Lusaka PO Box 30337, Lusaka, Zambia | Office 2, Sandy's Creations, Kafue Road, Lusaka
tel +260 977 770 302 | 24/7 Contact Number **737**
Kitwe PO Box 20324, Kitwe, Zambia | No 33 Freedom Ave, Parklands, Kitwe | tel +260 212 227 998
Livingstone PO Box 61116, Livingstone, Zambia
assist@ses-zambia.com | www.ses-zambia.com

"Giving healthcare a human *touch*"

Division of unihealth

A Your Personal Details

Please complete the following details for yourself as the main applicant

Individual Member Corporate Member (tick as appropriate)

Company Name:

Title:(Mr, Mrs, Miss, Other)

Surname:

First Name(s):

Date Of Birth: Sex at Birth: M F (tick as appropriate)

Nationality: Passport No:

Occupation:

Residential Address:

Postcode:

Postal Address:

Postcode:

Telephone No: Mobile No:

Email:(home) Email:(Other)

Next of Kin Name: Relationship:

Next of Kin Address: Mobile No:

Do you and/or any applicant participate in any competitive sporting activities? Yes No

If yes, please give full details of any sporting activities you participate in, and how often:

Competitive sporting activities include (but are not limited to): parachuting; gliding; paragliding; parascending; scuba diving; hanggliding; bungee jumping; polo; motor rallying and motor-cycle racing, equestrian events, or any other high risk activity.

Have you previously held a policy, or do you currently hold a policy with Specialty Emergency Services Yes No

Previous/Current policy No: Date of Expiry of Policy:

Have you previously been insured, or are currently insured, with another health insurer? Yes No

Name of insurer:

Were you excluded from any benefits as a result of a pre-existing medical condition/chronic illness? Yes No

Please Explain:

B Health Plan Applied For

Tanzanite	Amethyst	Sapphire	Silver	Gold	Platinum
Tanzanite+	Amethyst+			Gold+	Platinum+

Frequency of Premium Payment: 1) Annually 2) 6 Monthly 3) Monthly (Online Direct Debit Only)

OPTIONS: Sports Cover

C Family Members

Please enter the names and details of all dependents for whom cover is required. You may include your partner and children, up to age 18 (or up to age 25 if in full-time education - proof will be required). Children aged 18 or over who are not in full-time education must submit their own application for cover.

	Surname	First Name	Occupation	Passport No	Date of Birth	Sex at Birth
Main Member						
Spouse						
Child 1						
Child 2						
Child 3						
Child 4						

D Health Declaration

Specialty Emergency Services is not obliged to provide cover for any pre-existing or past conditions for which you have previously received medication, advice or treatment or experienced symptoms, whether the condition has been diagnosed or not, at any time before the start of your cover. A related condition is any disease, illness or injury that is caused by a pre-existing condition or result from the same underlying cause as a pre-existing condition.

Should Specialty Emergency Services accept pre-existing or past conditions, then special terms, exclusions or loading may apply, at Specialty Emergency Services' discretion.

Should treatment for any pre-existing or related condition be required, and has not been declared on this application, or the full details disclosed, Specialty Emergency Services is not obliged to pay these associated claims.

Specialty Emergency Services has the right to refuse membership or apply special terms, exclusions or loading for any new application or renewal.

Please, therefore, take the greatest care to ensure that this application form is completed fully and accurately.

If you are uncertain if any particular fact needs to be disclosed, you must include it.

If, after completing your application form, any changes occur that may affect the information provided by you on this form, such as a change in your state of health or the state of health of any of your dependents, please inform Specialty Emergency Services in writing about the change. Specialty Emergency Services reserves the right to decline or accept an application with special terms, exclusions or loading on receipt of any further health information
.
PLEASE NOTE: Failure to disclose all current and previous medical conditions on each new application or renewal, renders the Specialty Emergency Services membership void.

E Medical History

This section asks for health and medical details, past and present, about the applicant/s named in section C. Please complete every question for each individual.

If the answer to a question is yes, please give full details in section F on the next page. If you are unsure of the relevance of any details, please include them.

Have you ever?:

- Seen a GP or other health care professional?
- Received treatment?
- Experienced symptoms?

	Main Member	Spouse	Child 1	Child 2	Child 3	Child 4
Name						
1. Heart or Cardiovascular Disorders: e.g coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers, cholesterol, deep vein thrombosis.						
2. Glandular disorders: e.g diabetes, thyroid, hormonal problems.						
3. Breathing or respiratory disorders: e.g Asthma, bronchitis, shortness of breath, chest infections, TB, Emphysema, Pulmonary Embolism.						
4. Ear, Nose, Throat or Eye Problems: e.g hay fever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections.						
5. Stomach, Intestines, Liver or Gallbladder: e.g ulcer, colitis, repeated indigestion, irritable bowel, change in bowl habits, hepatitis, piles, rectal bleeding.						
6. Cancer, Tumors, Growths, Cysts or Moles that itch or bleed						
7. Skin Problems: e.g eczema, rashes, psoriasis, and acne.						
8. Brain or Nervous System Disorders: e.g stroke, migraines, repeated headaches, MS, epilepsy, nerve pains, fits, chronic fatigue syndrome						
9. Muscle or Skeletal problems: e.g arthritis, cartilage and ligament problems, back and neck problems, sprains, joint replacements, gout, sciatica.						
10. Urinary Problems: e.g bladder, kidney or prostate problems, urinary infections, incontinence.						
11. Blood Disorders: e.g anemia, hepatitis, HIV, abnormal blood tests						
12. Reproductive System Disorders: e.g pregnancy and/or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause.						
13. Allergies						
14. Psychological Disorders: e.g. depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety, addiction						
15. Auto-immune Disorders: e.g. sjorgens syndrome, lupus, multiple sclerosis, rheumatoid arthritis.						
16. Any other medical condition not mentioned above or any other previous surgery.						

Please also answer the following questions:

17.Are you, or any prospective member, taking any chronic medicines, prescribed or otherwise?						
18.Are you, or any prospective member, receiving any treatment of any kind?						
19.Current Smoker/ Ex Smoker						

Height			
Weight			
Alcohol Consumption/ Week 1unit= 1 Tot/ Small glass Wine/ 1 Bottle Beer			

F Additional Information

If you have answered YES to any questions, please give full details below. Please continue on a separate sheet if necessary.

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which the illness/injury occurred:

Diagnosis:

Treatment/test performed and results: (please attach medical report)

Date you last suffered symptoms or received treatment relating to this condition:

Name and contact details of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Please give details of the doctor who is most familiar with the medical history of each person named in this application

Name of Doctor: Tel:

Email: Length of time treating applicant:

Name of Doctor: Tel:

Email: Length of time treating applicant:

Name of Doctor: Tel:

Email: Length of time treating applicant:

Name of Doctor: Tel:

Email: Length of time treating applicant:

Name of Doctor: Tel:

Email: Length of time treating applicant:

Name of Doctor: Tel:

Email: Length of time treating applicant:

G Disclosure by Applicant

I have made full and complete disclosure about the medical history of each person included on this application and fully understand that pre-existing conditions will not be covered by this policy.

To the best of my knowledge and belief, each person included on this application is in good physical health and free from physical defect or infirmity except where the condition has been disclosed herein on the medical questionnaire.

I am not aware of any reason for the above cover to be cancelled or curtailed and I have not withheld any material facts. I understand that non-disclosure or misinterpretation of material fact will entitle the underwriters to void this policy.

Signed: Date:

*Please supply passport copies for all individuals included in this application form. (Not necessary for Tanzanite, Tanzanite+, Amethyst, & Amethyst+)

H Legal Declaration

I hereby apply for cover on behalf of all the persons named on this application form for the Specialty Emergency Services Health Plan specified above. I declare that I have read and understood the Health Plan Terms and Conditions, and that I am aware that cover shall be provided in accordance with the Terms and Conditions, and that pre-existing conditions will not be covered by this Health Plan.

I also understand that I must notify Specialty Emergency Services of any changes in the details contained on this application form, including a change in the state of health of any person named on it, or contact information.

I authorize any doctor who has ever treated or advised any persons named on this application to provide Specialty Emergency Services with information they may require in connection with treatment related to any claim under the above plan.
I, and all those named in this application, understand that in order to assess my claim, Specialty Emergency Services may need to obtain details of my medical history.

I, and all those named in this application, hereby authorize any physician, healthcare professional, hospital, clinic and other healthcare institution to disclose to Specialty Emergency Services, to the extent allowed by applicable law, any information concerning the medical history, services, supplies or treatment provided to anyone listed in this application. I understand that Specialty Emergency Services may rely on this information to administer my policy and claims and to determine policy coverage according to applicable laws and regulations.

I understand that Specialty Emergency Services will hold and process my personal data for the purpose of processing my Health Plan, processing any claims submitted under my Health Plan and providing other related services, which may include sharing my personal data with doctors and other medical professionals involved in my treatment or care (or the treatment or care of the persons insured on my policy). I understand that this may include the transfer of personal data to countries outside Zambia and in signing this form I consent to such transfer and use. SES employees are bound by patient confidentiality and data protection processes.

I understand that on receipt of my Health Plan documents, if I am not entirely satisfied, I can cancel this application and receive a full refund of the premium I have paid minus an administration fee, provided that I have not submitted any claim and that I return my documents to the company within 30 days of the start of the plan.

I declare that I have been provided with a copy of the cover Terms and Conditions which I have read for myself and on behalf of the persons insured on my policy. I understand that this Health Plan starts from the date of the cover and, therefore, no refund of premium will be allowed after 30 days if this cover is cancelled.
I understand that an excess is deductible for each international claim I make on my Health Plan Policy, and that Specialty Emergency Services have the right to collect the excess.

I declare that to the best of my knowledge and belief, all the information I have given on this application form is true and complete and that I have confirmed the family details with the respective family members, and that, in the event of fraud or suspected fraud my Health Policy will be annulled immediately by Specialty Emergency Services, and my personal data may be disclosed to other parties, including, but not limited to, the appropriate law enforcement agencies.

I understand that Specialty Emergency Services will give me reasonable notice on renewal and premiums which may vary each year.

I understand that Specialty Emergency Services cannot be liable if my cover has lapsed should the credit/debit card be declined and if I do not respond to requests for alternative methods of payment.

I agree that I will inform Specialty Emergency Services if any of the details given on this application form change.

Signature of Applicant:

Date:

How did you hear about SES?

Social Media
Website
Family/Friend Referral
Billboards
Magazines
Brochures
Walk In

For Office Use Only

Application approved?

If not reason why

Exclusions:

Group Name:

Subscription Fee:

Receipt No:

Membership No:

Policy start Date:

Renewal date: