Tel. (233-302) 246147, 020 0203967 Fax: 0302 246169

CHANGE IN HEALTH STATUS

PLEASE USE BLOCK LETTERS

SURNAME	FIRST NAME	MIDDLE
MEMBER'S NAME IN FULL:		BIRTHDATE:
NAME OF EMPLOYER:	POL NO:	TEL NO.:

1. In the past policy year have you or any of your dependants suffered from any of the following diseases? If yes give details; Dates & Duration

	IF YES GIVE DATES & DURATION
A. Any Disability or physical defect	
B. Nervous breakdown	
C. Fainting episodes	
D. Fits/Seizures/ Convulsions	
E. Heart Attack	
F. Heart Enlargement	
G. Paralysis of any kind	
H. High Blood Pressure	
I. Diabetes	
J. Asthma / Other Respiratory Condition	
K. Hernia	
L. Piles	
M. Slipped Disc	
N. Joint Disease/ Rheumatism	
O. Fibroid	
P. Cancer	
Q. Stroke	
R. Varicose Veins	
S. Urinary Tract Disease	
T. Stomach Ulcer	
U. Allergy	
V. Jaundice	
W. Sexually Transmitted Diseases including genital sores.	
X. Glaucoma/ Cataract	
Y. Sickle Cell Disease	
Z. Are you Pregnant?	
Z (a) Any Other Condition(s) apart from the above mentioned:	

2. Have you been told by your Doctor that you will need Surgery in the coming year?

If so for what condition:

3. List current medications and dosage

4. **Selected Clinic Name**: **Dentist's/Clinic Name:**

NOTES: 1. Failure to disclose relevant information may lead to cancellation of membership or denial of claim.
2. The obligation of Gemini Health Care commences only after this application has been duly accepted

EMAIL ADDRESS:

Signature: **Date:**