MEDICARE

ZENITH MEDICARE LIMITED

Principal Enrollee Photo Here

ENROLLEE APPLICATION FORM
(INDIVIDUAL PLANS)

Please complete in BLOCK LETTERS and return with a passport photograph of each beneficiary to Zenith Assurance Medicare

A. Personal Data

Surname | Middle Name | First Name

Residential Address **(Not P.O.Box)**

Gender (M/F) | Date Of Birth (DDMMYYYY) | Telephone | Occupation

Nationality | Blood Group | E-Mail

B. Have you or any of your immediate family had any of the following? (Please tick where applicable)

Asthma	☐	Persistent Cough	☐	Cataract	☐	Sickle Cell Disease	☐	Persistent Chest Pain	☐	Diabetes Mellitus	☐
Heart Disease	☐	Duodendal Ulcer	☐	Skin Infection	☐	Hypertension	☐	Passing Bloody Urine	☐	Arthritis	☐
Glaucoma	☐	Viral Hepatitis	☐	Epilepsy	☐	Heamorrhoids	☐	Persistent Dizziness	☐	HIV/AIDS	☐
Goitre	☐	Major Surgery	☐	Hospitalization up to two weeks	☐			Persistent Swollen feet	☐		

Are you or your spouse pregnant at the moment? ☐ If so, how many months? ☐

C. Are you subscribing as : Individual Single ☐ Individual Family ☐

Plan Required

Instant Health ☐ Smart Health ☐ Classic Health ☐ SuperHealth ☐ Deluxe Health ☐

D. Individuals Covered

List Of Eligible Dependent(First, MiddleName)	Gender M	Gender F	Date Of Birth	Relationship	Primary Provider	Blood Group	Genotype
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

E. Passport Photos

Spouse | Child | Child | Child | Child

N.B Please inscribe name at the back of each passport photograph.

Declaration: I hereby apply to be enrolled in the Plan together with the Persons to be insured listed above. I declare that to the best of my knowledge on behalf of all persons to be insured under this application that I have read and understood fully the policy exclusions and conditions. It is agreed that this declaration and information given in this application shall form the basis of the contract (s) between the insured Person (s) and the HMO.

Signature and Date