LIBERTY

In it with you

Liberty Health Cover Amendment Form

FOR OFFICIAL USE ONLY Policy number

Important: please read the following before completing this application form

- Please write clearly using capital and block letters.
- Please submit your completed forms and documents required (see table below) to our Liberty Health Cover in-country office.
- Each page other than the signature page is to be initialled by the Principal Member.

DOCUMENTS REQUIRED FOR REGISTRATION

WHO DOES THIS APPLY TO	DOCUMENT(S) REQUIRED AS PROOF
Your spouse	• Marriage Certificate
Your living-in partner	• Please refer to point 3 under section 4. Declaration By Principal Member
Your adopted child / child placed in custody of Principal Member or their spouse or living-in partner	• Copy of the abridged birth certificate • Proof of legal adoption • Proof of custody
Your or your spouse or living-in partner's biological or natural child (including stepchildren)	• Copy of the birth certificate, or hospital confirmation reflecting baby's name (for newborns)
A child dependant due to disability	• Medical report as proof of disability
A child dependant student between the ages of 22 and 25 (inclusive)	• Written proof of registration as a full-time student at a recognised educational institution (student cards do not qualify as proof)

1. PERSONAL DETAILS | PRINCIPAL MEMBER

Last name

First name(s) Title

Other names

Policy number Initials

Employee number Date of birth Y Y Y Y M M D D

Identification Document/Passport Number (Optional)

Physical Address

Postal code

Postal Address (if different to Physical Address)

Postal code

Home telephone (please include country and area code) +

Work telephone (please include country and area code) +

Mobile (please include country and area code) +

Email

Do you or any of your nominated dependents enjoy cover with any other Health Insurer? Y N

If yes, please complete the following details:

First name and last name of dependant

Name of Health Insurer

Date this cover may cease Y Y Y Y M M D D

3. REGISTRATION OF DEPENDANTS

(Should you wish to add more dependants, please provide the necessary information on a separate page.)

Dependant 1

Last name | Title

First name(s)

Town/Village of residence

Date of birth (Y Y Y Y M M D D)

Identification Document/Passport Number (Optional)

Relationship to Principal Member

Gender M F | Height (cm) | Weight (kg)

Effective date of registration (Y Y Y Y M M D D)

Dependant 2

Last name | Title

First name(s)

Town/Village of residence

Date of birth (Y Y Y Y M M D D)

Identification Document/Passport Number (Optional)

Relationship to Principal Member

Gender M F | Height (cm) | Weight (kg)

Effective date of registration (Y Y Y Y M M D D)

Dependant 3

Last name | Title

First name(s)

Town/Village of residence

Date of birth (Y Y Y Y M M D D)

Identification Document/Passport Number (Optional)

Relationship to Principal Member

Gender M F | Height (cm) | Weight (kg)

Effective date of registration (Y Y Y Y M M D D)

Dependant 4

Last name | Title

First name(s)

Town/Village of residence

Date of birth (Y Y Y Y M M D D)

Identification Document/Passport Number (Optional)

Relationship to Principal Member

Gender M F | Height (cm) | Weight (kg)

Effective date of registration (Y Y Y Y M M D D)

Please see the descriptions of the type of relationship to the Principal Member in the first column, first table, page 1 of this document.
Should you wish to add more dependants, please provide the necessary information on a separate page.

I

(Name of Principal Member)

of

(Company Name)

certify that the persons whose names appear above, are my legal, registered dependants to be included under my Liberty Health Cover. I am aware that any false representation of any person as my dependant will result in me and all my dependants being removed from Liberty Health Cover, and I will be liable for any cost incurred for health services provided.

Signature of Principal Member

Date signed Y Y Y Y M M D D

Employer Group Representative Details

Full name and surname

Designation

Signature

Date Y Y Y Y M M D D

Company Stamp
(This stamp is a mandatory requirement)

4. HEALTH QUESTIONNAIRE

All sections below must be fully completed – failure to do so will delay processing. ONLY yes or no answers will be accepted. Please refer to point 8. f in Section 4 when providing this information.

Note: If answering "YES", please complete all the relevant details for that section. If the space provided to complete your answer is not sufficient to disclose the necessary information, please provide additional information on separate pages.

First and last name of current family doctor

Telephone

How long have they been your doctor? year(s)

Postal address

Email

Postal code

Have you or any of your nominated dependants received, or currently receive medical advice, care, treatment or hospitalisation for any of the following?

1. Heart & Circulation	e.g. Chest pain/Angina; Heart attack; Heart failure; Heart valve defects; Rheumatic fever; High blood pressure (Hypertension); High cholesterol; Heart murmurs; Circulatory problems/disorders; Varicose veins; Deep Vein Thrombosis (DVT) or any other heart or circulatory problems.	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

2. Breathing & Respiratory	e.g. Asthma; Difficulty with breathing; Bronchospasm; Tuberculosis (TB); Coughing up blood; Emphysema; Pneumonia; Cystic Fibrosis; Chronic bronchitis; Shortness of breath or any other respiratory problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

3. Bladder & Kidneys	e.g. Blood in urine; Kidney failure; Polycystic kidneys; Kidney or bladder infections; Kidney removal (Nephrectomy); Kidney stones; Abnormal kidney or urine tests or any other bladder or kidney problems				Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

4. Reproductive Organs	e.g. Endometriosis; Infertility; Ovarian cysts; Hysterectomy; Abnormal pap smears; Cervix or breast biopsies; Fibroadenosis of the breast; Laparoscopies; Hormone Replacement Therapy (HRT); Prostate infections or surgery; Prostate enlargement or any other reproductive problems				Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

5. Digestive System	e.g. Ulcer, Hiatus hernia; Colon problems; Crohn's Disease; Ulcerative Colitis; Gall bladder problems; Pancreas; Liver problems or any other digestive system problems				Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

6. Ear, Nose & Throat	e.g. Deafness; Ear infections; Sinus problems; Nasal surgery; Throat surgery; Orthodontics; Dental surgery; Speech impairments; Harelip; Cleft Palate or any other nose or throat problems				Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

7. Eyes	e.g. Blindness (partial or full); Eye surgery; Lens implants; Cataracts; Glaucoma; Retinitis Pigmentosa; Retinal detachment; Impaired vision or any other eye or eyesight problems				Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

8. Endocrine	e.g. Diabetes ("high blood sugar"); Thyroid condition; Cushing's Syndrome; Addison's Disease; Pituitary gland problems or any other endocrine or glandular problems				Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

9. Back, muscles & joints	e.g. Neck or back problems (specify if lower, middle or upper) or operations; Recurrent back pain; Osteoporosis; Ankylosing spondylitis; Rheumatoid arthitis; Osteoarthritis; Paget's Disease or any other bone or skeletal disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

10. Neurological	e.g. Epilepsy; Stroke/Cerebrovascular accident (CVA); Migraine; Brain injuries; Spinal cord injuries; Paralysis; Cerebral palsy; Multiple sclerosis; Mental disorder; Narcolepsy; Motor neuron disease; Parkinson's Disease; Alzheimer's Disease or any other neurological problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

11. Psychological	e.g. Depression; Anxiety; Psychosis; Suicide attempts; Bipolar disorders; Manic depression; "Stress"; Schizophrenia; Tourette's syndrome; Anorexia Nervosa; Received advice, counselling or treatment for alchohol or drug abuse; Attention Deficit Disorder, Bulimia or any other psychological problems	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

12. Tumours & Growths	e.g. Benign or malignant growths or lumps or tumours including but not limited to: Melanoma; Lymph gland cancer; Leukaemia and breast cancer or any other tumors, growths and cancers	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

13. Blood & bleeding disorders	e.g. Haemophilia; Platelet, immune disorder or any other blood clotting disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

14. Skin	e.g. Eczema; Acne; Dermatomyositis; Pemphigus; Psoriasis; Scleroderma; Systemic lupus erythematosis or any other skin disorders	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

15. Sexuality Transmitted Diseases (STIs)	e.g. Advice, treatment or counselling for any of the following: HIV/AIDS; Syphilis; Gonorrhoea; Herpes; Genital ulcers; Pelvic Infectious Disease (PID); Genital warts; Hepatitis B or any other STI or disorder	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

16. Pregnancy	Are you or any of your dependants currently pregnant?	Y N
	If the answer to this question is "Yes", when is the expected date of delivery? Y Y Y Y M M D D	
	Name of patient:	

17. Other medical conditions	Have you or any of your nominated dependants got advice or treatment for any medical symptom or condition in the past 12 months that is not mentioned in the above questions? If "yes", please give details of the conditions in the table below.	Y N

Patient	Condition/ diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare Provider	
				Y Y Y Y M M D D	Name:	
				Y Y Y Y M M D D	Tel:	

18. Operations	Have you or any of your nominated dependants had any operation not already mentioned above. If yes, please provide full details	Y N

Patient	Type of operation	Year of operation	Surgeon		Further operations required
		Y Y Y Y M M D D	Dr Name		
		Y Y Y Y M M D D	Tel No		
		Y Y Y Y M M D D			

5. DECLARATION BY PRINCIPAL MEMBER

1. I, the undersigned, hereby apply to have my nominated dependants sign up for Liberty Health Cover.

2. I understand that this application, together with any supporting documents and the Liberty Health Cover Policy Conditions, form the basis of my contract with the Insurer.

3. Declaration in respect of my living-in partner (if applicable): I confirm that my partner and I are in a committed relationship akin to a marriage based on mutual dependency and a shared household.

4. Liberty Health Cover Policy Conditions and benefits
   a. I agree that I, and my dependants, will be bound by the Liberty Health Cover Policy Conditions and will abide by them.
   b. The Insurer shall not be bound in any way by any representations or undertakings made or given by any person save as contained in the Liberty Health Cover Policy Conditions.

5. Exclusions
   a. I understand that the Insurer may impose exclusions in respect of myself and / or any of my nominated dependants. This may include one or more of the following:
      - A Waiting Period of up to 24 months applicable for a specified condition, benefit limit (including maternity), avocation, occupation or general health status.
      - Lifetime exclusion of cover in respect of a specified condition, avocation or occupation.
      - Declining of cover.
      - Three-month condition-specific waiting period for COVID-19 treatment (in and out-patient treatment).
   b. I accept any such exclusion that may be imposed in terms of the Liberty Health Cover Policy Conditions.

6. Banking Details
   a. I agree to advise the Insurer in writing of any changes to my banking details.
   b. I understand that failure to do so will result in me being liable for any subsequent banking charges or other costs / losses incurred due to the use of the incorrect banking details.

7. Premiums and any other amounts owed to the Insurer
   a. I acknowledge that it remains my responsibility to ensure that any amounts due by me to the Insurer are paid to the Insurer.
   b. I agree that any amounts owing by me as a result of claims debt must be paid to the Insurer.
   c. I also accept that I will be responsible for any costs associated with the recovery of any debts.

8. Disclosure of information
   a. I confirm that I have the necessary authorisations to disclose the information that the Insurer may require and provide the necessary authorisations in respect of my nominated dependant(s).
   b. I confirm that the information provided in this application, and in any other documents submitted in support of this application, is true, correct and complete and that I have not withheld, concealed or misstated any information.
   c. I furthermore confirm that I understand that my membership will become null and void should the above statement be found to be incorrect and that in such an event, all monies paid in respect of my membership shall be forfeited and that the Insurer shall furthermore be entitled to recover any amounts paid for services rendered from the provider and/or myself.
   d. I undertake to promptly advise the Insurer of any change in status of health of myself and any of my nominated dependants that occurs prior to the date of registration with the Insurer and acknowledge that the additional information may be subject to underwriting. I acknowledge that not doing so may lead to the Insurer reconsidering the basis of my membership application.
   e. By signing the above agreement, I hereby and expressly consent to indemnifying Liberty Health Cover, its agents and/or administrator against any claim, of whatsoever nature, which may be made against any of them; arising from, as a result of or in connection with the disclosure(s) of any medical information in fulfilling this agreement.
   f. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information about my own, or my nominated dependants' health status to the Insurer or any entity contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement and I agree that this authorisation shall remain in force after my/their death(s).
   g. I authorise the Insurer to collect, process and share my personal information and that of any nominated dependants(s) with any entity, ***including any foreign entity***, contracted by the Insurer in order to fulfil its functions, duties and obligations in terms of this agreement, agree that this authorisation shall remain in force after my/their death(s) and understand that this may partially limit my/their right to privacy.

9. Cancellation
   a. I acknowledge that upon cancellation of my policy, any amounts owing to the Insurer will be deducted from any amounts due to me.
   b. I confirm that I, and all my dependants, will cancel any existing health insurance cover prior to commencement on Liberty Health Cover.

10. Personal contact
    a. I consent to the use of any of the contact details given in this application to send me information pertaining to my policy (confidential or other).
    b. I undertake to inform the Insurer of any change of address and contact details. The Insurer shall not be held liable as a result of my neglecting to inform the Insurer of any changes to the aforementioned.
    c. I consent to my telephone conversations with the Insurer being recorded and forming part of the Insurer's records. I also agree that such records shall remain the sole property of the Insurer.

11. Marketing
    In order to keep you updated on activities about Liberty Health Cover (LHC), we would like to communicate, where necessary, via email, or SMS.

    a. Do you wish to receive LHC marketing communications? Y N

    b. If yes, how would you like to receive them? Email Y N SMS Y N

    c. I consent to LHC marketing products, services and special offers being sent to me from time to time. Y N

    d. I consent that any Third Party contracted to perform services relating to Liberty Health Cover may contact me from time to time regarding their products, services and special offers. Y N

Signed at _____ on this_____day of _____20___

Signature of Principal Member _____