Avenue Healthcare

Client Services Department
P.O. Box 45280 Nairobi 00100
Tel: (020)3743028 Fax: 3750154
◆**Nairobi** ◆**Mombasa** ◆**Kisumu** ◆**Thika**

Attach one recent passport size photo of each member.

Please do not staple or pin.

Application for Individual / Family Membership

PERSONAL DETAILS (FILL IN BLOCK LETTERS - One form for each member)

Title	First Name	Middle Name	Surname
Dr Mr Mrs Ms			

Date of Birth: D D / M M / Y E A R

Blood Group: +/-

P.O. Box:	Town:	Postal Code:
Physical Location:		
Office Tel:	Home / Mobile Tel:	E-mail Address:
Occupation:	Choice of Cover	
Allergies:		
In case of an emergency, contact:*(name)*		
Relationship:	Tel / Mobile No:	

MEDICAL HISTORY

1	Have you ever been hospitalised for any reason in the past? YES☐ NO ☐ Please give details Admission Date Hospital Reason Have you consulted a doctor or medical specialist in the past one year? YES ☐ NO ☐ Please give details Doctor's Name & Address Illness Drugs / Treatment What is your current condition with regards to the items listed above?
2	Are you currently under treatment, taking any medication or do you require treatment for any illness or condition? YES☐ NO ☐ Please give full details Illness / Condition Medication / Drugs or treatment

3	Do you have any known allergies? YES ☐ NO ☐ Please give full details
4	Have you ever been tested for HIV ? YES ☐ NO ☐ Date _____ Result _____
5	Have you ever been refused or denied medical insurance in the past or have you had your medical insurance cancelled for any reason? YES ☐ NO ☐ Please give details
6	Do you suffer from any medical condition such as varicose veins, skin problems, cardiac / heart disease, stomach or digestive problems, recurrent headaches, nervous or mental disorders, physical defects, high blood pressure, diabetes or any other impairment of health which has not been disclosed in the form above? YES ☐ NO ☐ Please give details

Avenue Health Maintenance Plan Exclusions

AHC shall not accept for membership anyone who is over 65 years * of age, or cover anyone who has a malignant, neoplastic, renal (kidney), or cardiac disease. AHC shall not be responsible for the cost of treatment for chronic *(conditions which reequire long term care or are incurable)* or pre-existing medical conditions *(conditions which originated before commencement of cover)* , genetic and congenital conditions, HIV / AIDS or AIDS related disorders, drug and/or alcohol dependence, cosmetic surgery except for treatment of severe accidental disfigurement, the costs of scientifically unrecognised drugs and/or treatments, drugs not registered with the Ministry of Health, ante-natal care, obstetric or maternity care, non-emergency gynaecological surgery (e.g. fibroids, dysmenorrhoea etc. unless the condition is life threatening), family planning or infertility treatments, dental examinations and/or treatment except in the event of severe accidental damage, eye examinations and/or corrective lenses, chiropractors, Magnetic Resonance Imaging, treatment in a High Dependency Unit or Intensive Care Unit, medical equipment, prosthetic devices, hearing aids, elective medical tests and treatments or admissions not associated with obvious ill health, home nursing care, or any other medical service and/or items not specifically mentioned.

AHC shall not be responsible for the costs of any admission, prescription, X-ray, laboratory test, or specialist consultation unless a written referral is first given by an AHC Doctor.

AHC shall not be responsible for the costs of any treatment or care other than that available at Avenue Hospital at the time of signing of this agreement except where specifically mentioned.

AHC shall not be responsible for the costs of any ambulance, evacuation or transfer.

AHC shall not be responsible for the costs of admission to hospital except for accidents or accidental injury during the first sixty days of each membership.

* *Members who are between 55 - 65 years of age may be required to undergo a medical examination by an Avenue Healthcare doctor, at the member's cost, prior to approval of their application.*

Declaration

I hereby declare that the statements in this form are true to the best of my knowledge. I have not withheld any information which might affect AHC's decision to provide me with medical care. I further declare that I am in good health now and agree to notify AHC if there should be any change in my current condition, lifestyle and / or occupation which might affect my health in the future. I have no objection to Avenue Healthcare personnel or their representatives obtaining information from my Medical Doctor(s) with regard to this application. I have read and understood the exclusions and benefits of the Avenue Managed Care Plans, and agree to abide by all procedures and policies of AHC in the exercise of my benefits if my application is approved.

Signed: _____ Date:_____