TACAWUN COOPERATIVE INSURANCE

Tacawun
Cooperative Insurance

GROUP MEDICARE TACAWUN

DEPENDANT ADDITION FORM

APPLICATION INSTRUCTIONS:

1. This Form use only Dependants **ADDITION** of the Existing Member with Tacawun Insurance
2. To be completed by Employee (On behalf of his Dependants).
3. Please answer all Questions clearly in **BLOCK/CAPITAL** Letters.
4. Kindly **complete** all questions in full. Incomplete applications form cannot be processed.
5. Application Form must be **signed** and **stamped** by your **HR/Admin Manager** where indicated **(Page 3)**. Without sign and stamped by HR/Admin Manager applications forms cannot be accepted.
6. Be sure **your** (Principal Member) **Sign** and Date. Without your sign applications form cannot be accepted.
7. Attached **Photo** where indicated **(Page 3)** and write the appropriate Name and DOB under the Photo.

1. PRINCIPAL MEMBER INFORMATION

Full Name of Principal Member	
Membership No **(Mandatory)**	
Policy No	

2. CHANGE INFORMATION

Reason For ADDING Dependants (Please Select)										
	Marriage									
	Birth									
	Others (Pls. Explain)	**With Effect From**	D	D	M	M	Y	Y	Y	

3. DETAILS OF DEPENDANT(S)

[Please note children will be eligible for cover from the age of 61 Days up to 21 years (Unmarried Only). Children above 21 years but below 25 years may be accepted on proof of fulltime schooling.]

No	Full Name	Date of Birth								Gender		Relation
1		D	D	M	M	Y	Y	Y	Y	M	F	
2		D	D	M	M	Y	Y	Y	Y	M	F	
3		D	D	M	M	Y	Y	Y	Y	M	F	
4		D	D	M	M	Y	Y	Y	Y	M	F	
5		D	D	M	M	Y	Y	Y	Y	M	F	
6		D	D	M	M	Y	Y	Y	Y	M	F	
7		D	D	M	M	Y	Y	Y	Y	M	F	
8		D	D	M	M	Y	Y	Y	Y	M	F	
9		D	D	M	M	Y	Y	Y	Y	M	F	
10		D	D	M	M	Y	Y	Y	Y	M	F	

Please Provide Additional Information while ADDING Spouse:

Full Name			
Nationality		ID/Passport No	
Mobile Phone		Email ID	

4. CONFIDENTIAL MEDICAL HISTORY

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State whether **any of your dependants** have ever been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including but not limited to:

		Please indicate YES or NO in the box below	
	Question	**Spouse**	**Dependants**
1	Blood disorders. e.g. anemia, bleeding disorders, leukemia		
2	Cancer, growths or tumors whether benign or malignant		
3	Cardiovascular (heart and blood vessels) disorders e.g. high blood pressure, varicose veins, palpitations, deep vein thrombosis		
4	Endocrine disorders e.g. diabetes, high cholesterol , thyroid abnormalities		
5	Genito-urinary system, Gynecological and Obstetrical disorders		
6	Neurological disorders e.g. epilepsy, Stroke		
7	Psychological disorders e.g. alcohol or drug dependency, anxiety disorder		
8	Respiratory disorders e.g. asthma, rhinitis, chronic bronchitis, cigarette smoking related disorders, tuberculosis, pulmonary disease,		
9	Skin disorders e.g. eczema, melanoma, skin cancer, burns, scars, keloids, warts		
10	Have you or any of your dependants ever treatment in connection with HIV or AIDS infections or tested positive for HIV or AIDS?		
11	Do you or any of your dependants have any hereditary disorders, birth defects or congenital conditions?		
12	Are you or any of your dependants on any medication (please indicate in the table provided below)		

If you **answered YES (No. 12)** please write details below:

Name of Person	Prescribed Medication	Diagnosis	Date Started/To Be Started

If you **answered YES** to any of the questions (**No. 01-11**) above, please write details below:

Q. NO.	Name of Person	Date	Diagnosis	Treatment	Consulting Doctor

(If the space provided is insufficient, please attach additional information to this application.)

N.B: Any misrepresentation or non-disclosure of material or factual information will render all benefits granted by Tawacun Insurance null and void. In addition, any claims payment made due to such actions will be recoverable from the policy holder.

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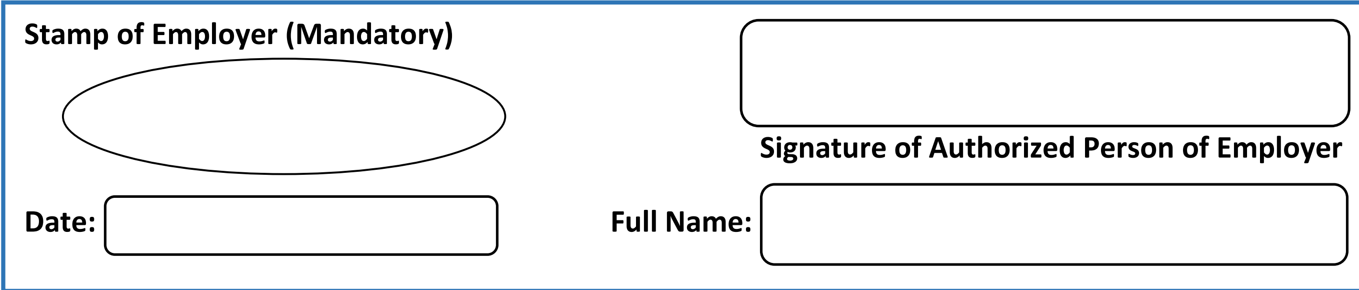
4. DECLARATION

I, the undersigned principal applicant member Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete to the best of my knowledge and belief. This addition form is the part of my application form which I submitted earlier.



Stamp of Employer (Mandatory)

Signature of Authorized Person of Employer

Date:

Full Name:

PHOTO SHEET: **(Write the appropriate Name and DOB under the Photo.)**

Dependant Photograph	Dependant Photograph	Dependant Photograph
Dependant Name: **DOB:**	**Dependant Name:** **DOB:**	**Dependant Name:** **DOB:**
Dependant Photograph	Dependant Photograph	Dependant Photograph
Dependant Name: **DOB:**	**Dependant Name:** **DOB:**	**Dependant Name:** **DOB:**

(If the space provided is insufficient, please attach additional page to this application.)