Renewed Life Limited
"Where the new life begins"
www.renewedlifelimited.com
47 Marina, Lagos Island
Lagos State
Tel: 01- 8509650, 01- 7921351

Application for coverage for Individual and family

Note: Application must be typed or completed in Ink. Please be sure to answer all questions correctly and truthfully to avoid any delay in processing or denial of your application.

Reason for Application:	New Application:	Family Member Added:

I.D. Number:	First Name:	MI:	Last Name/Surname:

Male Or Female **Married/Single/Household** **Date of Birth:** _____

Height: _____ **Weight:** _____ **Telephone Number:**

Home Address: _____

Mailing Address (If different from above): _____

E-mail Address: _____

Applicant Occupation: _____ Employer's Name and Address: _____

_____

Spouse Occupation: _____ Employer's Name and Address: _____

_____

Applicant and Dependent information

Name:	Gender:	DOB: dd/mm/yy	Relationship:

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Applicant Name: _____ **I.D. Number**:

Medical History Questionnaires – Please answer ALL questions.

	YES	NO
Have you or any applying family member in the past 10 years received any professional advice or treatment, including prescription medications, from a Licensed health practitioner or had any symptoms pertaining to any of the following:		
1. Brain or nervous system – such as: dizziness, headache, seizure disorder, loss of consciousness, epilepsy, paralysis, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, mental retardation?	☐	☐
2. Cardiovascular system – such as: heart or valve problems, coronary artery disease, heart attack, heart murmur, pericarditi, mitral valve prolapse, mitral regurgitation, rheumatic fever, palpitations, high blood pressure, shortness of breathe, chest pain?	☐	☐
3. Circulatory – such as: varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder (except HIV infection), anemia, enlarged lymph nodes?	☐	☐
4. Respiratory tract – such as: asthma, reactive airway disease, bronchitis, hayfever, allergies, sinusitis, lung/chest problems of any kind, emphysema, tuberculosis, spitting or coughing up blood, shortness of breath, pneumonia, cystic fibrosis, pulmonary fibrosis, chronic obstructive pulmonary disease, sleep apnea? **If asthma or allergies (circle frequently): daily, weekly, monthly, seasonal** **Severity (circle one): mild, moderate, severe, other**	☐	☐
5. Digestive system – such as: mouth, tongue, esophagus or stomach problems, ulcer, gall bladder disorder, liver disease, cirrhosis, jaundice, ascites, pancreatitis, colon, intestinal or rectal problems, colitis, chronic diarrhea, hemorrhoids, hernia, weight or eating problems, hepatitis? **If hepatitis, type(s): A, B, C, other**	☐	☐
6. Urinary tract – such as: renal colic, gravel or stone, urethra, bladder, ureter or kidney problems, infections, stricture, pyelonephritis?	☐	☐
7. **Male reproductive system** – such as: prostate problems, impotency, male breast problems, gynecomastia, infections, herpes, syphilis, gonorrhea, or other venereal disease, or is either the applicant or spouse, whether or not listed on the application, currently being treated for infertility?	☐	☐
8. A. Female reproductive system – such as: breast problems, breast implants, adhesions, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal pap test, problems of the ovaries, uterus and associated female organs, in-vitro fertilization, infections, genital warts, herpes, syphilis, or other venereal disease, or is either the applicant or spouse, whether or not listed on the application, currently being treated for infertility? **Type of implants (circle one): saline or silicone** B. Does any female applicant between the ages of 12-60 menstruate? a. If yes, list the names of family member(s): _____ _____ _____ b. Has it been more than 40 days since her/their last menstrual period? _____ c. If yes, list the names of family member(s): _____ _____ _____ d. Please explain: _____	☐	☐
9. Is either the applicant, spouse, domestic partner or dependant, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy?	☐	☐
10. Males only: are you expecting a child with anyone even if the birth mother is not listed on the application? Who?	☐	☐
11. Musculo-skeletal system – such as: neck, spine/back sprain, pain, injury, sciatica, herniated or bulging disc(s), or problems; curvature of the spine, scoliosis; any pain, injuries, or problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis, temporo-mandiabular joint syndrome ™, Lyme disease, fractures/residual hardware, disclocations, bunions, hammertoe, carpal tunnel syndrome, physically handicapped, polio amputations? **If chiropractic treatment, please explain reason for treatment:** _____ **Number of chiropractic treatments within the past 6 months**: _____	☐	☐
12. Skin conditions – such as: skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns?	☐	☐
13. Metabolic system – such as: diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, or immune system disorders (except HIV infection) such as: lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or treatment for AIDS/ARC with AZT, HIVID or Pentamidine therapy?	☐	☐
14. Cancer (malignancy) – such as: leukemia, Hodgkin's, tumor/cyst, lymphoma? Type _____ **If Yes, circle treatment type: chemotherapy, radiation therapy, other?**	☐	☐
15. Been an inpatient or outpatient in a hospital, surgical center, sanitarium, or other medical facility, including an emergency room, or had surgery, including angioplasty, cosmetic/reconstructive, bypass, or transplant surgery?	☐	☐

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ACKNOWLEDGEMENT: I understand and agree that this coverage does not covers any prescribed medication, plastic surgery or provide coverage for any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that existed at the time of application or prior to the effective date of this Coverage, including any subsequent, chronic or recurring complications or consequences relating thereto or arising there from (a "pre-existing condition"), whether or not previously manifested or known, diagnosed, treated, or disclosed, and that all charges and/or claims for pre-existing conditions will be excluded from the coverage

CERTIFICATION: I hereby certify, represent and warrant that: (i) I have read the foregoing statements or they have been read to me, and I understand them, (ii) I am (we are) eligible to participate in this coverage program, (iii) I am (we are) currently in good health and have not been diagnosed with, treated for, and do not suffer from any pre-existing or other medical condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this coverage. If signed as proxy of the Insured, the undersigned warrants their authority and capacity to so act and to bind the Insured. By acceptance of coverage, the insured ratifies the authority of the signatory to bind Insured.

Print Name: _____

Signature: _____ **Date Signed:** _____

How to return your signed and completed application: Please do not send in two applications or send the application to two different addresses. Also make a copy for your personal records and send the original.

By Fax:

By Mail:
47 Marina,
Lagos Island, Lagos State

P.O. Box 7251
Marina, Lagos Island, Lagos State

Drop Off In Person at any of our network hospitals: