7 La Chapelle St., San Fernando, Tel: 224-3315 or 657-3812
116 Abercromby St., Port of Spain. Tel: 627-0473
Email: service@mediservinternational.com

Application for Membership in the Society of the Ventures & Investments Programme (VIP)

Application Date ____-____-____ Annual Membership Fee (*State Only If Not Paid with Contributions*): $ ______ Previous RAN ____________________
Principal's Name ____ Member's RAN ____________________
BLOCK LETTERS
Sex ☐M ☐F Birth Date ___-___-___ ID/DP/PP No. __________________ Marital Status __________ Nominator's RAN ____________________
Home Phone ____________________ Cell Phone: ____________________ email: ____________________
Home Address: ____
Employer Name ____________________________________ Employer Phone ____________________
Employer Address ____
Date Employed ___-___-___ Occupation/Skill ____________________________ Average Monthly Income $ ________________
Beneficiary Name ____________________________________ Relationship ____________________
Address ____
How were you informed about the VIP? ____
Religion ________________________ Social Group or Club Membership ________________________
Social/Sporting Interests ____
What do you desire from the VIP? ____

AGREEMENT: I hereby apply for membership in the Society of the Ventures & Investments Programme (VIP), a Non-profit Company, to assist me to achieve my Wellness Goals of Success, Health, Wealth and Happiness. If accepted: I authorize Capital Ventures Ltd., trustee, service provider and Patron of the VIP; (and parent company of both Mediserv International Ltd., trustee, service provider and Manager of the VIP; and Salubrity Ltd., trustee, service provider and Wellness Manager of the VIP); to negotiate with other entities, on my behalf, for group benefits in the VIP. I understand I can invite others to join the VIP, but unless specifically stated in writing, I am not an employee or representative of Capital Ventures Ltd., Mediserv International Ltd., Salubrity Ltd., the VIP or any activity supported by such entities. I promise to abide by the VIP Bye Laws and respective Primary Contracts and respective Attachments. My membership shall lapse, be voided, and I shall suffer penalties and charges, if I do not honour my pledged Membership Fees and or Contributions. I also accept that I can be expelled from the VIP for acts of infidelity in my financial affairs or willful involvement in terrorism, illegal drug trafficking or money laundering or for engaging in any activity that can be harmful to the VIP. I understand that considering the VIP being a Non-profit Organization, and NGO, my Membership Fees and or Contributions are voluntary irrevocable pledges which are donations, which I make as a donor and as a beneficiary of an Irrevocable Trust with Funds operated by the VIP via Trustees, in support of the operations, benefits and affairs of the VIP; nothing is bought or sold. Therefore, I understand that as a donor to the Trust, I have not engaged in any transaction of trade or commerce with the VIP or any entity associated with or related to the VIP. This means my benefits are Commercially Free and, in this regard, Philanthropy is VIP Currency. I understand that I may enjoy benefits in relation to my contributions to the operations, benefits and affairs of the VIP; which shall include my time, talents and treasures. I agree to support the VIP's National Wellness Lifestyle Management Programme (NWLM) and its Civil Society Economy, not limited to the ViaMed Network and the AntsNest Wellness Plan, directed towards diversifying the economy of Trinidad & Tobago into a Medical & Wellness Economy.

Applicant's Signature ________________________ Date: ___-___-___ Registration Officer: ____________________ RAN ____________

Application for Coverage from the VIP

SECTION I **A**

1) Name of Group (*Default is VIP*) ____________________________________ Group No ____________
2) Principal applying for coverage for: - Self☐ And Or Dependent(s)☐ The Suggested Commencement Date: - ___-___-___
3) State whether: - Initial Coverage☐ Upgrade☐ Downgrade☐ Endorsement☐ Reinstatement☐ Other☐
4) List: (i) all past coverages ____________________ **(ii)** Date terminated ___-___-___ **(iii)** Reason Terminated? ____________________

B1) **Family Status**: Single☐ Principal + 1☐ Family☐. **Payment Mode**: Monthly☐ 3 Consecutive Payments☐ Lumpsum Annual Payment☐
2) **Plan Package** ____________________________ **Code** ____________________ **Annual Payment Due$** __________
3) Benefit**1** ____________________________ Code ________ Beneficiary ________________ Due$ ________
4) Benefit**2** ____________________________ Code ________ Beneficiary ________________ Due$ ________
5) Benefit**3** ____________________________ Code ________ Beneficiary ________________ Due$ ________
6) Benefit**4** ____________________________ Code ________ Beneficiary ________________ Due$ ________
7) Benefit**5** ____________________________ Code ________ Beneficiary ________________ Due$ ________
8) Benefit**6** ____________________________ Code ________ Beneficiary ________________ Due$ ________
9) **Total** Due $ __________ **Add☐/(Minus☐) Reason?** ________________________ **Value$** ________ **Final Due$** ________
10) Immediate Payment Due: - ⇒⇒ $ ____________
11) Actual Initial Payment Effected: - ⇒⇒ $ ____________
12) **Payment Schedule**: I shall pay $ __________ immediately; then $ __________ for the next _____ months; then $ __________ monthly.
13) Receipt No: __________ Remarks ____________________________________

Agreement: I promise to pay the **Annual Payment Due** plus all my Dues and shall settle these obligations according to the above **Payment Schedule**.

Signature ____________________________________ Date: ___-___-___

HEALTH STATEMENT FORM

SECTION II

To be completed by the PRINCIPAL

NOTE: (Rel)ationship Codes:- Principal = 0; Spouse = 1; Son (Male) = 2; Daughter (Female) = 3; Step = 4; Adopted = 5; Guardian Child = 6; Economic Dependent = 9; (E.g. Stepson = 42)

A	Full Names (USE BLOCK LETTERS)	Rel	Birth Date	Height	Weight	ID Type	ID No.	Blood	Allergy or Chronic Ailment	X
1		0								
2										
3										
4										
5										
6										
i	I Authorize for Self, Spouse & Dependents (Tick Your Decision): (A) Blood Transfusions YES ☐ NO ☐ (B) Surgery YES ☐ NO ☐									
ii	Family Doctor (BLOCK LETTERS): Cell: ( ) : Ph: ( ) :									
iii	In Emergency Contact: Relationship: Cell: ( ) : Ph: ( ) :									
iv	Emergency Contact's Address:									

SECTION III **PERSONAL PHYSICIAN**

A	First Names (USE BLOCK LETTERS)	Physician & Address (Use Multiple Lines Per Person If Necessary)	Date Last Visit	Reason
1				
2				
3				

i) Anyone actually receiving treatment for any or all of the above sicknesses or accidents mentioned, including prescriptions? Yes ☐ No ☐ (Use section **E**)

B Have you or any applicant ever been treated for or ever had any known indication of:	PRINCIPAL YES	PRINCIPAL NO	SPOUSE YES	SPOUSE NO	CHILD YES	CHILD NO	INSERT ONE TICK PER CHILD
1) disorder of eyes, ears, nose or throat?							
2) dizziness, fainting, convulsions, headache, speech defect, paralysis, stroke, mental or nervous disorder?							
3) shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder?							
4) chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels?							
5) jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestine, liver, or gall bladder?							
6) sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive organs?							
7) diabetes, thyroid or other endocrine disorders?							
8) neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine, back or joints?							
9) deformity, lameness or amputation, or any congenital or acquired physical defects or impairment?							
10) disorder of skin, lymph glands, cyst, tumor or cancer?							
11) allergies, abnormal cholesterol levels, anemia, any disorder of the blood, or disorder of any body fluid, body structure or body excretion?							
12) AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorder?							
C Other than the above, have you or any applicant ever:							
(1) had any mental or physical disorder not listed above?							
(2) had any check-up, consultation, illness, injury or surgery?							
(3) had been a patient in a hospital, clinic, sanatorium, or other medical facility?							
(4) had an electrocardiogram, x-ray or other diagnostic test?							
(5) been advised to have any diagnostic test, hospitalization or surgery which was not completed?							
(6) been advised to pursue any personal weight management programme							
(7) been advised to change employment or lifestyle for medical or related reasons?							
(8) used alcohol? If yes, how much daily? If terminated, state year and reason. (Use section **E**)							
(9) used tobacco or any tobacco products? If terminated, state year and reason. (Use section **E**)							
D Females only: (**1**) Are you now pregnant as far as you know?							
(**2**) Do you have any gynecological disorder?							

E Details for questions if any of the above answers are yes, give full details below, referring to item numbers above. Use extra sheets if necessary.

MEMBER'S NAME & QUESTION No.	SUBJECT, DISEASE OR INJURY	DATE	DETAILS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL

SECTION IV

I hereby apply for coverage from the VIP for benefits enjoyed under the Community Benefit Plan, and administered under the Success & Wellness Lifestyle Management Contract (Primary Contract) and respective Attachments. I understand and accept that my relationship with the VIP shall be bound by the VIP Bye Laws, respective Primary Contracts and such Attachments which may apply to me or my affairs from time to time. I promise to manage my affairs, expectations and obligations according to the VIP Bye Laws, Primary Contracts and Attachments as aforementioned. I understand that after I accept the terms of the VIP Bye Laws, Primary Contracts and Attachments, as outlined in related documents, if I remain enrolled and or covered for any part of any given year, I shall be obligated to make payments against the full annual value (Annual Payment) of the Base Plan under which I am enrolled in that year, plus all other costs, fees, penalties or charges and such other obligations which has accrued or which has been incurred by me. With respect to my participation in the GEMS Attachment, I hereby authorize Mediserv International Ltd. **(The Company)**, or its assigns, to conduct credit checks on my personal financial history and related dealings.

I understand and agree that the coverage herein applied for shall not become effective unless and until such coverage shall have been approved for issuance by **The Company** at its Home Office during the lifetime of the person proposed for coverage and while the health, physical condition and such relevant circumstances of such person remain as represented herein. I also understand and agree that any non-disclosure, misrepresentation or omission of any material fact in response to any questions on this form and or in any other form or format, now and in future relationships and dealings with **The Company** and or the VIP, shall render any contract or agreement issued in consequence thereof void.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, and or my financial dealings to give to **The Company** any such information.

I expressly waive on behalf of myself and of any person who shall have or claim any interest in any coverage granted pursuant here to all provisions of law forbidding any creditor, physician or hospital official or employee, or other persons heretofore attended or examined me, or who may hereafter attend or conduct any financial dealing with or examine me, or who has been or may be consulted by me from disclosing any knowledge or information thereby acquired and from testifying with reference thereto.

A photographic copy of this authorization shall be as valid as the original.

Date Completed ____-____-____	Principal's Signature ⇨		Signature of Witness
If person to be considered for coverage is an adult dependent, the dependent also signs here. ⇨			RAN:

SECTION V (Official Use Only)

Plan Administrator: _____ Date ____-____-___ Commencement Date: a) As suggested☐ b) ____-____-____

Approved☐ Exclusion☐: _____