MEMBERSHIP APPLICATION FORM (MAF)

NEW ☐ **RENEWAL** ☐

PERSONAL INFORMATION	DATE OF APPLICATION:

NAME:_____ Account No. : _____
ADDRESS : _____ Tel No: _____
Birth Date : _____/_____/_____ Sex : ___ M ___ F Civil Status : _____ Age: _____
Beneficiary : _____ Relationship : _____
Room Accommodation____WARD____

MEDICAL INFORMATION

IF ANSWER IS NO DISREGARD QUESTIONS IF YES, GIVE DETAILS, INCLUDING DATES ON A SEPARATE SHEET IF NEEDED, FOR EACH ILLNESS	
1.	Do you have any disorder or illness present at birth?
2.	Have you had any injury or illness in the past? What?
3.	Have you received any consultation/ treatment for, any of the following:
	A. Loss of consciousness, dizziness, headache, seizure disorder , mental disorder , behavior problem, paralysis, weakness, mental retardation, strokes?
	B. Heart disease, rheumatic fever, palpitation, shortness of breath, chest pain, high/ elevated blood pressure, heart murmur, etc.?
	C. Peripheral Vascular disease s – such as varicose veins, Phlebitis, Aneurysm, Embolism, etc.?
	D. Ulcer, gall bladder, liver disease, colitis, chronic diarrhea, fistula, hemorrhoids, colon or intestinal disorder, hernia, malabsorption syndrome and pancreatitis?
	E. Low back pain, bladder or kidney disorder, stricture prostate disorder, Syphilis or other venereal disease, etc.?
	F. Diabetes, Gout, thyroid or adrenal disorders and immune system disorder including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), etc.?
	G. Neck and back disorder, Arthritis, fractures, slipped disc, dislocations, joint problems, physical handicap, etc.?
4.	Have you ever needed to be:
	A. Hospitalized? B. Operated on?
5.	Do you have any history of anemia or blood abnormalities e.g. Leukemia, increased white blood cell count or unusual bruising marks on the skin?
6.	Have you ever received consultation or treatment for: A. Disease of eyes, ears, nose or throat?
	B. Any skin disorder, i.e. skin cancer, Psoriasis, Keratosis, Herpes, etc.?
	C. Any Cancer/ Tumor?
7.	Have you ever been rejected for medical insurance or offered insurance at a higher premium?

I understand that: this medical information must be updated to include any condition or illness, after the date of submission of the application and prior to COOP HEALTH approval of application; my failure to provide such information to COOP HEALTH will void the coverage; receipt of membership fees by COOP HEALTH does not constitute acceptance of the applicant as a member, and finally, COOP HEALTH reserves the right to reject any application for any reason.

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I hereby certify that the answers to the medical questionnaire are correct and complete and, to the best of my knowledge, accurately represent my health. I understand that COOP HEALTH may require me to undergo physical examination or review my medical history.COOP HEALTH physicians may discuss with any hospital, healthcare facility, physicians or other healthcare professional, any and all medical information related to this application. I understand this information is collected in order to evaluate and process my application , change the benefits , or to evaluate and process my application , change the benefits or to determine eligibility for the benefits.

With this mind, I apply for COOP HEALTH membership and agree to abide by the terms and conditions of the Contract and COOP HEALTH regulations. I understand that unless my application for membership is approved by COOP HEALTH, the latter will not be liable for any medical expenses between the time that I sign this application and the effective date of membership. Any money I may have remitted will be returned if the application is rejected.

Further, I agree to hold COOP HEALTH and/or its directors, officers, and employees free and harmless from any claim or suit caused by or arising out of non-performance or non-delivery of the services or benefits under this Program or the denial of a claim for reimbursement, due to the failure of the Group or Company/ principal member / payor or guardian to inform COOP HEALTH of my application and/or remit the applicable dues, resulting in the suspension or inactivation of membership and subsequent denial of coverage benefits.

I also understand that the effectivity and duration of my membership will depend on the date of payment and remittance of membership fees, as well as submission of required application forms and other documents required by COOP HEALTH

_____
APPLICANT
(Signature over printed name)

ACKNOWLEDGEMENT

I have learned and understood from the orientation briefing that our Cooperative provides group medical and hospitalization program for its members. I acknowledge receipt of this application form needed for my inclusion in the program, and I assure its completion and submission the soonest possible time.

In this connection, I hereby authorize _____ Cooperative to negotiate and approve in my behalf the terms and conditions of membership in the above-mentioned program, facilitate processing of my membership, collect and remit my membership fees and fully represent my interests in all other matters pertaining to my membership.

CAROLINE D. DAVE/CEO

_____
Authorized / Coop Representative
(Signature over printed name)

_____
Applicant / Coop Member
(Signature over printed name)