



Be Smart. Keep it Simple.

KeyHealth

MEDICAL SCHEME

86 Koranna Avenue Doringkloof Centurion 0157 | PO Box 14145 Lyttelton 0140 | Application Enquiries: 0860 873 628 | Fax: 086 605 0656

Declaration of Health

Membership Number

Important note: Please do not resign from your current medical scheme until you have received written notification of acceptance from KeyHealth.

Section 1: Medical Details Questionnaire

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

The Scheme may, within the first twelve (12) months of membership initiate a possible non-disclosure investigation for any major medical services (e.g. hospitalisation).

All questions must be answered with either 'Yes' or 'No'. If the answer to any question is 'Yes', please provide full details. If more space is required, please include additional pages.

1.1 Have you or any of your dependants suffered from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, headaches, Systemic Lupus Erythematosus (SLE) depression, anxiety, epilepsy, and/ or thyroid disorders)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.2 Have you or any of your dependants suffered from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/or a spastic colon)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.3 Have you or any of your dependants suffered from muscle, bone, joints, skin or nerve illnesses or disorders (e.g. back and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, motor neuron disease, osteoporosis, dermatitis)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.4 Have you or any of your dependants suffered from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts, irregular menstrual cycle / abnormal (irrespective of severity) menstrual bleeding)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.5 Have you or any of your dependants suffered from eye, ear, nose, mouth (teeth or gums) or throat disorders (e.g. glaucoma, cataracts, sinusitis, visual disorders, deafness, rhinitis, orthodontics) If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

1.6 Have you or any of your dependants suffered from any blood disorders, cancer (either benign or malignant)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

