BONVIE
MEDICAL AID SCHEME
For your well-being.

No 8 Mt Pleasant Drive
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Harare
P.O.Box 2392

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Email:membership@bonvie.co.zw

Amendment Form
Please complete all relevant sections

Personal Details

Company Name:	
Company Code:	Effective Date:
Principal Member Number:	
Principal Member:	
Home Address:	
Email Address:	Phone:
Date of Birth: d d m m y y y y	Sex: Male ☐ Female ☐
Marital Status: Married ☐ Divorced ☐ Widowed ☐ Single ☐	
Weight: Kg	Height cm
I.D Number:	
Company Authorisation	

Scheme Applied for

Oak Scheme	☐	Teak Scheme	☐
Mukwa Scheme	☐	Pine Scheme	☐
Mukwa Lite	☐	Other Schemes ----------------------	

Please Enter Below Details of all dependants to be added / removed / details to be amended.

Surname	First Names	DOB	Sex	I.D Number	ADD	REMOVE	AMEND	Relation to P/Member

Medical History

(To be completed by all applicants) (Pre-existing conditions may be excluded from foreign travel emergency)

Please read carefully and complete all the required information by placing a tick in the correct box. If the answer to any of the questions is YES please provide details in the space provided below in respect of the member or dependants applicable.

Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of your membership benefits.

Are you, your spouse or any of your dependants experiencing or have experienced any of the following?

	Tick Yes	No
1. **Heart (cardiac) Diseases**: heart attack, rheumatic fever, congenital heart abnormalities, angina, embolism, high blood pressure		
2. **Circulatory Disorders**: varicose veins / thrombosis, blood disorders (e.g anaemia, leukemia)		
3. **Diseases of the Liver**: jaundice, gall bladder diseases, liver cirrhosis		
4. **Disease of the Airway / Lungs**: Asthma, chronic bronchitis, tuberculosis, emphysema, cystic fibrosis, interstitial fibros of any cause.		
5. **Disease of the digestive system**: gastric / duodenal ulcers, hiatus hernia, severe recurring diarrhoea		
6. **Disease of the bladder / kidney**: kidney stone, congenital kidney disorder, nephritis, bladder infections		
7. **Neurological Disorders**: Migraine, stroke, epilepsy		
8. **Diseases of the bone**: joints and muscles, rheumatic arthritis, gout, back. neck. joint problems		
9. **Endocrine Disorders**: diabetes mellitus, thyroid disease (e.g ; goitre)		
10. **Mental Health Disorders**: Psychotic disorders (e.g schizophrenia) mood disorder, Anxiety disorder (e.g panic disorders)		
11. Any condition not mentioned above		
12. Are you currently taking medication for any permanent or recurring condition? If so please detail name, dosage & frequency		
13. Is there any illness or factor not mentioned on this questionnaire that might affect your health in the next 12 months		
14. Are you pregnant? If so what is the expected date of delivery		

If you have ticked YES for any of the above, please complete the section below. Please note all important information must be disclosed. The following section is for details of 1-14.

Quest No:	Name	Date	Please supply full details of disorder, date, duration of treatment and medication if any

If there is insufficient space above, please attach a separate sheet with additional information.

NB: If you or your family suffer from any chronic illness, (ie diabetes, asthma, etc) please complete the chronic registration form in order to receive special chronic drugs. Section 15 above must be completed.

Declaration by applicant on behalf of himself and all his dependants (please read carefully)

I declare that any false information in the above questionnaire, or the non disclosure of any material information will render the membership entirely null and void.

1. I understand that any condition for which I or any of my dependants have received medical advice or treatment in the previous 3 months may be excluded from benefits offered under the scheme.
2. I understand that I or any of my dependants may be required to obtain a medical report or undergo a medical examination to provide further information on any of the conditions declared above.
3. I authorise Bon Vie to have unrestricted access to my medical records but require their confidentiality to be maintained.
4. I have completed the medical history for myself and all my dependants declared in this application.

Principal Member's Signature ____________________ Date ____________________

Liaison or Salaries Officer signature authorising cover and date of commencement ____________________ Date of commencement ____________________