Surgical/Medical Catastrophe Proposal Form

One Catastrophe Form to be filled per family

Company Name: _____

Beneficiary Name: _____

Occupation: _____

Persons to be covered	Relation to Member	Date of Birth	Limit chosen	Weight	Height	Waist (cm)	Hip (cm)
SELF							

For questions 1 to 3 below, please tick in the appropriate box.

1. **Has any of the applicants above ever suffered from or been treated for any of the following?**

	YES	NO
a) High blood pressure, vascular or heart disease		
b) Diabetes or kidney diseases		
c) Malignant diseases of any kind		
d) Lung diseases		
e) STD (Sexually Transmissible Diseases)		
f) Intervertebral disorder		
g) Any other illness, disability or accident lasting more than 15 days during the past two years		

2. Have any of the applicants above ever had any X-Ray / Scan or blood investigation or any other investigation with an endoscopic equipment carried out on the recommendation of a a doctor or by own?

3. Have any of the applicants above been advised to follow in the future a specific treatment or to undergo a surgical operation?

Surgical/Medical Catastrophe Proposal Form

4. Please give full particulars together with a copy of medical reports available if any of the answers from no. 1 - 3 above is a Yes.

Question No.	Name	Nature of Illness or Injury	Attending Doctor	Date of First Occurrence	Duration

For all dependants aged less than 11 years old, please produce a paediatrician health certificate (a copy of the format required is available on demand)

5. FAMILY HISTORY:

Have any of your parents including brothers and sisters suffered from the following conditions

	YES	NO
1. High blood pressure		
2. Diabetes Mellitus		
3. Heart disease		
4. Disease of kidney		
5. Malignant Tumours		
6. Increase in Cholesterol / LDL / Triglycerides		

6. Does any of the applicants

a) Smoke?		
b) Consume alcohol?		

If yes, please give details in the table below.

Name of Applicants	Daily Cigarette	Drinks	
		Daily	Weekly

Surgical/Medical Catastrophe Proposal Form

I hereby declare that the above statements and answers are true and correct and that I have not concealed or withheld any information that might influence the acceptance of this Proposal.

I agree that any such concealment might invalidate any claim relating thereto.

I further agree that cover for the benefits proposed will not take effect until this Proposal has been accepted by BMPA and the full contribution has been paid.

I authorise any person or organisation to release on demand to BMPA, any relevant medical information concerning myself or any of my dependants listed in 4 above.

Date : ..... Signature: .....

Once completed, please return this form to:

Medscheme (Mtius) Limited, 1st Floor, Tower A, 1Cybercity, Ebene.

Kindly write NEW MOSANTÉ MEMBERSHIP FORMS on the top RHS of the envelope.