HEALTH INSURANCE
MEMBERSHIP APPLICATION FORM (MAF)

PARNELL Assurance PNG

PLEASE COMPLETE THIS FORM IN CAPITAL LETTERS

Section A and B to be completed by the employee; Section C to be completed by the employer.

Section A — Employee Details

Employer Name:*			
Employee Name:*			
D.O.B		Gender:*	• Male • Female
Occupation:			
Telephone (work):		Mobile:	
Email:			

Section B — Dependents to be included under your health insurance Plan

	Firstname	Surname	D.O.B	Gender		Relationship to you (Spouse, Child)
				Male	Female	
1.				•	•	
2.				•	•	
3.				•	•	
4.				•	•	
5.				•	•	
6.				•	•	
7.				•	•	

Section C — Health Declaration by Employee

PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE OR BELIEF

If the answer to any question is "Yes", Identify the question number and include diagnosis, dates, duration, degree of recovery or results and names and addresses of all attending medical practitioners and medical facilities in the space below.

TICK APPLICABLE ITEMS	Yes	No
1. Are you or any of your dependents under medical treatment by diet, medicine or other means?	•	•
2. Have you or any of your dependants ever had or sought advice for:	•	•
a) Chest pain, high blood pressure, heart murmur, heart or circulation disorder?	•	•
b) Asthma, chronic cough, shortness of breath or lung disorder?	•	•
c) Diabetes or sugar in urine?	•	•
d) Ulcer, Colitis, liver or digestive disorder?	•	•

Continued on the next page….

		Yes	No
	e) Cancer, tumour or enlarged glands?	•	•
	f) Anaemia, bleeding or blood disorder?	•	•
	g) Dizzy or fainting spells, epilepsy, nervous system or mental disorder?	•	•
	h) Urine, kidney or bladder disorder?	•	•
	i) Arthritis or other joint disorder?	•	•
	j) Any other illness, surgery or injury?	•	•
	k) Have you, or any of the dependents to be covered, ever been diagnosed with a congenital condition?	•	•
3.	Do you or any of your dependents have any of the following which are unexplained: Fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	•	•
4.	Have you or any of your dependants within the past 5 years:	•	•
	a) had any mental or physical disease or disorder not listed above	•	•
	b) had a check-up, consultation, illness, injury or surgery	•	•
	c) been a patient in a hospital, clinic, sanatorium, or other medical facility?	•	•
	d) had an electrocardiogram, X-ray, other diagnostic test?	•	•
	e) been advised to have any diagnostic test, hospitalisation, or surgery which was not completed.	•	•
	f) had a blood transfusion?	•	•
5.	Are you or any of the named dependants presently pregnant? If yes, Name:_____	•	•
6.	Are you or any of your dependents aware of a condition(s) that require medical, surgical, dental or optical treatment at the present time? If so, give full particulars below:	•	•

Section D Declaration and Authorisation

I hereby declare that the statements in this form are true and complete. I further declare that I have not withheld any material information in regard to this application that ought to be disclosed to the Insurer. I agree to abide by rules governing the Insurer and further agree that this declaration and the answers given in this application form shall be the basis of the contract between me and the Insurer.

I consent to the Insurer seeking information from any doctor, hospital or clinic I have consulted or from any Company from whom I have requested insurance and I hereby authorise the giving of such information

Employee Sign:* …… Date (dd/mm/yyyy):* ……

Section E Employer confirmation (To be completed and stamped by Employers HR Department)

As Employer, I confirm that this employee and his/her dependents is/are to be included in the Scheme with effect from date ……../……../…….

HR Representative Name:* _____ Sign:* _____ Date:……/……/……