TACAWUN COOPERATIVE INSURANCE

Tacawun
Cooperative Insurance

GROUP MEDICARE TACAWUN
NEW MEMBER APPLICATION FORM

APPLICATION INSTRUCTIONS:

1. This Form use only **ENROLLED** the New Member with Tacawun
2. To be completed by Employee (For Himself and on behalf of the 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 4)** and write the appropriate Name and DOB under the Photo.

1. DETAILS OF MAIN/PRINCIPAL APPLICANT

Full Name			
Gender/Sex	☐ Male ☐ Female	Marital Status	☐ Married ☐ Un Married
Date of Birth	D D M M Y Y Y Y	Nationality	
Occupation		ID/Passport No	
Mobile Phone		Email ID	
Home Address			
PARTICULARS OF BENEFICIARY OF LAST EXPENSE COVER			
Full Name of Beneficiary			
Relationship		Beneficiary ID/PP No	

2. 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	
11		D D M M Y Y Y Y	M	F	

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Please Provide Additional Information while Adding Spouse:

Full Name			
Nationality		ID/Passport No	
Mobile Phone		Email ID	

3. CONFIDENTIAL MEDICAL HISTORY

State whether you or 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	**Applicant**	**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 Takaful 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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شركة التعاون للتأمين التكافلي

4. DECLARATION

I, the undersigned principal applicant member:

I. Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete, should there be any change in the state of health or illness suffered by myself or any of my dependants from the date of signing this application form and the date of acceptance of the risk or by the insurer, notification of such change will be provided to the insurer in writing with full details of condition/ailment;

II. Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non-disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null and void and all premiums paid shall be forfeited;

III. Understand and accept that no benefit will be payable by the policy unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary including the results of such medical examinations and tests that they may require me or my dependants to undertake;

IV. The Insurer to obtain from any person, whom I hereby so authorize and direct to give, any information which the insurer deems necessary,

V. I further authorize any hospital concerned to give away information relating to myself and my dependants to the insurer for the purpose of ensuring that the members of the policy receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources,

VI. I also declare that:

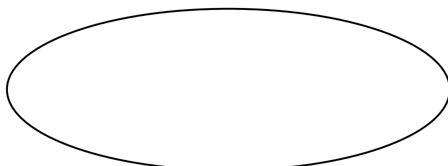
a) My dependant(s) is/are residing with me,
b) I am liable for his/her family care,
c) The dependant(s) is/are my immediate family (Must be a blood relative),
d) I undertake to repay the insurer/hospital any amount by which claims paid out exceed benefits covered.

Date

Signature of Principal Applicant Member

THIS SECTION FILLED UP BY THE EMPLOYER/ORGANIZATION								
REASON FOR APPLICATION (Please Select)								
☐ **New Contract with Tacawun** ☐ **New Hire/Recruitment** ☐ **Return To Employment**								
☐ **Part-Time To Full-Time**	☐ **Others** (Pls. Explain)							
	With Effect From	D	D	M	M	Y	Y	Y

Stamp of Employer (Mandatory)



Signature of Authorized Person of Employer

Date:

Full Name:

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

Main Applicant Member Photograph	Spouse (Dependant 1) Photograph	Dependant 2 Photograph
Main Member Name: **DOB:**	**Spouse Name:** **DOB:**	**Dependant 2 Name:** **DOB:**
Dependant 3 Photograph	Dependant 4 Photograph	Dependant 5 Photograph
Dependant 3 Name: **DOB:**	**Dependant 4 Name:** **DOB:**	**Dependant 5 Name:** **DOB:**
Dependant 6 Photograph	Dependant 7 Photograph	Dependant 8 Photograph
Dependant 6 Name: **DOB:**	**Dependant 7 Name:** **DOB:**	**Dependant 8 Name:** **DOB:**

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