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**MEDICAL FUND MEMBERSHIP APPLICATION FORM**

**1. PERSONAL DETAILS**

Member Surname: Title:

First Name(s):

Date of Birth: D D | M M | Y Y Y Y

Residential Address:

Postal Address:

Email Address:

Telephone(H): (M):

ID Number:

Membership Commencement Date: D D | M M | Y Y Y Y

Next of Kin: Contact Tel:

**2. PLAN OPTIONS**

Tick () preferred plan

Plan A: Plan B: Plan C:

**3. DEPENDENT DETAILS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname | First Name (s) | DOB | Gender | ID Number | Relation to Member |
|  |  | dd mm yy |  |  |  |
|  |  | dd mm yy |  |  |  |
|  |  | dd mm yy |  |  |  |
|  |  | dd mm yy |  |  |  |
|  |  | dd mm yy |  |  |  |
|  |  | dd mm yy |  |  |  |
|  |  | dd mm yy |  |  |  |
|  |  | dd mm yy |  |  |  |

*Please attach copy of members’ ID and were necessary marriage and / or births certificates of dependents*.

**4. MEDICAL DETAILS**

Give details and year of any illness, operation, or injury su­ffered or sustained by yourself or any of your dependents. (If none, please state "NONE")

|  |  |  |  |
| --- | --- | --- | --- |
|  | CONDITION | YES(√) | NO (√) |
| 1 | Heart Diseases: Heart Diseases, Rheumatic Diseases, Congenital Heart Abnormalities, Angina, Embolism & Hypertension. |  |  |
| 2 | Circulatory Disorders: Varicose Veins/Thrombosis, Blood Disorders e.g. Anaemia and Leukemia. |  |  |
| 3 | Disease of the Liver: Jaundice, Gall Bladder, Liver Cirrhosis. |  |  |
| 4 | Disease of the Airway/Lungs: Asthma, Chronic Bronchitis, Tuberculosis, Emphysema, Cystic Fibrosis, Interstitial Fibrosis. |  |  |
| 5 | Disease of the Digestive System: Gastric/Duodenal Ulcers, Hiatus Hernia, Severe Recurring Diarrhoea. |  |  |
| 6 | Disease of the Bladder/Kidney: Kidney Stones, Congenital Kidney Disorder, Nephritis, Bladder Infections. |  |  |
| 7 | Neurological Disorders: Migraine, Stroke & Epilepsy. |  |  |
| 8 | Disease of the Bone, Joints & Muscles: Rheumatic Arthritis, Gout, Back, Neck, Joint problems. |  |  |
| 9 | Endocrine Disorders: Diabetes mellitus, Thyroid disease e.g. Goitre. |  |  |
| 10 | Mental Health Disorders: Psychotic Disorders (e.g. Schizophrenia), Mood Disorders, Anxiety Disorders (e.g. Panic Disorders). |  |  |
| 11 | Are you currently taking medication of a permanent or recurring condition? If so please give detail of name, dosage & frequency in the table below. |  |  |
| 12 | Is there any illness or factor not mentioned above that might affect your health in the next 12 months? |  |  |
| 13 | Are you pregnant? If so what is the expected date of delivery? |  |  |
| 14 | Any other condition not stated above. If yes please give detail in the table below. |  |  |
| 15 | If you have ticked YES for any of the above, please complete the section below. Please disclose all the important information. |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Question  # | Name | Date diagnosed | Full Details of Condition, Duration of Treatment and Medication (If Any) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**5. DECLARATION**

I have read the rules by which I agree to abide and declare that the above statements are true and complete. I consent to the company seeking information from any doctor I or my dependants have consulted.

Date: Signature: