Month of Participation: _______________ Year:_________

kindly attach a photo for each subscriber

Application Form

AUC ID No. : ---

Medicare ID No. : **C -**

Subscriber personal data :

Name : ……………………………………………………………………………………………..……………………

Gender : F ( ) M ( ) Date of birth : / /

Application Type: ( ) New Enrollment ( ) Dependents Addition ( ) Level Upgrading ( ) Enrollment Renewal

Nationality : …………………………………… Marital status : ………………………………….. Blood group : ………………………………………

Passport No. Or / ID No. : ……………..……………………… Issue date : / /

Home address : ……………………………………………....…………………………….…………….... Home telephone/Mobile : ………………………..

Position : ……………………………………………………………………………….…. AUC Department : ……...……………………………….………

Office Building/Location : ………………………… Office telephone : ……………………………

Name of contact Person in case of emergency : ……………………………………………………..…..………… Telephone : ……………………………

Address : …………………………………………………………………………………………………….…………..…. ...

For reiumbursment/claim purposes:

Bank Name: ……………………………………………………………………………………… Branch: …………………….…. ...

Bank Account Name : ………………………………………………………………………………… Bank Account #: …..…..…..…..…..….……………..…………

Family data (Only Spouse/Children you are requesting their Medicare Enrollment through which separate application must be filled per each):

Name : ……………………………………… Relationship: …………………………… Date of birth : / /

Name : ……………………………………… Relationship:……………………………… Date of birth : / /

Name : ……………………………………… Relationship:……………………………… Date of birth : / /

Name : ……………………………………… Relationship: …………………………… Date of birth : / /

Name : ……………………………………… Relationship: …………………………… Date of birth : / /

Maximum ceiling needed : Egyptian Pounds A-25,000 ( ) B-50,000 ( ) C-75,000 ( ) D-100,000 ( )

Medical history	Please state name of the subscriber with the relevant medical history
Congenital diseases ?	
Any chronic diseases ?	
If yes please specify :	
Hypertension	Epilepsy and convulsions
Heart disease	Fever &endemic diseases
Diabetes	Ear nose and throat diseases
Chest and allergy	Speech disorders
Neurological diseases	Skin and venereal diseases
Liver problems	Gynecology & obstetrics
Kidney problems	Endocrinological disease & obesity
Dialysis	Blood diseases
Rheumatic diseases	Immunology diseases
Musclo skeletal diseases	Eye diseases
Malignancy & tumors	Accidents & or trauma
Gastro intestinal diseases.	Others ……

Details of current & previous diseases , treatment and medication

(please use additional paper if needed)

Participant Signature: …………………………………………………………………

Date:…………………………………………………..

Do you use any medical prosthesis ? Y ( ) N ( )

Do you use any glasses / lenses ? Y ( ) N ( )

Do you use hearing aids ? Y ( ) N ( )

Do you use contraceptive ? Y ( ) N ( )

Medical procedures and surgeries and hospital stays Diagnosis : ....

Type of surgery : .... Date of surgery : .... Period of stay : ....

Treating physician : .... Hospital : .... Date : ....

Statement

I hereby acknowledge my full awareness & commitment to the following Medicare conditions:

* Medicare enrollments, additions, removals, and withdrawals are permitted only at the beginning of the plan year, i.e. 1st of July.

* Withdrawals are made for seperating employees only, where a withdrawal form is filled out and the Medicare ID card is submitted.

However, in case of a participant consuming 600LE or more worth of medical services, premium should be paid till end of June. In such case, both the participant as well as the employer costs should be incurred in full, throughout the remaining period and till the end of the plan year i.e. end of June.

* In case of exceeding the corresponding ceiling/sub-ceilings, the employee is to pay the over-ceiling amount as per the AUC Over-ceiling Policy.

* Coverage is provided to main subscribers and spouses up to the age of 70, whereas it is provided to children from the date of birth (including incubator coverage for newly born) until the age of 21. Such coverage could be extended to the age of 25 for male participants provided they are full-time students, and for female participants provided they are not married. In case of any changes that conflicts with such provision, I hereby declare that I shall immediately inform the AUC of such change.

* Upgrading of levels is only permitted on the renewal date of the contract, i.e. July 1st; where a form is required to be filled 3 weeks prior date.

* Downgrading of levels is only permitted for retirees, those who are joining the plan on voluntary basis, and those who have portion of their premium contribution are totally incurred by them.

Participant Signature : ___________

Date : / /

Payment with		**To be completed by Medicare administration**
Cash ( ) Check ( )		Sale's Name : Signature : Date :

Main		**Spouse**	**Child**	**Total**	
....		....	....	....	………………

Notes :

1 - Incomplete data will lead to the delay of processing your card until all data is submitted in full.

2 - It may be necessary, at Medicare's discretion, to adjust your subscription fees or decline your application. Failure to disclose full details or any facts material to this application will result in canceling your membership from inception.

N.B. Medicare is the soul judge as to what constitutes non-disclosure.

	Executive Department
Pre-existing diseases :	
Date of physical examination :	
Notes :	
Accepted ( ) Not accepted ( )	
Physician's name :	**Signature :**
Medical Director :	**Date :** / /

Important attachment :

Kindly attach with this application the following :

A.copy of the ID