DATE

TELEPHONE (HOME)

E-MAIL

2. PERSONS TO BE COVERED

If the scheme covers your spouse/children and or Insured Dependants provide information required below (S-spouse, C-child & O-other - Niece, Nephew)

S/N	SURNAME	OTHER NAMES	NRC/PP NUMBER	SEX	DATE OF BIRTH R/SHIP

3.1 Are you or any other person to be insured covered by another medical insurance scheme? if yes, please give details.

4. CONFIDENTIAL MEDICAL HISTORY (Please tick YES/NO)

4.1 Are you or any other person to be insured in very good health now and usually enjoy good health?

YES ◯ **NO** ◯

4.2 Have you or any other person to be covered ever been hospitalized in the previous 36 months?

YES ◯ **NO** ◯

4.3 Have you or any other person suffered or incurred in the previous 12 months treatment of diseases such as cataract, benign prostatic hypertrophy, hysterectomy for menorrhagia of fibromyoma, hernia, hydrocele, congenital internal diseases, fistula in anus, piles, sinusitis and related disorders.

YES ◯ **NO** ◯

4.4 Have you or any other person suffered or incurred in the previous 12 months treatment of diseases such as diabetes, nervous disorder, tuberculosis, asthma, epilepsy, stroke or any form of heart disease or disorder of the lungs? if yes please give details.

YES ◯ **NO** ◯

4.5 Are you or any of the persons to be covered pregnant?

YES ◯ NO ◯

4.6 Are you or any of the persons to be covered wearing spectacles or uses contact lenses?

YES ◯ NO ◯

4.7 Have you or any of the persons to be covered had any dental treatment?

YES ◯ NO ◯

4.8 Have you or any of the persons to be covered ever suffered from impairment of vision?

YES ◯ NO ◯

4.9 Are you or any of the persons to be covered ever experienced depression or psychiatric disorders?

YES ◉ NO ◯

4.10 Are you or any persons to be covered ever suffered from jaundice, liver conditions, gall bladder disease?

YES ◯ NO ◯

4.11 Are you or any persons to be covered ever experience back, neck, joint problems, arthritis, gout, any physical disability or muscular disorder?

YES ◯ NO ◯

4.12 Is there any illness/factor not mentioned on this proposal that might affect your health in the next 12 months?

YES ◯ NO ◯

IF YOU TICKED YES FOR ANY OF THE ABOVE, (EXCEPT 4.1)PLEASE COMPLETE THE SECTION BELOW ALL IMPORTANT INFORMATION MUST BE DISCLOSED.

Question number	Name	Date	Please supply full details of disorder, date, duration of treatment, medication (if any)

PLEASE ATTACH ANY RELEVANT MEDICAL REPORTS

5. HEALTHCARE INFORMATION

NAME OF YOUR FAMILY / USUAL DOCTOR

POSTAL ADDRESS

PHYSICAL ADDRESS

TELEPHONE FAX

6. DECLARATION

I DECLARE THAT ANY FALSE STATEMENT IN THE PROPOSAL FORM OR NON-DISCLOSURE OF ANY MATERIAL INFORMATION WILL RENDER THE MEMBERSHIP THEREBY NULL AND VOID.

I ACKNOWLEDGE THAT ANY BENEFITS PAID BUT NOT COVERED BY THE TERMS AND CONDITIONS OF THE PROMED POLICY WILL BE REFUNDED TO THE INSURER.

EMPLOYEE SIGNATURE: _____ DATE: _____

PROMED CHRONIC MEDICINE

Patient's Details	First name.....Middle name.....Family name/Last name..... Date of birth...../...../..... Age..... Sex.....Cell..... Email.....
Principal Member	First name.....Middle name.....Family name/Last name..... Date of birth...../...../..... Age..... Sex.....Cell..... Email.....

Provider Details	Hospital Name..... Address..... Phone..... Doctor's first name..... Surname..... Speciality..... Practice no.....

To be completed by treating Doctor in Block letters

TESTS DONE DATE OF TEST

....

....

....

Doctor's comments

.....

.....

Diagnosis/ICD 9/ICD 10 CODE	MEDICINE TRADE NAME	ACTIVE INGREDIENT	STRENGTH(e.g 10mg)	Directions (e.g 1 tab TDS

Doctor's declaration

I certify that the particulars are, to the best of my knowledge and belief, true and accurate. I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

DR'S SIGNATURE..... DATE.....

I hereby declare that the information in this form is true and correct. I am aware that the Insurer may request medical information form any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires. In order to fully assess this application for benefits, I hereby give my consent for the Insurer to obtain this information. I understand that this application is subject to the **Promed** Health insurance Policy Conditions and benefits.

PATIENT/GUARDIAN SIGNATURE..... DATE.....