SIERRA LEONE INSURANCE COMPANY LIMITED

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ENROLMENT FORM AND DECLARATION OF HEALTH STATUS

THIS FORM MUST BE COMPLETED BY EACH APPLICANT

(ANY INFORMATION PROVIDED WILL BE TREATED AS PRIVATE AND CONFIDENTIAL)

Personal details

Principal member
(Please use block letters)

1. Title…… Initials…… First name…… Middle names……

   Surname…… Sex: **Male** ☐ **Female** ☐

2. ID/Passport Number …….. Country of Issue……

3. Date of Birth (DD/MM/YYYY) ……. Height (cm) …..…… Weight (kg) ……..……

4. Marital Status Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

5. Occupation…… Tel No. ……

6. Residential Address …… Res Tel No……

7. Email Address ……

8. Employer's Name and Address……

9. In case of emergency contact Mr. /Miss/Mrs. …… Tel No……

10. Do you or any of your dependants have any insurance policy with personal accident benefits?

    Yes ☐ **No** ☐ If yes, please give details……

11. Please indicate your selected package: **SL Standard** ☐ **GH Plus** ☐ **GH Enhanced** ☐ **GH Prestige** ☐ **GH Prestige +** ☐

Dependant details

12. Please provide below full details of dependants to be covered.

DEPENDANT'S NAME IN FULL (SURNAME FIRST)	SEX M/F	OCCUPATION	RELATIONSHIP	DATE OF BIRTH (DD/MM/YYYY)	ID NUMBER

13. Medical details

It is very important to disclose full information regarding any pre-existing medical conditions or symptoms experienced by you or your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from your treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

All questions must be answered with a 'Yes' or 'No'. If you have answered 'Yes' to any questions, please provide full details. If more space is required, please include additional pages.

13.1	Do you or any of your dependants wear corrective lenses (spectacles)?	**Yes**		**No**	

If yes state date you last changed the lenses.....

13.2	Do you or any of your dependants have any disabilities or physical defects?	**Yes**		**No**	

If yes, please specify……

13.3	Are you or your dependants currently taking ongoing medication or reasonably expecting to take medication for any condition in the next 12 months?	**Yes**		**No**	

If yes, please specify……

13.4	Have you or your dependants had an operation or admission to any hospital in the last 12 months?	**Yes**		**No**	

If yes, please specify……

13.5	Are you or your dependants awaiting or planning an operation or admission to any hospital (including current pregnancy) for treatment in the next 12 months?	**Yes**		**No**	

If yes, please specify……

13.6	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, and could potentially result in a medical claim within the next 12 months?	**Yes**		**No**	

If yes, please specify……

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14. Medical details cont.

It is very important to disclose full information regarding any pre-existing medical conditions or symptoms experienced by you or your dependants. If authorisation for any benefits is requested within the first 12 months of membership, we may request a full medical history from your treating doctors. If we find that you did not disclose all the relevant information, we may limit and/or exclude certain benefits, or terminate your membership.

All questions must be answered with a 'Yes' or 'No'. If you have answered 'Yes' to any questions, please provide full details. If more space is required, please include additional pages.

In the last 12 months, have you or your dependants had any of the following:

14.1 **Disorders or problems with the heart or cardiovascular system.** E.g. heart murmur, high blood pressure, raised cholesterol, shortness of breath, palpitations, chest pain, angina pectoris or heart attack?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.2 **Respiratory or lung trouble**. E.g. tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.3 **Disorders of the digestive system, stomach, gall bladder, pancreas or liver**. E.g. gastric or duodenal ulcer, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis, cirrhosis, liver failure, or have you ever had a gastroscopy, colonoscopy, or other special examinations?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.4 Di**sease or disorders of the kidneys, bladder or reproductive organs.** E.g. abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections, or sexually transmitted disease?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.5 **Disorders of the nervous system or brain.** E.g. epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis,

Yes		**No**	

Parkinson's disease, or have you or any of your dependants had or been advised to have a specialised scan, e.g. MRI, CT or PET scan?

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.6 **Mental disorders**. E.g. depression, anxiety, panic attacks, schizophrenia, eating disorders, ADHD, stress, post-traumatic stress disorder or substance abuse?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.7 **Ear, nose, throat or eye disorders**. E.g. defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.8 **Disorders or diseases of the skin, muscles, bones, joints, limbs or spine**. E.g. any skin rash, arthritis, gout, fibromyalgia, any back/neck/hip/knee or other joint problems or replacements, multiple sclerosis, acne, eczema or psoriasis?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.9 **Diabetes, sugar in urine, thyroid or other glandular or blood disorders.** Eg anaemia, bleeding disorders, growth disorder, Cushing's disease or Addison's disease?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.10 **Diabetes, sugar in urine, thyroid or other glandular or blood disorders.** Eg anaemia, bleeding disorders, growth disorder, haemophilia, leukaemia, clotting disorders, Cushing's disease or Addison's disease?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.11 Have you or any of your dependants sought medical advice, counselling or treatment in connection with HIV/AIDS or any sexually transmitted disease, e.g. hepatitis B, gonorrhoea or syphilis?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.12 **Cancer**, a growth or tumour of any kind including moles removed (malignant/benign)? Please specify if these were benign or malignant.

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.13 Are you or any of your dependants currently undergoing, or anticipating any specialized maxillary dental facial treatment?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.14 Are you or any of your dependants taking ongoing medication for any condition not listed in any other question?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.15 Have you or any of your dependants had an operation or admission to any hospital (including for injuries sustained in an accident or motor vehicle accident) in the last 12 months?

Yes		**No**	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.16 Are you or any of your dependants awaiting or planning an operation or admission to any hospital in the next 12 months?

Yes		No	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.17 Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or your dependants, and could potentially result in a medical claim within the next 12 months?

Yes		No	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

Questions 14.18 to 14.19 apply to female applicants

14.18 Have you or any of your dependants had any of the following symptoms or conditions: abnormal pap smears or mammograms, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, recently missed or irregular menstrual cycles or do you suspect that you may be pregnant?

Yes		No	

Name of member	Condition and date diagnosed	Name of medication	Are you currently on treatment?	Last treatment/ symptoms date	Attending doctor

14.19 Are you or any of your dependants currently pregnant?

Yes		No	

If yes, state the expected date of delivery……

NOTE: Failure to disclose relevant information may lead to cancellation of Membership or denial of claim

17. Doctor/s consulted in the past 12 months

If you or your dependents have consulted a doctor I the past 12 months, please list all doctors you consulted:

Name and Surname……..… Location…….

Telephone (work) …….. How long have they been your doctor? …..……. When did you last see them? ……..

Name and Surname……..… Location…….

Telephone (work) …….. How long have they been your doctor? …..……. When did you last see them? ……..

Name and Surname……..… Location…….

Telephone (work) …….. How long have they been your doctor? …..……. When did you last see them? ……..

18. You may choose to continue with the services of your treating doctor provided he/she is listed on our Service Providers' List. Otherwise, select a doctor and Dentist from the list provided

DOCTOR'S/CLINIC NAME	DENTIST'S/CLINIC NAME

19. List below or attach a sheet and indicate the clinics each dependant will attend if different from yours.

Dependant's Name Clinic Dentist

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Declaration

I declare that to the best of my knowledge the statements in this form are true and correct.

I have read the notes to this form and understand that this forms part of a contract with the SLICO Health Insurance Scheme that no liability will be accepted for any condition that originated before the date of commencement of the policy, or the date of acceptance of this application, whichever is later unless the condition is disclosed on this application form and accepted by SLICO Health Insurance Scheme.

I also agree that SLICO Health Insurance Scheme may seek any information from any doctor who has attended to me, and I authorize the giving of such information.

....

Signature of Applicant Date

Notes:

1. Particulars of the dependants who are to be included in the scheme should be furnished, and any dependant who is suffering from any illness or disability on the date of this application will not be covered unless such a condition has been disclosed on this form and accepted by SLICO Health Insurance Scheme.

2. The obligation of SLICO Health Insurance Scheme commences only after this application has been accepted by its underwriter.

Head Office Use Only

Policy No.	Premium Payable	Benefits Provided	Approved by	Effective Date
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