Member Application Form

mosanté
lifetime care

INSTRUCTIONS:

1. Please complete in BLOCK CAPITALS marking the appropriate box(es) with an X

2. This Application Form must be fully completed

SECTION 1 : DETAILS OF MAIN MEMBER

NAME OF COMPANY															
TITLE	MR			MRS			MS								
MEMBER SURNAME															
MEMBER FIRST NAME															
GENDER	MALE			FEMALE											
DATE OF BIRTH	D	D	M	M	Y	Y	Y	Y							
NIC/PASSPORT NO													(Please provide us with a copy)		
EMPLOYEE NUMBER													(If Available)		
DATE OF EMPLOYMENT															
DATE CONFIRMED															
MARITAL STATUS									OCCUPATION						
RESIDENTIAL ADDRESS															
PHONE NUMBER	OFFICE						MOBILE						HOME		
EMAIL ADDRESS															

SECTION 2 : POLICY DETAILS

COVERS CHOSEN

COVER START DATE	D	D	M	M	Y	Y	Y	Y

	LEVEL CHOSEN	CONTRIBUTION RATE (MUR)
MERGED BENEFITS		
INPATIENT COVER		
CATASTROPHE COVER		

SECTION 3 : BANK DETAILS OF MAIN MEMBER FOR CLAIMS REFUND

BANK NAME	
BANK ACCOUNT NUMBER	

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SECTION 4 : DEPENDANTS TO BE COVERED

You may add your Spouse/Partner on the cover and/or your Child Dependant/s as long as they are unmarried. Kindly attach a copy of the birth certificate of each Child Dependant to this form.

DETAILS	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
	Mr Mrs Ms	Mr Mrs Ms	Mr Mrs Ms	Mr Mrs Ms
SURNAME				
FIRST NAME				
GENDER				
DATE OF BIRTH				
NIC/PASSPORT NO				
RELATION TO MEMBER				

COVERS CHOSEN		
	LEVEL CHOSEN	CONTRIBUTION RATE (MUR)
MERGED BENEFITS		
INPATIENT COVER		
CATASTROPHE COVER		

SECTION 5 : ADULT MEMBERS PHYSICAL DETAILS & LIFESTYLE

	SELF	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
WEIGHT					
HEIGHT					

It is compulsory to answer all the questions listed below, if not the application will be considered incomplete

Please indicate with (Y) for Yes or (N) for No in the boxes provided below.

	SELF	DEP 1	DEP 2	DEP 3	DEP 4
Does any of the applicant smoke?					
If yes, please specify daily consumption.					
Does any of the applicant consume alcohol?					
If yes, please specify daily/weekly consumption.					
Does any of the applicant practice any physical exercise?					
If yes, please specify which exercise and where.					

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SECTION 6 : MEDICAL HISTORY

It is compulsory to answer all the questions listed below, otherwise the application will be considered incomplete.

Please indicate with (Y) for Yes or (N) for No in the boxes provided below.

		SELF	DEP 1	DEP 2	DEP 3	DEP 4
1	High Blood Pressure, Vascular Disease and/or Heart Disease					
2	Diabetes					
3	Malignant Disease of Any Kind					
4	Lungs Disease and/or Respiratory System Conditions					
5	Liver and/or Digestive System Conditions					
6	Kidneys and/or Bladder Conditions					
7	Sexually Transmissible Disease					
8	Reproductive System Conditions (Male & Female)					
9	Nervous System					
10	Breast Problems					
11	Dental System					
12	Eye, Ear, Nose and/or Throat					
13	Intervertebral Disease					
14	Have any of the applicants been treated and/or admitted as an Inpatient in a Clinic and/or Hospital?					
15	Have any of the applicants been advised to follow in the future a specific treatment or to undergo operation?					
16	Are any of the applicants currently pregnant? If so, please provide the expected date of delivery.					
17	Any other Diseases/Illnesses/Conditions not mentioned above					
18	Any other Illnesses, Disabilities, and/or Accidents lasting more than 15 days during the past 2 years					

Please give full particulars together with a copy of medical reports available if any of the answers to nos. 1 – 18 above is a Yes.

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

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SECTION 7 : FAMILY HISTORY

Please indicate with (Y) for Yes or (N) for No in the boxes provided below.

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

NAME OF CONDITIONS	(Y) or (N)
High Blood Pressure	
Diabetes Mellitus	
Increase in Cholesterol/LDL/Triglycerides	
Heart Disease	
Disease of Kidney	
Malignant Tumours	

SECTION 8 : OTHER INSURANCE COVERS

Do you or any of your dependants have one of the following covers:

OTHER MEDICAL INSURANCE	YES		NO	

If yes, please provide full details:

Insured Name	
Name of Insurer	
Amount Covered	

PERSONAL ACCIDENT COVER	YES		NO	

If yes, please provide full details:

Insured Name	
Name of Insurer	
Amount Covered	

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NOTES

A copy of the Terms and Conditions has been remitted to the Employer and is available on the Online Member Portal.

Completion and submission of the Member Application Form does not automatically confirm your membership. A confirmation of acceptance, terms and conditions will be sent to you once your Member Application Form has been processed.

DECLARATION

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

I hereby apply to be a member of the Business Mauritius Provident Association with effect from the _____.

I hereby agree to be bound by the Rules of the Association and by the Terms and Conditions of the medical aid scheme and accept to regularly pay to my Employer the contribution due by me (if applicable).

I further agree that cover for the benefits proposed will not take effect until this Member Application Form has been accepted by Business Mauritius Provident Association 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 Section 2 above.

This form once completed should be submitted to: mosante@medschemeinternational.com

Business Mauritius Provident Association and Business Mauritius would love to send you information pertaining to its various services and/or initiatives by email, WhatsApp, SMS, phone and other electronic means from time to time.

We will always treat your personal details with the utmost care and will never sell them to other companies for marketing purposes. Please tick the box below if you would not like to hear from us.

☐ Yes, I want to hear about offers and services.

_____

Main Member
Signature

DATE	D	D	M	M	Y	Y	Y	Y