COHUM® PREMIUM MEMBERSHIP APPLICATION FORM

(Please fill ALL PARTS of the form clearly in ALL CAPITALS. Each individual applicant must fill separate form.) Mandatory items are highlighted in yellow. (Please refer to the last page for help and examples of information we require for the various sections.)

SECTION 1: PERSONAL INFORMATION

First name	Last name	❑Mr.	❑ Dr.
		❑ Mrs.	❑ Ms.

Name on COHUM ID (max 16 characters including space)	Aadhar Card No.	Birth date: DD/MMM/YYYY	Sex	
		/ /	❑ M	❑ F

Address Line 1	Line 2	Primary phone: (with Country Code)

City	Landmark	State	PIN Code

Occupation	Employer	Email

Registered organ donor?		If not, would you like to donate your organs?		Other Donor		Blood Group
❑ Yes	❑No	❑ Yes	❑ No	❑ Blood	❑ Bone Marrow	

SECTION 2: MEDICAL INSURANCE INFORMATION

(Please refer to your insurance card/ policy to fill this section.)

Is Applicant covered by insurance? ❑ Yes ❑ No	Insurance Contact Name & Phone
Please indicate primary insurance company	Insurance plan

Policy Holder's name: (if other than Applicant)	Birth date / /	Group no.	Policy no.	Deductible ₹

Applicant's relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary insurance (if applicable)	Policy Holder's name	Policy no.

Applicant's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

SECTION 3: IN CASE OF EMERGENCY

Primary Emergency Contact Name	Phone (with country code)	Email	Relationship
Second Emergency Contact (not living at same address)	Phone (with country code)	Email	Relationship

SECTION 4: GENERAL MEDICAL INFORMATION

Primary Doctor	Doctor's phone	Doctor's email
Doctor's Registration No.	Primary Hospital	Hospital Phone
Hospital Address	City, State, Landmark	
Last medical checkup date	Any major areas of concern identified	

SECTION 5: CRITICAL MEDICAL INFORMATION

(Please refer to medical reports or consult with your doctor to ensure accuracy. Please be as comprehensive as possible. Remember your life may depend on this information.) We strongly recommend that your doctor authenticate the information below.

List any severe allergies
List any severe drug allergies
List any implants
List any major surgeries you have undergone along with dates
List any major medical conditions that may help with treatment decisions
List any medications that you take regularly
List any family medical history or any other information that may help with treatment decision
Advance Care Directives

SECTION 6: MEDICAL AUTHENTICATION (OPTIONAL BUT HIGHLY RECOMMENDED)

Your immediate safety is our highest priority. Please consider having this medical information validated by your doctor.

To the best of my knowledge I believe the above medical information for _____ is correct and accurate as of date.

Doctor's Name	Doctor's signature and seal	Doctor's registration number	Date

Choose your COHUM Membership and COHUM ID Type

❑ Pendant	❑ Blue Bracelet ❑ Black Bracelet	❑ Black Eyelet ❑ Green Glow-in-dark Eyelet
		

For your convenience we accept electronic payment via NEFT.
Name: TRENTON ENTERPRISES PVT. LTD.
PAN: AAFCT1754Q

Bank: Kotak Mahindra Bank, Bhandarkar Rd Branch, Pune 411 004
Account #: 00 1209 2772
IFSC: KKBK 0000 723

Legal Release

1. I certify that the above information is provided by me voluntarily for my own benefit.
2. I acknowledge that the information I have provided is current, complete and accurate to the best of my knowledge.
3. I understand that COHUM cannot and need not verify any information I have provided.
4. My wishes about donating any of my usable organs are accurately reflected in Section 1.
5. I give my consent to COHUM to accept my information and release it all to authorized personnel in any medical or other emergency related to me. No further consent is required for COHUM to release this information.
6. I understand that COHUM is not a medical institution and has no medical expertise. COHUM is only providing my medical history to medical and emergency personnel on my behalf.
7. I acknowledge that COHUM cannot and will not be held liable for any type of direct or indirect use or misuse by recipients or third parties of the information provided by COHUM on my behalf.
8. COHUM will not be held liable by me or members of my family/friends for any action taken by medical staff.
9. I agree to pay all fees and taxes as applicable associated with my membership.
10. I understand that I am responsible for all my medical bills. COHUM is not responsible for any payment.

By signing this document I certify that I have read and agree with all the Terms and Conditions and Privacy Policy; that I am 18 years of age or older; and that the information provided is true and accurate to the best of my knowledge. Parent/guardian can sign for a child under 18 years of age; or for members with neurological disorders.

Signature (Please use blue pen) _____ Date _____

Name _____

Please scan and email signed copy to membership@cohum.co
AND send by courier/Speedpost to:

COHUM Membership
Flat # A-4, 1st floor, Liberty Society,
Opp Lane 5, North Main Rd, Koregaon Park
Pune 411 001 MH, INDIA

Instructions for completing the COHUM Membership Application. Highlighted items are mandatory.

Section 1: Please fill in your personal information. This section is mandatory.

Section 1: PERSONAL INFORMATION					
First name Raj	Last name Kumar		☒Mr.	❑ Dr.	
			❑ Mrs.	❑ Ms.	
Name on COHUM ID (max 16 characters incl space) RAJ KUMAR	Aadhar Card No. 1234 5678 9012	Birth date: DD/MMM/YYYY 20 / JUN /1976	Sex ☒ M	❑ F	
Address Line 1 123 MAIN STREET	Line 2 SHIVAJINAGAR	Primary phone: (with Country Code) +91 1234567890			
City ANYCITY	Landmark NEAR GPO	State MH	PIN Code 400001		
Occupation	Employer	Email FIRSTNAME@ANYMAIL.COM			
Are you a registered organ donor? ❑ Yes ☒No	If not, would you like to donate your organs? ☒ Yes ❑ No	Other Donor ☒ Blood ☒ Bone Marrow	Blood Group A +ve		

If you are not an organ donor yet we can help you register. However, it is important that you discuss with your family and make sure that your wishes are known to family members.

Section 2: This section is not mandatory. However, if you are covered by any type of medical insurance plan, please complete this section. It will expedite some procedures.

Section 3: This section is mandatory. We encourage you to complete information for both primary and secondary contact names.

Please put your initials and date at the end of the page to certify that the information is accurate to the best of your knowledge.

Section 4: This is a not mandatory section. Please fill in your doctor's information. However, we understand that not everyone may be affiliated to a specific hospital. We recommend that you provide the name of the hospital closest or most convenient to you. The date of your last medical checkup is important.

Section 5: This section is mandatory. Please fill as comprehensively as possible. Examples of information we seek are provided below. PLEASE NOTE these are only examples and not a comprehensive list. We are looking for any kind of information that will help doctors make appropriate decisions about the treatment for you should you be in an emergency situation.

Allergies: foods like nuts, gluten, fish, egg, milk, materials such as latex, chemicals like cosmetics, preservatives, perfumes, animals or pet dander, dust, pollen, or medicine (drug) allergies like penicillin, morphine, sulpha, antibiotics, etc. If you do not have any allergies, please write 'NO KNOWN ALLERGY".

Implants: insulin pumps, pacemakers, stents, catheters, metal plates, cochlear, hearing/visual aids, artificial knees, hips, cardio valves, etc.

Major surgery or intervention: cardiac bypass, angioplasty, neuro, gastric, etc.

Major medical conditions: diabetes, hemophilia, renal conditions, epilepsy, cardiac trouble, blood disorders, hypertension, asthma, Alzheimer's, Parkinson's, dementia, autism, Asperger's syndrome, anaphylaxis, cancer, malignant hyperthermia, hypothyroid, etc.

Regular medication: anticoagulants, insulin, beta blockers, chemotherapy, monoamine oxidase inhibitors, steroid therapy, dialysis, epinephrine, streptokinase, etc. Any other medical condition can be added to the next row. For example any partial or complete disability such as visual impairment, audio impairment, speech impairment, etc. or family history

Advance Care Directive could include things such as your wishes to not be resuscitated under certain conditions. Please discuss this with family members and ensure your legal advisors are also appraised of your wishes.

Please read and sign the box to indicate that you certify the information as accurate to the best of your knowledge.

Section 6: This is a validation of your medical information by your doctor. This section is optional but we highly recommend that you complete it. Doctor's validation may be updated at any time.