

First Mutual Health Head Office: First Mutual Park 100 Borrowdale Road Borrowdale Harare P. O. Box 1083 Harare, Zimbabwe Telephone: +263 242 886018-38 Fax: +263 242 886068-9 Email: info@fmlmedical.co.zw Web: www.fmlmedical.co.zw

**MICROMED APPLICATION FORM**

**For administrative use**

|  |  |  |  |
| --- | --- | --- | --- |
| MEMBERSHIP NUMBER |  | PAYER NO. |  |
|  | | | |
| COMPANY NAME |  | | |
| **Section 1. INTERMEDIARY**  **Agent/Broker ………………………. Unit**  **Name of Agent………………………………………………………………… Date** | | | |

**Section 2. DETAILS OF PRINCIPAL MEMBER**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| TITLE |  | | | | | | | | | | | | | | | | | | | |
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| FIRST NAME(S) |  | | | | | | | | | | | | | | | | | | | |
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| SURNAME |  | | | | | | | | | | | | | | | | | | | |
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| GENDER |  | | | | | | | | | | | | | | | | | | | |
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| MARITAL STATUS |  | | |  | | | |  | | | | |  | | | | | |  | |
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| ID NUMBER |  |  |  | |  |  |  | |  |  |  |  | |  |  |  |  |  | |  |
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| DATE OF BIRTH |  | | | | | | | | | | | | | | | | | | | |
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| EMAIL |  | | | | | | | | | | | | | | | | | | | |
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| POSTAL ADDRESS |  | | | | | | | | | | | | | | | | | | | |
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| PHYSICAL ADDRESS |  | | | | | | | | | | | | | | | | | | | |
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| CELL NUMBER |  | | | | | | | | | | | | | | | | | | | |

**Date from which membership is supposed to** **commence:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Section 3. DETAILS OF DEPENDANTS TO BE INCLUDED**

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**Section 4. DETAILS OF NEXT OF KIN**

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| --- | --- | --- | --- | --- | --- |
|  | **First Name** | **Surname** | **Title** | **Relation to main life assured** | **Mobile Number** |
| **Next of Kin 1** |  |  |  |  |  |
| **Next of Kin 2** |  |  |  |  |  |
| **Next of Kin 3** |  |  |  |  |  |

**Section 5. BANKING DETAILS FOR REFUNDS**

Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Branch Name: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Branch Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Account Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Principal Member**:** \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

**Section 6. EMPLOYER/ACCOUNT HOLDER INFORMATION**

This section MUST be completed by the Employer/Account holder. No application form will be processed without the Employer/Account holder authorisation signature or stamp.

**Name of Employer/Account holder**

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|  |

**Employer Account No**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employee EC No.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Aid Start Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employment Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

**Employer Telephone No.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 7. BANKING DETAILS FOR REFUNDS**

Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Branch Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Branch Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Account Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Principal Member**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**TERMS AND CONDITIONS ON APPLICATION FOR MEMBERSHIP**

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

**Section 1 Intermediary**

This section should be completed by the Agent

**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 Dependants**

May include your spouse, your children, or in certain circumstances, other dependant the member wishes to benefit from the Scheme. 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”.

**Section 4 Next of Kin**

Please provide full details of your next of Kin.

**Section 5 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 wants 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 6 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 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\_George Mugumi\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

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