MEMBERSHIP FORM

ACE MEDICAL INSURANCE

Suite B903
The Octagon
Barnes Road
Accra

Dependent

Passport picture

Surname | First Name

Other Names | Date of Birth

Sex: Male | Female | Tel. No.

Are you registered under NHIS? Yes | No | If yes, NHIS No.

Principal Member's Name

Principal Member's Company

Relationship to Principal Member

Medical History (Kindly Tick as many as apply to you)

Heart Attack		High Cholesterol Level	
Heart Murmur		Dizziness/Fainting Spell	
Extra/Skipped Heartbeats		Increased Anxiety or Depression	
Frequent Breathing Difficulty		Migraine/Recurrent Headache	
Frequent/Abnormal Shortness of Breath		Epilepsy/Seizures	
Abnormal Electrocardiogram (ECG or EKG)		Spectacles	
Any Other Heart Trouble		Rheumatic Fever	
Disease of the Arteries		Cold Hands/Feet even in hot weather	
Varicose Veins		Abdominal Aortic Aneurysm	
Phlebitis (Inflammation of a Vein)		Critical Aortic Stenosis	
Arthritis (Legs, Arms, etc.)		Chronic/Recurrent/Morning Coughs	
Frequent Leg Cramps Leg		Coughing up Blood	
Frequent Swelling/Painful Knees or Ankles		Significant Vision/Hearing Problems	
Swollen/Stiff/Painful Joints		Glaucoma/Increased Pressure in Eyes	
Leg Pains After Walking Short Distances		Exposure to Loud Noises for Long Periods	
Diabetes/Abnormal Blood-sugar		Recent Change in a Wart/Mole	

Recurrent Fatigue/Trouble Sleeping/Increased Irritability

Stomach/Intestinal Problems such as Recurrent Heartburn/Ulcers/Constipation/Diarrhoea

Foot Problems including Hammertoes/Blisters/Bunions/Ingrown Toenails/Toenail Fungus

Disclaimer: *Ace Medical reserves the right to conduct a health screening on members. The results alongside our Doctors' opinion will be used to amend your forms retrospectively.*

Declaration:

By submitting this form, you confirm to the best of your knowledge and belief that the information you have provided is accurate and truthful. The information you have provided will be processed according to our privacy policy. Any false information provided on this form will result in the refusal of your application or termination of your membership and any payments made on your behalf shall be demanded.

I confirm that I have read and understood the terms above.

Sign *(For Children, Principal Member should sign on their behalf)*

For HR Use Only

Plan Option: Smartcare | Maxcare | Maxcare+ | Royalcare | TPA

Sign