MEDICARE

ZENITH MEDICARE LIMITED

MEMBER UPDATE REQUEST FORM

DATE: _____ MEMBER ID NO: _____

NAME (Surname Middle First): _____

I hereby Apply For: Addition Of Dependent ☐ Addition Of Benefit ☐ Change Of Provider ☐ Change Of Health Policy ☐ Others ☐

PLEASE COMPLETE RELEVANT SECTION BELOW

ADDITION OF A DEPENDENT

SPOUSE ☐ CHILD ☐

NAME OF DEPENDENT: _____ _____

Middle Name First Name

Gender (M/F) ☐ Date Of Birth (DDMMYYYY) _____ Blood Group ☐☐☐ Genotype ☐☐☐

Photo Here

ANY EXISTING CHRONIC ILLNESS/ALLERGY: YES/NO

IF YES, PLEASE SPECIFY: _____

CHOICE OF PRIMARY CARE PROVIDER _____

NB: Please affix passport photo of beneficiary

ADDITION OF A BENEFIT

CURRENT HEALTH PLAN: _____

BENEFIT REQUIRED: _____

NB: You may be required to pay an additional premium to cover chosen benefit.

CHANGE OF PROVIDER

CURRENT PROVIDER _____

PREFFERED PROVIDER _____

REASON FOR CHANGE: LOCATION ☐ DISSATISFACTION ☐ SPECIAL NEEDS ☐ OTHERS ☐

PLEASE SPECIFY OTHERS: _____

PREFFRRED EFFECTIVE DATE OF CHANGE: ____/____/____

CHANGE OF HEALTH POLICY

PRESENT POLICY: _____ OPTION: SINGLE ☐ FAMILY ☐

PREFERRED POLICY: _____ OPTION: SINGLE ☐ FAMILY ☐

PREFERRED EFFECTIVE DATE OF CHANGE: ____/____/____

OTHER UPDATE

Please state other update (e.g change of name, address, telephone number or removal of a dependent):

Declaration: I confirm that information submitted is true and valid.
I therefore advise the HMO to update my records accordingly.

_____ Signature

_____ Date