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KeyHealth MEDICAL SCHEME

86 Koranna Avenue Doringkloof Centurion 0157 | PO Box 14145 Lyttelton 0140 | Application Enquiries: 0860 873 628 | Fax: 086 605 0656

Declaration of Health

Membership Number | | | | | | | | | | |

Important notes:

- Please do not resign from your current medical scheme until you have received written notification of acceptance from KeyHealth.
- Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

Section 1: Medical Details Questionnaire

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

All questions must be answered with either 'Yes' or 'No'. If the answer to any question is 'Yes', please provide full details. If more space is required, please include additional pages.

1.1 Have you or any of your dependants suffered from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, headaches, Systemic Lupus Erythematosus (SLE) depression, anxiety, epilepsy, and/ or thyroid disorders)? If yes, provide details.

Yes | | No | |

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.2 Have you or any of your dependants suffered from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/or a spastic colon)? If yes, provide details.

Yes | | No | |

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.3 Have you or any of your dependants suffered from muscle, bone, joints, skin or nerve illnesses or disorders (e.g. back and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, motor neuron disease, osteoporosis, dermatitis)? If yes, provide details.

Yes | | No | |

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.4 Have you or any of your dependants suffered from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts, irregular menstrual cycle / abnormal (irrespective of severity) menstrual bleeding)? If yes, provide details.

Yes | | No | |

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.5 Have you or any of your dependants suffered from eye, ear, nose, mouth (teeth or gums) or throat disorders (e.g. glaucoma, cataracts, sinusitis, visual disorders, deafness, rhinitis, orthodontics) If yes, provide details.

Yes | | No | |

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.6 Have you or any of your dependants suffered from any blood disorders, cancer (either benign or malignant)? If yes, provide details.

Yes | | No | |

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

Section 1: Medical Details Questionnaire - Continued

1.7 Are you or any of your dependants pregnant or planning a pregnancy within the next 12 months? If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.8 Were you or any of your dependants hospitalised or had surgery in the past (including but not limited to pacemaker, VP shunt, joint replacements)? If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.9 Are you or any of your dependants planning any hospitalisation or surgery within the next 12 months? If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.10 Is there any other condition or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim (including planned procedures, paraplegia, quadriplegia and birth defects)? If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.11 Have you or any of your dependants experienced any symptoms, how insignificant it might seem, that have not yet been treated or diagnosed? If yes, provide details.

Yes ☐ No ☐

Current Doctor

Name and surname

Telephone number (code - number)

How many months/ years has she/ he been your doctor? M M Y Y

Section 2: HIV/Aids

Failure to disclose a pre-existing condition as stipulated, could limit and/or exclude certain benefits or result in termination of membership. If you and/or any of your Dependants are living with HIV/Aids and would prefer not to disclose your and/or their HIV-status on this form due to confidentiality, you may wait until you have received your membership number; please then dial **0860 50 60 80** in order to notify the Scheme that you and/or any of your Dependants are living with HIV/Aids. This information must be disclosed to KeyHealth within 7 days of your official entry onto KeyHealth.

Name

Start date D D – M M – 2 0 Y Y

Signature

Date D D – M M – 2 0 Y Y

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