SCHEDULE 2

Regulations

FORM OF APPLICATION
GIBRALTAR HEALTH AUTHORITY
MEDICAL (GROUP PRACTICE) SCHEME

Application for Registration

Please fill in the following details:

Surname: _____

First Name: _____ Initial(s): _____

Address:_____

Nationality: _____

Tel. No:. _____ Date of Birth: _____ Sex:_____

No. of dependants:_____ I.D. No. _____

Doctor: _____ Blood Group:_____

Are you diabetic? Yes/No Are you a blood donor? Yes/No

I of
hereby declare that the above particulars are true to the best of my knowledge and belief. I acknowledge that it is an offence wilfully to make any false statement or any material misrepresentation in this application, with the intention of obtaining or attempting to obtain any benefit to which I or any of my dependants are not entitled.

DATE: _____ SIGNATURE: _____

Please complete a form in respect of each of the dependants for whom an application for registration is being made.

Please produce when registering, the following documents (if applicable):

A) Photocopy of Schedule of Social Insurance.
B) Identity Card/ Passport.
C) Permit of Residence.
D) ETB Notice of Terms & Engagement (Work contract)
E) A Passport size Photograph
F) Birth Certificate (If applicable)
G) S1 – contributions unit (if applying as a Cross Border Worker)

Collected By: _____ Issued By: _____

Gibraltar Health Authority
Medical (Group Practice) Scheme

Application for first time applicants

SECTION A

Religion

(*Optional*)

Ethnicity (optional)

Marital status (Please tick appropriate box)

Single ☐ Married ☐ Civil Partner ☐ Divorced ☐ Widowed ☐ Cohabitees ☐

SECTION B *(To be filled in by Pensioners, Unemployed, Retired or District Medical Services)*

My income per month is as follows

DETAILS PER MONTH	**SELF**	**SPOUSE**
INCOME FROM EMPLOYMENT IF ANY		
OCCUPATIONAL PENSION		
OLD AGE PENSION (O.A.P)		
HOUSE COST ALLOWANCE (COMMUNITY CARE)		
MINIMUM INCOME GUARANTEE (M.I.G)		
DISABILITY ALLOWANCE		
DISABLEMENT BENEFITS		
MAINTENANCE ALLOWANCE		
DISTRICT MEDICAL SERVICES		
ANY OTHER INCOME		
TOTAL INCOME =		

SECTION C *(To be filled in by all applicants)*

NEXT OF KIN

Surname

First and middle names

Address

Post Code

Contact Details Home

Mobile

Relation *(Please tick appropriate box)*

Spouse ☐ Child ☐ Civil Partner ☐ Relative ☐ Carer ☐ Foster Parent ☐

Parent ☐ Sibling ☐ Social Services

Other *(Please Specify)*

SECTION D *(To be filled in by all Applicants)*

Please tick appropriate boxes *(Select one of the GP's from your chosen area. If applying for the first time you may wish to discuss this with the registration officer for further information)*

Blue Area ☐	Yellow Area ☐	Green Area ☐
Dr Flores ☐	Dr Perez ☐	Dr Chichon ☐
Dr Jones ☐	Dr Galloway ☐	Dr Penrice ☐
Dr Montero ☐	Dr Mena ☐	Dr Ferrera ☐
Dr Negrette ☐	Dr Cortes ☐	Dr Higgins ☐
Dr Thoppil ☐	Dr Gupta ☐	Dr Poyatos ☐
Dr Falero ☐	Dr Rawal ☐	Dr Pinto ☐
Dr Robles ☐	Dr Martyn ☐	Dr Pincho ☐
Dr Manasco ☐		

Collected by:_____ Issued by:_____