ZESA GROUP MEDICAL FUND

MEMBERSHIP APPLICATION FORM

This application will not be processed if it is not completed in full

Tick Plan ◯ SILVER

Employer/Subsidiary Name:

SECTION I: MEMBER DETAILS

Surname: First Name:

Title: ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr. ◯ Prof. ◯ Eng. Occupation:

Date of Birth: mm/dd/yyyy ID No.: Employee No.:

Residential Address:

Mobile Number: Email Address:

NEXT OF KIN DETAILS

Full name: Relationship:

Mobile Number: Email Address:

SECTION II: DEPENDANTS' INFORMATION (Attach copies of ID, valid Passport or Birth Certificate for all members on this form)

Surname	First Name	Date of Birth	Gender	Relationship	ID Number	Mobile Number

SECTION III: BANKING DETAILS

Name of Bank: Branch:

Branch Code:: Account Number:

SECTION IV: DETAILS OF YOUR GENERAL PRACTITIONER

Full name: Mobile Number:

Address:

SECTION V: CHRONIC DISEASE CONDITION DECLARATION

If you or your dependants suffer from any chronic condition like Diabetes, Hypertension, Asthma, Congestive Cardiac Failure, Auto Immune Conditions, and Chemotherapy, Haemodialysis, please provide details below:

Full Name	Condition	Treatment Administered	Name of Doctor	Doctor's Contact No.

SECTION VI: DECLARATION

I certify that the information given above was submitted willfully and is correct. I agree that should my application be accepted, I will abide by the rules, benefits and regulations set by ZESA Group Medical Fund which is administered by CellMed Health Medical Fund (CellMed); details of which is available on request. Signing of this contract signifies the basis of contract between ZESA Group Medical Fund and myself.

Member Signature: Date: mm/dd/yyyy

Authorised HR Signatory: Date: mm/dd/yyyy

Administered By