

## The Guernsey Oddfellows Health Care Plan

### Application Form (Part B)

Please complete a Form B for each applicant listed in Form A. If you need additional forms please contact us.

Full name	
Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>	Date of birth
Name and Practice of registered Doctor	
How long have they known you?	
If you have changed Doctors Practice in the last 2 years please provide details	

1.	Are you in good general health so far as you are aware and free from any condition which may cause prolonged or recurrent illness? <span style="float: right;">YES    NO</span> If NO please provide details below		
2.	Have you consulted a General Practitioner over the last two years? <span style="float: right;">YES    NO</span> If YES please provide details below		
	Date                      Nature of illness    Duration                      Present health		
3.	On average, how many times do you visit your doctor/nurse per year? <input style="width: 50px;" type="text"/>		
4.	Are you suffering from any condition that you are aware of which may require future or ongoing medical treatment? <span style="float: right;">YES    NO</span> If YES please provide details below		
5.	Have you at any time over the last two years received treatment at any Hospital Emergency Department? <span style="float: right;">YES    NO</span> If YES please provide details below		
6.	Have you used St John Ambulance in the last two years? <span style="float: right;">YES    NO</span> If YES please provide details below		

7.	Have you at any time over the last five years applied for and been refused medical cover by any other Medical Health Insurance provider? If YES please provide details below	YES	NO
8.	Please list any prescribed medication currently taken		

*I consent to the Society seeking medical information from any doctor who at any time has attended me and I hereby authorise the giving of such information at any time during the term of the contract.*

*I also consent to the Society providing information to third parties (such as my doctor's practice and the States of Guernsey Health and Social Services Department) as necessary to administer the Health Care Plan for which I have applied.*

*Further I declare that any answers to the above questions which have not been written by me have been written in my presence and agreed to by me.*

Signature	
Date	
Name if different from applicant	

NB: Each applicant must complete and sign Application Form (Part B). Where the applicant is under the age of 16 the form must be completed and signed by the principal member (parent or legal guardian). Please print name to indicate different from applicant.

Membership No.		(Only if additional member to existing plan)
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<http://www.oddfellowsguernsey.org/>