

# Gibraltar Health Authority Medical (Group Practice) Scheme

## Application for Renewal

### SECTION A *(To be filled in by all applicants)*

REG NO. *(Gib Health Card No.)*

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Identification Number (I/D)

Surname

First and middle names

Date Of Birth

Address

Post Code

Contact Details

Home No.

Work No.

Mobile No.

Email Address

Religion (Optional)

Ethnicity (Optional)

Gender *(Please tick appropriate box)*

Male

Female

Nationality

Marital status *(Please tick appropriate box)*

Single

Married

Civil Partner

Divorced

Widowed

Cohabitees

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**SECTION A2** *(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		
<b>TOTAL INCOME =</b>		

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**SECTION B**

NEXT OF KIN *(To be filled in by all applicants)*

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

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**SECTION C** (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 Group	<input type="checkbox"/>	Yellow Group	<input type="checkbox"/>	Green Group	<input type="checkbox"/>
Dr V Flores	<input type="checkbox"/>	Dr K Rawal	<input type="checkbox"/>	Dr N Chichon	<input type="checkbox"/>
Dr S Jones	<input type="checkbox"/>	Dr A Falero	<input type="checkbox"/>	Dr L Penrice	<input type="checkbox"/>
Dr N Montero	<input type="checkbox"/>	Dr S Lines	<input type="checkbox"/>	Dr J Ferrera	<input type="checkbox"/>
Dr J Negrette	<input type="checkbox"/>	Dr F Mena	<input type="checkbox"/>	Dr D Higgins	<input type="checkbox"/>
Dr J Thoppil	<input type="checkbox"/>	Dr P Cortes	<input type="checkbox"/>	Dr M Poyatos	<input type="checkbox"/>
Dr C Taylor	<input type="checkbox"/>	Dr A Gupta	<input type="checkbox"/>	Dr R Pinto	<input type="checkbox"/>
Dr Y Robles	<input type="checkbox"/>	Dr D Martyn	<input type="checkbox"/>	Dr E Pincho	<input type="checkbox"/>
Dr J Manasco	<input type="checkbox"/>	Dr E Flores	<input type="checkbox"/>		
		Dr N Perez	<input type="checkbox"/>		

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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 dependants are not entitled.

Signature:

Date:

**Kindly note that if you are submitting your application electronically, you should receive an automatic reply, confirming receipt. If for any reason you do not receive an automatic reply, please contact us on 20007860.**

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Data Protection – How we use your information.

We treat all the information you give us about you and others as private and confidential. We respect your right to privacy and understand the importance of protecting the personal information we hold. See our privacy notice for full details.