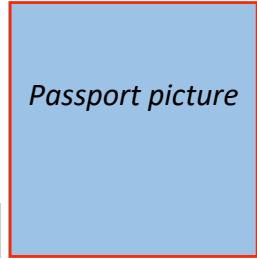


MEMBERSHIP FORM



Suite B903
The Octagon
Barnes Road
Accra

Dependent



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

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