

Member Enrollment Form



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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COVER TYPE (Please tick the appropriate box)

Self only	Self & spouse	Self, spouse & dependents
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAYMENT DETAILS

Amount Paid	Date Paid	Reference Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

PRINCIPAL MEMBER DETAILS

Surname:	<input type="text"/>		
First name:	<input type="text"/>	Other name:	<input type="text"/>
Date of Birth:	<input type="text"/>	Sex:	<input type="text"/>
Marital status:	<input type="text"/>		
Hospital name:	<input type="text"/>		
Hospital address:	<input type="text"/>		
Office address:	<input type="text"/>		
Local Govt Area:	<input type="text"/>	Town:	<input type="text"/>
State:	<input type="text"/>		
Home address:	<input type="text"/>		
Local Govt Area:	<input type="text"/>	Town:	<input type="text"/>
State:	<input type="text"/>		
Telephone:	<input type="text"/>	Email:	<input type="text"/>
Designated next of kin:	<input type="text"/>		
Address of next of kin:	<input type="text"/>		
Telephone of next of kin:	<input type="text"/>		

SPOUSE MEMBER DETAILS

Surname:	<input type="text"/>		
First name:	<input type="text"/>	Other name:	<input type="text"/>
Date of birth:	<input type="text"/>	Sex:	<input type="text"/>
Hospital name:	<input type="text"/>		
Hospital address:	<input type="text"/>		
Home address:	<input type="text"/>		
Local Govt Area:	<input type="text"/>	Town:	<input type="text"/>
State:	<input type="text"/>		
Telephone:	<input type="text"/>	Email:	<input type="text"/>

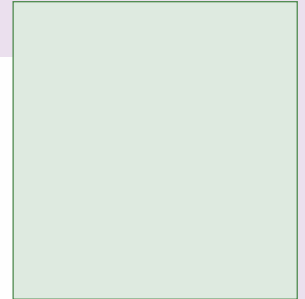
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(For Individual / Family)

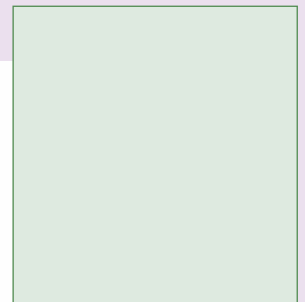
DEPENDENT DETAILS

Surname: _____
First name: _____ Other name: _____
Date of birth: _____ Sex: _____
Hospital name: _____
Hospital address: _____
Resident address (indicate principal / spouse address): _____



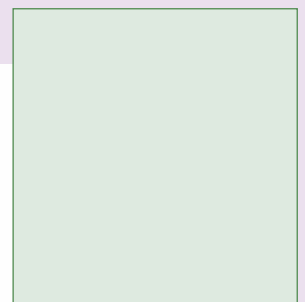
DEPENDENT DETAILS

Surname: _____
First name: _____ Other name: _____
Date of birth: _____ Sex: _____
Hospital name: _____
Hospital address: _____
Resident address (indicate principal / spouse address): _____



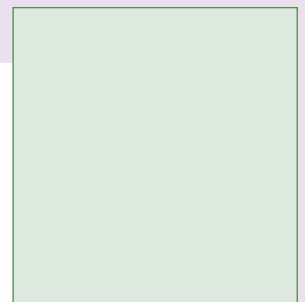
DEPENDENT DETAILS

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): _____



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 diverticulitis 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 disorder 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? YES NO
If yes, please circle any that pertain to you:

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? YES NO
If yes, please give details

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? YES NO
If yes, what drugs?

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

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.

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