

RC: 413934

POLICY PLAN UPGRADE FORM

"Liability of SONGHAI Health Trust Limited does not commence until this application is accepted, premium received and policy issued. Please NOTE that benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and if you are in any doubt as to whether any facts are material, you should disclose them. This applies even if medical advice has not been sought. A material fact is one that is likely to affect the assessment of this application".

Principal Name:			Policy Number:										
							(Picture of the principal)						
1. PRESENT PLAN (PIG	ease tick one box only	·)											
SHTL Gold Plus	SHTL Gold		SHTL Silver		SHTL Classic		SHTL Standard 🔘						
2. PROPOSED UPGRADE PLAN (Please tick one box only)													
SHTL Gold Plus	SHTL Gold		SHTL Silver		SHTL Classic		SHTL Standard						
3. EFFECTIVE DATE OF UPGRADE: dd mm yyyy													
4. CHOICE OF HOSPITAL: (Please state clearly with the appropriate address of the Hospital):													
5. REASONS FOR PLAN UPGRADE: (Please state clearly):													
6. SPOUSE AND DEPENDANTS NAMES & PHOTOGRAPHS:													
SPOUSE	DEPENDAN	T1	DEPENDAN	IT 2	DEPENDA	ANT 3	DEPENDANT 4						

7. MEDICAL HISTORY

Diabetes, High Cholesterol or other blood disorders

10 Mosculo-Skeletal disorders

	P	rincip	al S	al Spouse		Dependant 1		ant 1	Dependant 2		Dependant 3		Dependant 4	
	Y	es	Υ	es	No	Ye	s N	lo	Yes	No	Yes	No	Yes	No
a.	Do you smoke?													
b.	Has any person named in this form been admitted to a hospital or nursing home or had any medical tests done in the last 2 years?													
C.	Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 1 year?													
d.	Has any application for life, accident, health or any other insurance been refused or had special terms applied?													
e.	Does any person named in this form anticipate the need or has been recommended to undergo any medical tests or investigations in the foreseeable future?													
	Has any person named in this form e below?	vers	uffe	red	d fro	m (or are	sufferi	ng fro	om any	disease	or con	dition	tated
		Principal Spou		se Dependant		ndant 1	Dependant 2		Depe	ndant 3	Depe	Dependant		
		Yes	No	Ye	es N	No	Yes	No	Yes	No	Yes	No	Yes	No
	High Blood pressure or circulatory disorders													
2	Stroke or Paralysis													
3	Heart diseases													
	Fainting, blackout, dizziness, seizures, fits, etc													
	Stomach ulcer, hepatitis, gall bladder disease, intestinal or bowel disorders													
	Asthma, persistent cough, breathlessness or other respiratory disorders													
	Kidney, Bladder, Prostrate or Genito-Urinary disorders													
3	Gynecology or hormone disorders													

Medical condition Cont'd

SIGNATURE OF APPLICANT

		Principa		Spouse		Dependant 1		Dependant 2		Dependant 3		Dependant	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11	Tumour, growth, cancer or glandular diseases												
12	Diseases or disorders of the eyes, ears, nose and throat												
13	3 Mental disorders												
14	Any diseases, disorders or conditions which are long lasting or recurrent												
15	Management for drug or substance abuse												
16	Any other illnesses, disabilities or defects that have not been mentioned above												
f yc	our answer to Question 16 above is Y	ES, p	leas	e pro	ovide	deta	ils:						
8.	DECLARATION												
	I hereby declare that the information given in this form is complete and true. I am aware that if I give any false of misleading information deliberately, my Policy Plan Upgrade may be rejected, or may be terminated back to the date of this application. I am also aware that if I leave out important information in this form, my Policy Plan Upgrade may be rejected.												
I understand and agree that any disputes between myself (including any of my enrolled family members on the submitted to final and binding arbitration. I also understand that dispute may have with Songhai Health Trust involving claims for medical malpractice (that is, whether any services rendered were unnecessary or unauthorized or were improperly, negligently or incommendered) are also subject to final and binding arbitration.											outes th ny med	at I lical	
	My signature below indicates that I understand and agree with the terms of this Agreement.												

DATE