Member Detail Amendment & Dependant Registration Form

* SCHEME NAME

ADMINISTERED BY: METROPOLITAN MALAWI

Kang'ombe House, 1st Floor, East Wing, City Centre, Lilongwe, Malawi.
TEL: +265 1771 978 or +265 1771 979 FAX: +265 1771 976

INDICATE YOUR REQUEST

Where there are YES/NO questions mark like this: [Y] for a Yes answer and [N] for a NO answer. Where there are tick boxes, mark with a tick ✓.

☐ Change of address/ contact details ☐ Change of option ☐ Cancellation of dependants ☐ Registration of newborn child ☐ Registration of any other additional dependant

PRINCIPAL MEMBER DETAILS UPDATE

Membership No. 200076057 Title MRS Initials

Surname DZABALA Registered First Name ATUPELE

CHANGE OF ADDRESS/CONTACT DETAILS

Postal address P.O.Box 2447

Town/city BLANTYRE Postal Code

Residential address KS 11/20
NKOLOKOSA

Town/city BLANTYRE Postal Code

Email address atu.indira@gmail.com

Alternative Email

Tel no. (h) (w) Cell no. *(essential)* 0999631500

REGISTRATION OF NEWBORN CHILD

Name of Newborn CHINAMO ARIEL MACHEZA DZABALA

Date of birth (dd mm yyyy) 06082016 Relationship SON

Benefit Date (dd mm yyyy) Gender M

Name of Newborn

Date of birth (dd mm yyyy) Relationship

Benefit Date (dd mm yyyy) Gender

CANCELLATION OF DEPENDANTS *(Stipulate details as on membership card)*

Name of Dependant

Date of birth (dd mm yyyy) Relationship Gender

Benefit Date (dd mm yyyy) Cancellation Date (dd mm yyyy) *(last day of month)*

Name of Dependant

Date of birth (dd mm yyyy) Relationship Gender

Benefit Date (dd mm yyyy) Cancellation Date (dd mm yyyy) *(last day of month)*

Name of Dependant

Date of birth (dd mm yyyy) Relationship Gender

Benefit Date (dd mm yyyy) Cancellation Date (dd mm yyyy) *(last day of month)*

REGISTRATION OF SPOUSE/PARTNER/ADDITIONAL DEPENDANT

Dependant 1 ☐ Spouse/Partner ☐ Student ☐ Grandchild ☐ Late registration of own child ☐ Other

Name of Dependant | Surname

Date of birth (dd mm yyyy) | Relationship | Gender

Benefit Date (dd mm yyyy) | Marital Status | Cancellation Date (dd mm yyyy)

Dependant 2 ☐ Spouse/Partner ☐ Student ☐ Grandchild ☐ Late registration of own child ☐ Other

Name of Dependant | Surname

Date of birth (dd mm yyyy) | Relationship | Gender

Benefit Date (dd mm yyyy) | Marital Status | Cancellation Date (dd mm yyyy)

Dependant 3 ☐ Spouse/Partner ☐ Student ☐ Grandchild ☐ Late registration of own child ☐ Other

Name of Dependant | Surname

Date of birth (dd mm yyyy) | Relationship | Gender

Benefit Date (dd mm yyyy) | Marital Status | Cancellation Date (dd mm yyyy)

COMPULSORY FOR ADULT DEPENDANTS (OVER AGE OF 18)

NUMBER OF DEPENDANT

If "YES" Complete

Name of Employer | Pension (state type)

Is the dependant totally reliant on you for financial support and maintenance?

If "YES" Motivate

NUMBER OF DEPENDANT

If "YES" Complete

Name of Employer | Pension (state type)

Is the dependant totally reliant on you for financial support and maintenance?

If "YES" Motivate

STUDENT REGISTRATION *(Complete and provide a copy of student registration)*

Nature of study - Full time ☐ Part time ☐ | Period of study | Nature of academic institution

PREVIOUS MEDICAL SCHEME INFORMATION

Complete this section if you are currently a member/dependant of a medical scheme or were/have been a member/dependant of a medical scheme for the past two years. Please attach a certificate of membership (not a copy of a card).

Name of Member/ adult dependant | Name of previous scheme

Membership No. | Period from | to

Was the main member and/or any of the dependants subject to restrictions /exclusions on the other medical scheme?

If "YES" provide details

Name of Member/ adult dependant | Name of previous scheme

Membership No. | Period from | to

Was the main member and/or any of the dependants subject to restrictions /exclusions on the other medical scheme?

If "YES" provide details

MEDICAL HISTORY OF MAIN MEMBER AND DEPENDANTS

Any previous or current treatment for a disorder or condition must be marked as YES. Answer all questions by selecting YES or NO. Where the answer is Yes, please give full details. A doctor's report may be requested in some cases.

Please circle the specific condition

EXAMPLE

Condition	Yes	No
Birth defects & inherited disorders - Spina Bifida, injuries, Heart Disorders or other.		

Condition		Yes	No
1.	**Birth defects & inherited disorders** - Spina Bifida, injuries, Heart Disorders or other.		O
2.	**Dermatological** - Acne, Eczema, Pemphigus, Psoriasis, Fungal infections or other.		O
3.	**Musculo-Skeletal** - Osteo-arthritis, Rheumatoid arthritis, Osteo-sarcoma, Gout, Osteoporosis, Lupus Erythematosus or other.		O
4.	**Ear, Nose and Throat** - Deafness/Hearing impairment, Allergic Rhinitus, Recurrent Throat Infections, Vertigo, Chronic Sinusitis, Meniere's Disease or other.		O
5.	**Respiratory disorders** - Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis, Bronchiectasis or other.		O
6.	**Gastro-Intestinal** - Hiatus Hernia, Chronic Peptic Ulcer, Crohn's disease, Oesophageal reflux, Spastic Colon, Ulcerative Colitis, Malabsorbtion Syndrome or other.		O
7.	**Urological Disorders** - Chronic Renal Failure, Kidney Stones, Chronic Pyelonephritis or Prostatic Hypertrophy, Neurogenic bladder, Urinary incontinence, Urinary retention or other.		O
8.	**Neurological** - Cerebro Vascular Accident, Neuropathy, Epilepsy, Multiple Sclerosis, Neuralgia, Migraine, Parkinson's disease, Myasthenia Gravis, Stroke, Alzheimer's, Narcolepsy or other		O
9.	**Psychiatric** - Anxiety, Depression, Bipolar Mood Disorder, Schizophrenia, Sleep disorders, Attnetion Deficit Hyperactivity disorder, Neurosis, Obsessive-Compulsive disorder or other.		O
10.	**Metabolic disorders** - Lipid Disorders, Porphyria or other.		O
11.	**Cardiovascular** - Hypertension, Hypotension, Dysrrhythmias, Cardiac Failure, Hypercholesterolaemia, Aneurysm, Angina, Ischaemic Heart Disease, Peripheral Vascular or other		O
12.	**Liver and Pancreas Disorders** - Hepatitus, Cirrhosis, Gall-stones, Pancreatitis, Chronic Cholecystitis or other.		O
13.	**Blood Disorders** - Anaemia, Leukemia, Haemophilia, Clotting Disorders, Thrombocytopenia or other.		O
14.	**Endocrine Disorders** - Diabetes Insipidus, Hypothyroidism, Hyperthyroidism, Addison's Disease, Cushing's Syndrome, Diabetes, Mellitus, Hypoglycemia or other.		O
15.	**Infections** - HIV, Hepatitus or any sexually transmitted disease		O
16.	**Cancer** - any form		O
17.	**Gynaecologist system** - Infertility, Endometriosis, Ovarian Cysts, Menopause, Menstrual disorders, Mastalgia or other.		O
18.	**Eye Disorders** - Impaired vision, Glaucoma, Retinopathy, other		O
19.	**Have/are you being compensated for any disability?**		O
20.	**Are you pregnant or do you suspect you are?**		O
21.	**Any previous surgery?**		O
22.	**Any exclusions on previous medical aid?**		O

Any other conditions *(Please use a seperate page if more than two conditions)*

If YES to any of the previous questions please complete the section below, and fill in the applicable condition number:
(Please use a seperate page if more information applies to relevant questions)

Condition No. | Patient | Doctor

Treatment | Last Date of Treatment (dd mm yyyy)

Condition No. | Patient | Doctor

Treatment | Last Date of Treatment (dd mm yyyy)

Condition No. | Patient | Doctor

Treatment | Last Date of Treatment (dd mm yyyy)

CURRENT CHRONIC MEDICATION *(Please use a seperate page if more than three chronic medications are used)*

Initials | Registered First Name

Surname | Medicine

Duration of use | From (dd mm yyyy) | To (dd mm yyyy)

Initials | Registered First Name

Surname | Medicine

Duration of use | From (dd mm yyyy) | To (dd mm yyyy)

Initials | Registered First Name

Surname | Medicine

Duration of use | From (dd mm yyyy) | To (dd mm yyyy)

CHANGE OF OPTION

Current Option - name of option	
New option - name of option	

TO BE COMPLETED BY MAIN MEMBER'S EMPLOYER

Name of Employer	DZABALA TRUST
Employer address	P.O.Box 2447 IBT
Employer Tel. No.	0911672767
Employer Fax No.	

Please indicate the appropriate box with an "X" and complete the information

☐ The company has a medical scheme BUT

is not a member and is not eligible for membership of the fund for the following reasons:

☐ The company has a medical scheme AND ATUPELE DZABALA

is a member of our fund. His/her details are:

Membership No.	20007605 7
Dependants covered	HUSBAND
	SON

Main member join date (dd mm yyyy)

Dependant/s join date

Signature of Employer

Designation CHAIRPERSON

Date 15 09 2016

DECLARATION BY MAIN MEMBER

I hereby declare that to the best of my knowledge, the information herein this document is true and correct.

Signature

Date 15 09 2016