health INTERNATIONAL

SHORT TERM ACCIDENT AND EMERGENCY PLAN APPLICATION FORM

Principal's Membership Number / Expiry Date

PLEASE ENSURE THAT ALL RELEVANT SECTIONS ARE COMPLETED IN BLOCK CAPITALS.

OFFICE USE ONLY			
COUNTRY		LETTER ISSUED	
MONTH		ACCOUNTS	

PERSONAL DETAILS (PLEASE PRINT)
To be completed by Principal Member

Surname		Title:	
First Name(s)			
Residential Address:			
Email:		Mobile No:	
Business No:		Residential No:	
Company Name:			
Business Address:			

SECTION 1: DETAILS OF PERSON/S REQUIRING SHORT TERM ACCIDENT AND EMERGENCY COVER - AGED 40 YEARS AND YOUNGER

FULL NAME	DATE OF BIRTH	RELATIONSHIP TO PRINCIPAL MEMBER	PERIOD OF SHORT TERM COVER (MAXIMUM 3 MONTHS / 90 DAYS)	TOTAL DAYS
1			FROM (DD / MM / YY) - TO (DD / MM / YY)	
2			FROM (DD / MM / YY) - TO (DD / MM / YY)	
3			FROM (DD / MM / YY) - TO (DD / MM / YY)	

I, the Principal Member, confirm that the person/s nominated above will reside at the residential address indicated in Section 1 above.

Signature ____________________ Date (DD / MM / YY) ____________________

SECTION 2: PLEASE SPECIFY IF ANY APPLICANT HAS EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

	MEDICAL CONDITION	YES	NO
1A	Heart diseases - including thrombosis, angina, heart attack, rheumatic fever, congenital defects		
1B	Cholesterol and/or blood pressure levels requiring regular medical assessments or dietary interventions		
1C	Epilepsy, migraines, strokes or other neurological disorders requiring regular medical assessments/medication		
1D	Diabetes, thyroid disease or other endocrine disorder		
1E	Cysts, growths, benign or malignant cancer types (including Hodgkin's disease, leukaemia, skin cancers)		
1F	Any other condition which has required either hospitalisation or regular medical assessments (excluding maternity & casualty)		
2	Are you currently taking any medication? If so please detail the name, dosage and frequency.		

If you have indicated YES for any of the above, please complete the section below.
Acute-On-Chronic attacks resulting from a **PRE-EXISTING** condition are **NOT** covered.

QUESTION NUMBER	NAME OF APPLICANT	DATE	DETAILS OF DISORDER, DATES, DURATION OF TREATMENT, MEDICATION

PLEASE READ CAREFULLY

1. On behalf of myself, the principal applicant, and for each person included on this application I authorise the aforementioned cited doctors to provide Health International with such information as they may seek in connection with this application.
2. I authorise Health International to have unrestricted access to my medical records and the medical records of each person included on this application, but require their confidentiality to be maintained.
3. I understand that any false statement made in this document or the non-disclosure of any material information will render the membership null and void.
4. I understand that any condition for which I or any person included on this application have received medical advice or treatment at any time in the past may be excluded from the benefit.
5. I understand that I or any person included on this application may be required to obtain a medical report, or to undergo a medical examination to provide further information on any of the declared conditions, at my own expense, and that any of the declared conditions may be excluded from the benefits.
6. I agree to accept written communications from the authorised representatives of Health International of any conditions excluded from the benefits.
7. I accept I will have to refund to Health International any benefit paid out but not covered by the Terms and Conditions.
8. I acknowledge that I shall be solely responsible for prompt and timeous payment of all and any premiums payable to Health International pursuant to this application, whether or not my employer or any other third party enters into any agreement or arrangement whatsoever with Health International regarding the same, and I specifically acknowledge further that, subject to the Terms and Conditions set out in the Membership Guide of Health International (which has been made available to me), in the event that any premiums or part thereof are due and payable are not paid timeously, Health International shall not be obliged to meet any claims arising on or after the date on which any such payment fell due.
9. DATA PROTECTION FAIR PROCESSING NOTICE. In your dealings with us you may provide information that includes data that is known as personal data. The personal data we collect will include data relating to your name, address, email address, IP address, date of birth, nationality, country of residence, occupation, credit card details and medical information. We will process your personal data to allow us to administer your health insurance policy and any associated claims and for actuarial analysis. If you require further information on how we process your data and our lawful bases for doing so, please contact us at admin@healthintergrp.com or refer to our Privacy Policy which can be found on our website.
10. I understand and will meet my obligations under the Compliance Regulations as advised by authorised representatives of Health International.

    I understand that Health International will process my personal data, including medical data in relation to my insurance policy.

PLEASE NOTE: In the event of a CLAIM a copy of the Short-Term insured person/s passport / I.D. will be required.

IT IS IMPORTANT THAT ALL APPLICANTS HAVE VALID TRAVEL DOCUMENTS.

DECLARATION OF APPLICANT

I agree with the terms and conditions of membership, and I hereby apply for membership.

Applicant Signature ______________________________ Date (DD / MM / YY) ____________________

FOR OFFICE USE ONLY

THIS SECTION FOR ADMINISTRATION USE ONLY					
GROUP	REC. NO.	DATE	LOAD	DISC	
PRIMARY AGENT			SECONDARY AGENT		
NEW ☐	RENEWAL ☐	ANNUAL ☐	SHORT-TERM ☐	OTHER ☐	PROCESSOR ID

0 - 30 Days ($250)	Number of Additional Days at $4 per day (MAXIMUM 3 MONTHS / 90 DAYS)	PREMIUM

AUTHORISED REPRESENTATIVES OF HEALTH INTERNATIONAL

STRATTON AGENCIES (PVT) LTD t/a TRILOGY BENEFITS GROUP, REGIONAL HEAD OFFICE, HARARE, ZIMBABWE

Registration No. 827/1982

No. 23 Kenilworth Road,
Newlands, HARARE, Zimbabwe
P O Box BW 269, Borrowdale
Harare, Zimbabwe

Tel: +263 (0) 86 7700 8964
+263 (0) 772 443 902
+263 (0) 772 443 909
marketing@healthintergrp.com

AIR HEALTH INTERNATIONAL (PTY) LTD, JOHANNESBURG, SOUTH AFRICA

Registration No. 96/16923/07

67 Voortrekker Avenue,
Edenvale, 1609,
Johannesburg, South Africa

Tel: +27 (0) 11 452 2152
info@airhealthinternational.co.za

HEALTH INTERNATIONAL ZAMBIA LTD, LUSAKA, ZAMBIA

Registration No. 61450

Unit 2, 35991 Thabo Mbeki Road,
Mass Media, Lusaka, Zambia
Post Net Box 325
Private Bag E 10, Lusaka, Zambia

Tel: +260 (0) 211 263 570
zambia@healthintergrp.com

EXPACARE INSURANCE COMPANY (MAURITIUS) LIMITED, PORT LOUIS, MAURITIUS

Registration No. 23670/5472

Suite 335, 3rd Floor, Barkly Wharf,
Caudan Waterfront,
Port Louis 11306, Mauritius
Tel: +230 (0) 214 1841
compliance@expacareinsurance.com