



We're about you

# Application for chronic medication

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Reg No: MOHSS 0003

**Please note:**

**In order for the administrator to deliver efficient service to you, it is important that you provide and complete all information as required. Print clearly using capital letters. Only one character per block.**

## Member Details

Member name	<input type="text"/>		
Member surname	<input type="text"/>		
Title	<input type="text"/> Initial	<input type="text"/> Main member Y / N	<input type="text"/>
Contact no	<input type="text"/> Email	<input type="text"/>	
Nationality	<input type="text"/> Passport no	<input type="text"/>	
Date of birth	<input type="text"/> Gender M/F	<input type="text"/> Employment	<input type="text"/>
Membership no	<input type="text"/> Dep No	<input type="text"/> Option	<input type="text"/>

## Additional contact information

Relationship	<input type="text"/>		
Name	<input type="text"/> Surname	<input type="text"/>	
Contact no	<input type="text"/> Email	<input type="text"/>	

## Main member details (If applicant is a dependant)

Member name	<input type="text"/>	Member surname	<input type="text"/>
Title	<input type="text"/> Initial	<input type="text"/>	
Contact no	<input type="text"/> Email	<input type="text"/>	
Nationality	<input type="text"/> Passport no	<input type="text"/>	
Date of birth	<input type="text"/> Gender M/F	<input type="text"/> Employment	<input type="text"/>
Chronic medication	<input type="text"/>		

**Condition / Disease – Condition 1**

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date  Repeats

**Condition / Disease – Condition 2**

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date  Repeats

**Condition / Disease – Condition 3**

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date  Repeats

**Condition / Disease – Condition 4**

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date  Repeats

**Condition / Disease – Condition 5**

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date  Repeats

I, \_\_\_\_\_, hereby authorise any doctor, hospital, clinic, laboratory, and/or medical facility in possession of my medical records to disclose any relevant medical and historical information to the case manager of my Fund and/or its administrator, on the understanding that such information will be treated as strictly confidential at all times.

I further agree that this authorisation shall remain valid after my death. I indemnify the Fund and/or its administrator against any claims of whatsoever nature arising from, or in connection with, the disclosure of any medical information or test results in accordance with this authorisation. I confirm and warrant that the information provided in this application form is true, accurate, and complete.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date