

FIRST MUTUAL

MAI2

HEALTH

Go Beyond

FIRST MUTUAL HEALTH, First Floor, First Mutual Park, 100 Borrowdale Road,
Borrowdale, Harare, Zimbabwe | P O Box 1083, Harare.
tel: +263 (4) 886018 - 36, 886038, 886040-43 | Fax: +263 (4) 886068, 886069
E-mail: info@fmlmedical.co.zw | Website: www.fmlmedical.co.zw

MEMBERSHIP APPLICATION FORM (INDIVIDUALS)

(only new members should complete this form after reading the Terms and Conditions at the back)

PLEASE PRINT (Members are encouraged to complete this form in capital letters)

FOR ADMINISTRATIVE USE																							
Membership Number		<input type="text"/>										Account Holder Number		<input type="text"/>									
Accountholder Name: _____																							

Section 1. CHOICE OF PLAN (Please Tick)

Pearl Garnet

Section 2. DETAILS OF PRINCIPAL MEMBER

Title	M	R	S		Initials	H		First Name	A	N	I	T	A											
Surname	M	B	O	F	A	N	A																	
Marital status	Single	Married	Divorced	Widowed	Other	Race AFRICAN																		
ID Number	7	5	-	1	5	6	5	3	2	G	7	5		Gender	M	X	Date of Birth	D	D	M	M	Y	Y	Y
Telephone (H)														Telephone (B)										
Cell														Fax										
Email address																								
Postal Address	9	G	U	I	L	D	F	O	R	D	C	R	E	S,	S	O	U	T	H	E	R	T	O	
		H	A	R	A	R	E,	Z	I	M	B	A	B	W	E									
Physical Address	9	G	U	I	L	D	F	O	R	D	C	R	E	S,	S	O	U	T	H	E	R	T	O	
		H	A	R	A	R	E,	Z	I	M	B	A	B	W	E									

Section 3 DEFENDANTS YOU WISH TO REGISTER

Section 3. DEPENDANTS YOU WISH TO REGISTER

Adult rates apply to any dependant who is 18 years or older. Child rates apply from newly born babies to full time students aged between 18 - 24 years provided that proof of education for the current year is attached to the application form. Please attach copies of ID or birth certificates for all beneficiaries. Acceptance of the dependants will be in accordance with the Rules of the Scheme.

Section 4. DECLARATION OF MEDICAL HISTORY

Do you or any of your dependants suffer from any of the following medical conditions? If yes, tick the appropriate box and provide details below.

Diabetes	Hypertension	X	Arthritis	Asthma		Bone problems		Heart problems	X
Cancer	Renal/kidney disease		Abdominal problems			Orthodontics		Other (specify)	

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment ?		Date diagnosed	Attending Doctor
SELF	HYPERTENSION		Yes	No		
			Yes	No		
			Yes	No		

Are you or any of your dependants pregnant? If yes, provide details

Name of beneficiary	Expected delivery date	Attending Doctor
N / A		

Section 5. PREVIOUS MEDICAL INSURANCE INFORMATION (Please attach a certificate of membership with the terminated date)

Name of Medical Aid Fund	Plan/Package	Membership No.	Date of registration	Date of termination
PSMAS				

Are you changing your medical aid due to a change of employer? If yes, please provide a letter from previous employer confirming termination of employment and date.

Section 6. EMPLOYER/ACCOUNT HOLDER INFORMATION - This section MUST be completed and signed for by the Employer/Account Holder
No application form will be processed without the Employer/Account Holder's authorisation signature or stamp

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the Scheme Rules and Plan chosen. All sections of the application form have been completed.

COMPANY STAMP

Signature _____

Section 7. BANKING DETAILS FOR REFUNDS

Bank Name _____

Branch Name_____

Bank Branch Code

Name of Account Holder _____

Bank Account Number

TERMS AND CONDITIONS ON APPLICATION FOR MEMBERSHIP

This form should be completed by first time applicants to First Mutual Health or if you were a dependant and now wish to be a member in your own right. If you are a member of First Mutual Health and wish to add or remove a dependant or change from one plan to another, complete Membership Update Form.

Please complete all the sections of this application form as it forms the basis for your registration.

Section 1 Choice of Plan

First Mutual Health offers a variety of Plans. Please tick the appropriate box for the Plan you wish to join. Your employer should approve the Plan choice if you are joining through a company.

Section 2 Details of Principal Member

The personal details of the principal member should be entered here. Settlement advice slips and cheque refunds will be made out to this person. Please enter the personal details as they appear on your identity document as you may be asked to produce this along with your membership card when you see providers of health services.

Section 3 Dependents

May include your spouse, your children, or in certain circumstances, other dependant the member wishes to benefit from the Scheme. The Scheme may request a medical report before accepting other family members as dependants. Relationship to member describes the relationship of the dependant to the principal member. Spouse and child are normal dependants anyone else e.g. parents, in-laws etc is considered to be an "other dependant". A child aged between 18 and 24 years may be classified as a student provided they are studying full-time and proof of education for the current year is attached to the registration form. Otherwise such a child will be classified as an "other dependant".

Section 4 Declaration of Medical History

You need to inform the Scheme, if you, or any of your dependants you are registering, is currently undergoing, or likely to require medical treatment. It is very important that you disclose all information as failure to do so will be a breach of contract leading to failure to have claims settled.

Section 5 Previous Medical Insurance

Please provide a membership certificate with termination date if you are moving from another medical aid Scheme. If you are changing employer, please provide a letter confirming termination of employment and date.

Section 6 Employer /Account Holder Information

This section should be completed by the person who will be responsible for remitting your contributions to First Mutual Health either the individual account holder, or your employer designated officer. Employers need to stamp the form and sign as authorisation for applicant to be on the First Mutual Health Scheme. The account holder number is the number which appears on the billing invoice. If you are applying for membership without Employer affiliation you should submit a completed Employer/ Individual Account Holder application form along with your membership application. The Employer account number is automatically generated by First Mutual Health, please remember to quote the number each time you remit your contributions.

Start date is the effective date from which the membership want to be registered and benefit. Membership runs from the first day of the month to the last day of the month. Applications must be received before the 25th day of the month for registration to be effective from the following month.

Section 7 Banking Details of Principal Member

Please provide First Mutual Health with your banking details to enable the payment of claims refunds, savings pot or cash back through Electronic Funds Transfer (EFT).

Contribution Payments:

Please note that contributions are paid a month in advance. If contributions are not received for a period of ninety (90) days the membership will be terminated.

DECLARATION

I declare that the information contained in this form is materially true in all respects. I agree that should my application for membership be accepted, I will abide by the Rules, Benefits and Regulations set by First Mutual Health from time to time. I certify that none of my dependants suffer from any condition/s not declared. I authorise the deduction from my salary of the monthly contributions due in respect of my dependants and myself. Signing this application form, forms the basis of a contract between myself and First Mutual Health.

I acknowledge that should I terminate my membership before the medical benefit becomes payable there will be no refund of contributions.

Signature of Principal Member _____

Date

D	D	M	M	Y	Y	Y	Y
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YOUR CHECK LIST

IMPORTANT: WE WILL NOT PROCESS YOUR APPLICATION FORM IF IT IS not signed/stamped by the Employer/ Account Holder, incomplete , incorrect or if you have not attached the correct documents. PLEASE use this check list to make sure that you have completed your application form in full.

- Have you completed all fields on the application form?
- Have you provided us with the correct contact details; telephone, cell numbers, email and postal address?
- Have you provided us with your banking details?
- Have you ticked the Plan you wish to be registered on?
- Have you attached your previous membership certificate with the termination date?
- Have you signed the form? (Unsigned forms will not be processed and be returned to you for signature)
- Has your Employer/Account Holder signed or stamped your application form?

Delma Print 250478/83