Member Enrollment Form

AVON HMO

Account Information
United Bank for Africa
Avon Healthcare Limited - 1017738836

AVON HMO ENROLLMENT PROCESS

1. Please fill all fields carefully.
2. Select a hospital from the Avon Hospital list applicable to your chosen plan.
3. All forms received by AVON HMO before the 20th of the month will be effective by the 1st of the following month.
4. Forms received after the 20th of the month will be effective the 1st of the subsequent month.
5. If you have any question please call AVON HMO call center or email callcenter@avonhealthcare.com

PLAN TYPE (Please tick the appropriate box)

Boss Plan	Premium Life Plan	Family Life Plan	Couples Plan	Life Starter Plan

COVER TYPE (Please tick the appropriate box)

Self only ____ Self & spouse ____ Self, spouse & dependents ____

PAYMENT DETAILS

Amount Paid ____ Date Paid ____ Reference Number ____

PRINCIPAL MEMBER DETAILS

Surname: _____

First name: _____ Other name: _____

Date of Birth: _____ Sex: _____ Marital status: _____

Hospital name: _____

Hospital address: _____

Office address: _____

Local Govt Area: _____ Town: _____ State: _____

Home address: _____

Local Govt Area: _____ Town: _____ State: _____

Telephone: _____ Email: _____

Designated next of kin: _____

Address of next of kin: _____

Telephone of next of kin: _____

SPOUSE MEMBER DETAILS

Surname: _____

First name: _____ Other name: _____

Date of birth: _____ Sex: _____

Hospital name: _____

Hospital address: _____

Home address: _____

Local Govt Area: _____ Town: _____ State: _____

Telephone: _____ Email: _____

Member Enrollment Form

AVON HMO

(For Individual / Family)

DEPENDENT DETAILS

Surname: ____________________

First name: ____________________ Other name: ____________________

Date of birth: ____________________ Sex: ____________________

Hospital name: ____________________

Hospital address: ____________________

Resident address (indicate principal / spouse address): ____________________

DEPENDENT DETAILS

Surname: ____________________

First name: ____________________ Other name: ____________________

Date of birth: ____________________ Sex: ____________________

Hospital name: ____________________

Hospital address: ____________________

Resident address (indicate principal / spouse address): ____________________

DEPENDENT DETAILS

Surname: ____________________

First name: ____________________ Other name: ____________________

Date of birth: ____________________ Sex: ____________________

Hospital name: ____________________

Hospital address: ____________________

Resident address (indicate principal / spouse address): ____________________

DEPENDENT DETAILS

Surname: ____________________

First name: ____________________ Other name: ____________________

Date of birth: ____________________ Sex: ____________________

Hospital name: ____________________

Hospital address: ____________________

Resident address (indicate principal / spouse address): ____________________

Medical Questionaire

AVON HMO

BIODATA

Name:
Age:
Sex: MALE FEMALE
Weight (in kg):
Height (in metres):
Marital status: SINGLE MARRIED WIDOWED DIVORCED
Occupation:

MEDICAL CONDITIONS
(PLEASE TICK APPROPRIATE ANSWER)

DO YOU HAVE / HAVE YOU SUFFERED FROM ANY OF THE UNDERLISTED CONDITIONS

Chest pain / Angina or heart attack?	YES	NO
High blood pressure (hypertension)?	YES	NO
Lung/respiratory condition e.g. asthma, bronchitis, emphysema?	YES	NO
Stomach / bowel disorder e.g. peptic ulcer or diverculitis or ulcerative colitis?	YES	NO
Urinary or kidney disorder e.g. kidney stones, urine incontinence, recurrent urinary tract infections or any requiring dialysis?	YES	NO
Muscle / bone or joint discorder e.g. bone fractures, osteoporosis, gout or arthritis	YES	NO
Diabetes which is controlled by insulin drugs and / or diet?	YES	NO
Prostate disorder?	YES	NO
Epilepsy or seizures?	YES	NO
Depression or schizophrenia or bipolar or drug or / and alcohol dependency?	YES	NO
Blood disorder e.g. sickle cell anemia or thalassemias or G6PD deficiencies or leukemia?	YES	NO
Disease of the eye or nose or throat lasting longer than six months? If yes, please give details	YES	NO
Cancer that has been partially treated?	YES	NO
Congenital abnormalities	YES	NO

FOR FEMALES ONLY
(PLEASE TICK APPROPRIATE ANSWER)

Are you pregnant?	YES	NO
When was your last pregnancy?		
0 - 2 years	YES	NO
3 - 5 years	YES	NO
6 years and above	YES	NO
Any complications post delivery? If yes, please circle any that pertain to you:	YES	NO
Miscarriages	YES	NO
Still Birth	YES	NO
Difficult child delivery	YES	NO
Any history of irregular menstrual cycle?	YES	NO
Any history of gynecologic procedures or surgery? If yes, please give details	YES	NO

SURGICAL HISTORY
(PLEASE TICK APPROPRIATE ANSWER)

Have you suffered from any condition requiring surgery in the last six months?	YES	NO

GENERAL QUESTIONS
(PLEASE TICK APPROPRIATE ANSWER)

Have you ever had or advised to be tested for HIV?	YES	NO
Have you suffered any of the following unexplained weakness or weight loss or diarrhea or skin lesions or enlarged lymph nodes?	YES	NO
Are you currently taking any prescription medications for over 1 month? If yes, what drugs?	YES	NO
Had any prescription changed or reduced or stopped or increased?	YES	NO
Have you received any new prescription or investigation or new medical consultation in the past 6 months?	YES	NO

General Exclusions

AVON HMO

1. Any medical services required or injuries sustained as a result of:

(a) Naval, military or air force service or operations;
(b) Hazardous sports including but not limited to water sports mountaineering, hunting, polo, racing on horseback, rugby, league football, motorcycling or motor racing, riding or driving in any kind of race;
(c) Air travel except as a fare-paying passenger in any aircraft licensed for passenger carrying.

2. Any medical services required or injuries sustained as a result of:

- War ("declared or undeclared"), riot, strike and civil commotion; or acts of God or acts of terrorism;
- Intentional self-injury, suicide or attempted suicide (whether sane or insane), venereal disease, member's own criminal act, intoxication, the use of drugs not prescribed by a physician or injury sustained whilst in a state of insanity, alcoholism or costs resulting from dependency on or abuse of drugs or other addictive substance;
- Treatment by chiropractors, acupuncturists and herbalists;
- Pregnancy, childbirth, maternity benefits, abortion, miscarriage, ante-or-postnatal care, caesarean operation where purchased (is subject to twelve months waiting period);
- Fertility treatment where purchased (is subject to twelve months waiting period);costs of treatment of infertility related to hormonal imbalance, hormone replacement therapy (HRT) are totally excluded; surgical treatment is limited to one surgery per member lifetime;
- Cosmetic or beauty treatment and/or surgery;
- Dental treatment unless otherwise stated to be covered by the specific plan;
- Hearing tests or cost of hearing aids;
- Any injury, illness or disease specified as exclusion and complications caused by a condition that is excluded or follow up treatments or investigations that are due to a condition that is excluded;
- Birth defects, congenital illness, autoimmune disorders, sickle cell anemia, conditions and illnesses related to genetic disorders;
- Psychiatric illness, mental disorders and/or insanity expenses will be covered up to the sub limit subject to twelve months waiting period;
- Any medical treatment required relating to an accident or illness which may have occurred prior to the effective date or to any illness where it was within the knowledge of a Member that he was suffering from it at the effective date;
- Treatment of obesity and slimming preparations;
- Treatment protocols that are not normal, customary or standard practice within the country;
- All expenses associated with HIV/AIDS and related conditions where purchased (subject to twelve months waiting period);
- Pre-existing and chronic conditions where purchased (is subject to twelve months waiting period and full declaration on the application at policy inception);
- Treatment of hemorrhoids, fibroids, hernia, and adenoidectomy where purchased (is subject to twelve months waiting period);
- All expenses in respect of illnesses/conditions that were subject to waiting periods when the member and dependant joined the scheme;
- Upon expiry of the waiting period (s) as indicated above, members will be required to enroll and adhere to Avon HMO's chronic disease management program. These conditions must be declared at the time of application for a member to qualify for the benefit and is subject to Avon HMO's written acceptance. Any newly diagnosed must be notified in writing immediately to Avon HMO for you to qualify for the benefit subject to Avon HMO's written acceptance.

Declaration

AVON HMO

Any misrepresentation or non-disclosure of material or factual information will render all benefits granted by the scheme null and void. In addition, any payment made due to such actions will be recovered from the member by the scheme.

General

1. I, the undersigned member:

1.1. Hereby apply for myself to be registered on Avon HMO Scheme and have read, understood and agree to abide by the Rules of the Scheme.

1.2. Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete.

1.3. Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non-disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null and void and all premiums paid shall be forfeited;

1.4. Understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary including the results of such medical examinations and tests that they may require me to undertake.

1.5. Acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any due premium is not paid on the due date.

Authority

2. Accepting that I am curtailing my right to privacy but in order to facilitate the assessment of the risks and the consideration of any medical claim, I irrevocably authorize;

2.1. The Scheme to obtain from any person, whom I hereby so authorize and direct to give, any information which the Scheme deems necessary,

2.2. I further authorize and instruct the Scheme and any hospital concerned to give away information relating to myself to the Medical Case Managers appointed by the Scheme.

2.3. I understand and accept that the above authorization constitute a partial waiver of and my right to privacy.

Signature of Member

Date