ProHealth MEDICAL AID
for good health.....

Chronic Condition Application form

1. Full name..... Membership No .....
2. Date of birth: ..... ID …….. Sex : Female ☐ / Male ☐
3. Details of the chronic condition for which you are applying for additional cover:
   a)..... Date .....
   b)..... Date .....
   c)..... Date .....
   d)..... Date .....
4. Details of surgical operations performed on you during your lifetime.
   a) ..... Date .....
   b) ..... Date .....
5. Special treatment requirements including medication you are currently taking, their dosage and frequency.
   a) .....
   b) .....
   c) .....
6. Has your doctor indicated the need for further surgery in the foreseeable future? **Yes** ☐ **/ No** ☐
7. How often do you visit you Family Doctor/ GP for this condition?

   .....
8. How often do you visit the Specialist Doctor for this condition?

   .....
9. In addition to taking medication, what else do you do to manage the condition?

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10. Which of these devices would help you to better manage your condition;

    BP Monitor ☐ / Glucometre ☐ / Nebulizer ☐ / Thermometer ☐
11. Would you like regular health information and access to our 24 hour call centre? **Yes** ☐ **/ No** ☐
12. How would like us to send it to you, e.g. Email, sms?

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13. Would you like a reminder when your medication needs to be topped? **Yes** ☐ **/ No** ☐
14. Would you like the medication delivered to you? If yes, please give the delivery address.

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15. Is there any information needed in order to help you to better manage your condition?

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Signature..... Date.....