QUEST
VITALITY MEDICAL SCHEME

Membership Application Form

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www.questvitalitymed.com
questvitalitymed
06 Rochester Crescent Alexandra Park
Harare, Zimbabwe

Applicant to complete this section. Please use BLOCK CAPITALS

I _____ hereby authorise you to release the following information to Quest Vitality Medical Scheme.

Date of Birth

Signature

Date

Dear Doctor

The above person has applied to the Society for membership. Please assist us by providing a brief medical history of the person concerned.
Doctor to complete this area. Tick the appropriate box

Is your employer retaining your membership through their account? (If NO please complete Account Holder Registration Application Form)

1. Has the applicant ever suffered from any of the following;

Cancer | Epilepsy | Diabetes | Hypertension

Renal disease | Cardio-vascular problem | Psychiatric Condition | Asthma

2. 2. If any of the above applies or if any other chronic condition is present please give details of condition, when it was first diagnosed and any treatment that applicant is under.

Please return the completed form to Quest Vitality Medical Scheme. marked for the attention of the Assistant Manger Special Projects. The Society would like to thank you for your assistance in taking the time to provide this information.

Doctor's Name

Signature

Date

Surgery Stamp

This form is to be completed by all Members applying for registration under an account holder with less than 4 registered members.
It must also be completed by all members registering 'Other Dependant.'

Members wishing to register additional dependants after the initial member registration should also complete the form on behalf of those dependants. Note: There is no need to complete this form for new born babies being registered from the month birth.

Please note that the cost of pre-arranged surgery will NOT be covered within the first 6 months of membership. Maternity related treatment within the first 9 months of membership will not be covered.

Are you or any of your dependants currently undergoing, or expecting to undergo any medical or surgical treatment in the next 6 months?	Y N
Do you or any of your dependants suffer from any long-standing medical condition for which you are taking medication or medical advice?	Y N
To your knowledge will you or any of your dependants require maternity related care within the next 9 months?	Y N

If the answer to any of the above questions is 'YES' for you or your dependants, please state the name of the affected person below, and specify the condition which applies. The Medical History Request on the back of the form should be completed by the person's General Practitioner and submitted to the Society.

Name	
Condition	
Medication Taken	

Note: Failure to disclose relevant information may lead to the cancellation of your membership.

I hereby declare that to the best of my knowledge the above information is correct

Member's Name		Signature	
Member Number (If Known)		Date	