

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.)*

| | | | | | | |
|--|--|--|--|--|--|--|
| | | | | | | |
|--|--|--|--|--|--|--|

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

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 | | |
| TOTAL INCOME = | | |

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

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"/> | | |

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:

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.