Qalisa Fund Administration System

MAF -
EMF Medical Aid Society
USD Membership Form

TYPE OF Form (tick appropriate) | **Application** ☐ | **Change** ☐

Harare Branch
3rd Floor Engineering House
88 Rezende Street,Harare, Zimbabwe
P.O.Box 1922, HARARE
Tel:0242 775 144 / 734 538 / 759 962 / 780 437 / 775 145
Whatsapp:+263 718 571 570
Email: emfsecretary@necemf.co.zw
Website: www.emfmedicalaid.com

Bulawayo Branch
95 G.Silundika Street
P.O.Box 130, Bulawayo
Tel: (09) 881172/3
Email: emfsecretary@necemf.co.zw

Zvishavane Branch
Cell: 0712 123 570
0712 125 380

Kwekwe Branch
Shop No. 4
First Mutual Life Centre
R. G Mugabe Way
P.O.Box 1720
Kwekwe
+263 (5525), 22006, 23475
Email: nechq@necemf.co.zw

FOR EMF USE ONLY

		Member No.	*Date Effective*	*Member's Contribution*	*Employer Code*

M/F | *Payment advice to member (YN)* | *N.E.C GRADING*

(*) Member Category

(*) Required Fields (Application will not be successful if any are left out

1. Member DETAILS

(*) Surname:	(*) First Name(s):	Initials:	(*) Title		Miss/Mr./Mrs./Dr/Prof
(*) ID Number	(*) Sex	(*) Date of Birth			

Residential Address:

Town:____________ Suburb:____________ Address Line:____________

Contact Details:

(*) Primary Phone: ____________ Secondary Phone ____________ Primary Email ____________ Secondary Email ____________

(*) Marital Status: ____________ (Married, Single, Divorced, Widowed, Seperated, Life Partner, Unknown)

(*) Designation / Employment Title ____________

1.1 DEPENDANT DETAILS

	(*) First Name:	(*) Surname:	(*) Date of Birth: D D M M Y Y Y Y	(*) Sex:	(*) Relationship to Member	Type of Change	(*) ID Number:	(*) Phone Number
1								
2								
3								
4								

1.2 (*) PLEASE INDICATE THE PACKAGE YOU WISH TO JOIN

Family Gold		Bronze		Gold		Platinum		Diamond		Diamond Plus		Silver		I require medical cover from Date:____________

(*) Name of Bank or Building Society:____________

(*) Branch:	(*) Account Number:

Should the society erroneously deposit money into my account I hereby authorise the Society to deduct such amount from my account

2. DETAILS OF PREVIOUS MEDICAL AID (Please attach certificate of membership of the last medical aid society)

Name of Medical Aid Society	Scheme	Membership No.	From	Date	To	Date

3. MEDICAL HISTORY (Have you/your spouse/any dependants suffered from any of the following)

Cancer		Cardio Heart Problems		Arthritis		Hypertension		Diabetes		Renal Problem	
Psychiatric		Epilepsy		Asthma		Leprosy		Other			

If any of the above applies or if any other condition is present, please give details of the condition, when first diagnosed and treatment being taken

Name and Address of Doctor:..

Complete Declaration on Reverse

MEMBERSHIP FORM

4 **I AM EMPLOYED BY**____________________ DATE COMMENCED__________
MY LAST EMPLOYER WAS ____________________ DATE LEFT__________
ARE YOU SELF EMPLOYED ? Y/N__________ ARE YOU UNEMPLOYED ? YES/NO __________

5 **I AM EMPLOYED AS** ____________________ (JOB TITLE)
NEC GRADING ____________________
OTHER (state nature of employment) ____________________

Cross out the inapplicable

6 **RETIRED PERSONS ONLY:** Date retirement commenced __________ *Membership No.*__________
Retired from (name of firm) ____________________

PERIOD OF MEMBERSHIP From: __________ To: __________

7 **DECLARATIONS**

Declared by member
I declare that the information given to be correct and that the dependant's name is/are wholly dependant upon me.I authorize my employer to deduct from my wages /salary all subscriptions due to the fund and any amount due, in full or in part as agreed by the council, by Stop Order in terms of Rules for the Fund and to pay such amounts to the council. I agree to be bound by the rules for the council.

Date:__________ Signature: __________

Employer's declaration applicable

I confirm the above to be employed by me in the capacity stated and acknowledge his/her authorization as above

Date commenced with Firm__________ Employer's Signature:__________

8 **DECLARATION BY EMPLOYER OF COMPULSORY, SPECIAL VOLUNTARY OR APPRENTICE MEMBER**

THIS IS an irrevocable undertaking that upon receipt of notification by the fund ,I will make such deductions from the Salary or Wage of__________ (name of applicant),add the employer's amount and the total sum in the amounts to the Fund in the manner required by the agreement and rules of the Fund.

PHYSICAL ADDRESS: ____________________

SIGNATURE:__________ **DESIGNATION**__________ **DATE** __________

TELEPHONE__________ **EMAIL ADDRESS:** __________ **WEBSITE:** __________

CELLPHONES ____________________

NOTE: All members forms to be sent to EMF, P.O. BOX 1922, HARARE

emf