VITALITY Mutual Health
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VITALITY MUTUAL HEALTH
CORPORATE MEMBER APPLICATION QUESTIONNAIRE

PLEASE FILL IN CAPITAL LETTERS

MEMBERSHIP BENEFITS NUMBER: FOR OFFICE USE ONLY

FIRST NAME	OTHER NAME(S)	SURNAME

(DATE OF BIRTH) DD	MM	YYYY	SEX (Please Tick) MALE	FEMALE	NATIONALITY

MARITAL STATUS:

BENEFIT (Please Tick)

VITALITY GENERAL CARE		VITALITY SUPER CARE	
VITALITY PREMIER CARE		VITALITY TOP UP CARE	

EMPLOYER'S NAME	EMPLOYMENT TYPE	PREFERRED MEDICAL SERVICE PROVIDER (Choose from list)

POSTAL ADDRESS (Personal)	RESIDENTIAL ADDRESS
TEL:	TEL:

MEDICAL HISTORY (Please Underline or Circle the appropriate Medical Condition applicable to you)

1.Allergies	12.Cystic Fibrosis	23.HIV positive	34.Leukemia	45.Severe recurrent diarrhoea
2.Anemia	13.Depression or Psychiatric disorder	24.Heart attack	35.Life insurance rejected	46.Smoking
3.Angina	14.Diabetes Mellitus	25.Heart disease	36.Liver condition	47.Spectacles or contact lenses
4.Any medication for any condition	15.Disorder of the digestive system	26.Hepatitis	37.Lung disease	48.Stroke
5.Asthma	16.Embolism	27.Hepatitis B	38.Malaise	49.Thrombosis
6.Back Neck Joint Problems	17.Emphysema	28.Hernia	39.Malignant cancer	50.Thyroid disorder
7.Benign cancer	18.Endocrine disorder	29.High Blood Pressure	40.Migraine	51.Tuberculosis
8.Bladder Infections	19.Epilepsy	30.High Cholesterol Level	41.Nephritis	52.Ulcers
9.Chronic Bronchitis	20.Fibroid	31.Intestinal Fibrosis	42.Pregnancy	53.Varicose Veins
10.Congenital Heart Abnormalities	21.Gall bladder disease	32.Jaundice	43.Rheumatic Arthritis	54.No specific risks
11.Congenital kidney disorder	22.Gout	33.Kidney stone	44.Rheumatic Fever	**Please attach to form**

DECLARATION

APPLICANT,
I HEREBY DECLARE THAT THE INFORMATION
I HAVE GIVEN ABOUT ME AND MY DEPENDENTS IS TRUE.

SIGNATURE _____

DATE _____

HUMAN RESOURCE MANAGER,
I HEREBY CONFIRM THAT THE DETAILS GIVEN
BY THE APPLICANT IS TRUE

SIGNATURE _____

DATE _____

FOR OFFICIAL USE ONLY:

POLICY STARTS ON: | POLICY ENDS ON:

Status: Dependent # 1
VITALITY MUTUAL HEALTH

PLEASE FILL IN CAPITAL LETTERS

MEMBERSHIP BENEFITS NUMBER: FOR OFFICE USE ONLY

FIRST NAME | OTHER NAME(S) | SURNAME

DATE OF BIRTH: DD | MM | YYYY

SEX (Please Tick): MALE | FEMALE

RELATIONSHIP

BENEFIT (Please Tick)

VITALITY GENERAL CARE | VITALITY SUPER CARE

VITALITY PREMIER CARE | VITALITY TOP UP CARE

MEDICAL HISTORY (Please STATE The Numbers to the appropriate Medical Conditions applicable to you with reference to the list on the first page)

FOR OFFICIAL USE ONLY:

POLICY STARTS ON: | POLICY ENDS ON:

Status: Dependent # 2
VITALITY MUTUAL HEALTH

PLEASE FILL IN CAPITAL LETTERS

MEMBERSHIP BENEFITS NUMBER: FOR OFFICE USE ONLY

FIRST NAME | OTHER NAME(S) | SURNAME

DATE OF BIRTH: DD | MM | YYYY

SEX (Please Tick): MALE | FEMALE

RELATIONSHIP

BENEFIT (Please Tick)

VITALITY GENERAL CARE | VITALITY SUPER CARE

VITALITY PREMIER CARE | VITALITY TOP UP CARE

MEDICAL HISTORY (Please STATE The Numbers to the appropriate Medical Conditions applicable to you with reference to the list on the first page)