Member Application Form

ULUNTU MEDICARE — SUBSCRIPTION APPLICATION FORM

STAR MEDICAL SERVICES - THE PEOPLE'S PRACTICE

Application No.:		**Date:**	

1. PLAN SELECTION

Plan Type:	☐ Individual ☐ Corporate / Group

Payment:	☐ Monthly ☐ Quarterly ☐ Annually

2. PRINCIPAL MEMBER DETAILS

First Name:		**Surname:**	
ID / Passport No.:		**Date of Birth:**	
Gender:		**Nationality:**	
Residential Address:			

City / Town:		**Postal Code:**	
Mobile Number:		**Alternate Number:**	
Email Address:			
Employer / Organisation:		**Occupation:**	

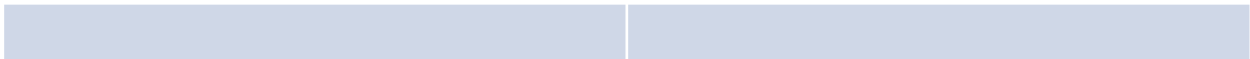
3. MEDICAL HISTORY

Age:	
Height:	
Weight:	
Existing Conditions:	☐No ☐Yes (please specify)
	☐ Smoker ☐ Non-smoker
Alcohol consumption	☐ Yes ☐ No

Currently on Chronic Medication:	☐No ☐Yes (please specify)
Parents/Siblings with chronic illnesses?	☐ No ☐ Yes(please specify)
Any previous Surgeries?	☐ No ☐ Yes (please specify)

Uluntu MEDICARE

Any previous accidents?	☐ No ☐ Yes (please specify)
Any previous hospitalizations?	☐ No ☐Yes (please specify)
Allergies	☐ No ☐ Yes (please specify)



Currently Pregnant:	☐ Yes ☐ No ☐ N/A

4. BANKING & PAYMENT DETAILS

Account Holder Name:			
Bank Name:		**Branch / Sort Code:**	
Account Number:		**Account Type:**	
Debit Order Date:	☐ 1st ☐ 15th ☐ 25th ☐ Other:		

5. EMERGENCY CONTACT / BENEFICIARY

Full Name:		**Relationship:**	
Contact Number:			

6.DECLARATION & SIGNATURE

I, the undersigned, confirm that all information provided in this application is true and correct. I understand that any false information may result in immediate cancellation of membership. I consent to Star Medical Services / Uluntu Medicare processing my personal information in accordance with applicable data protection legislation.

Signature:		**Date:**	

Print Name:	

FOR OFFICE USE ONLY

Received By: **Membership No.:**

Date Processed: **Approved By:**

Status: ☐ Approved ☐ Pending ☐ Rejected