

Declaration of Condition Form

Please complete this form when applying for benefits for the following:

1. Gym equipment (Health Management Program)
2. Fitness programs (Health Management Program)
3. Health aids

Contributor number:

Patient name:

Outline of medical condition or injury:

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Estimated date of diagnosis:/...../.....

Date doctor advised start of health management plan:/...../.....

Name of referring practitioner:

Name of practice:

Practice phone:

Recommended treatment by referring practitioner:

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Anticipated length of treatment:

Note: maximum approval is 12 months

Statement of declaration

I declare that the information I have provided is true and correct and understand that it may be used by *onemedifund* for auditing purposes.

Signature:

Date:/...../.....