Attach Photo

InvestMed
Health Fund

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MEMBERSHIP APPLICATION FORM

Instructions:

1. Please complete every section below in full and if not applicable, please write N/A.
2. Any incomplete or illegible information could delay your application for membership.
3. Membership is subject to the conditions, exclusions or limitations of benefits in accordance with the Act and Fund Rules.
4. The application form is to be completed and signed by the Principal Member on behalf of all the Dependants.
5. Applicants may not make use of medical services, to be paid for by the Fund, until such time as Written Confirmation of Membership has been received.

SECTION 1: Option Choice

Membership Type (Please tick √):

Individual	☐	Family	☐	Corporate	☐
SMEs	☐	Student	☐	Diaspora	☐

Plan Option (Please tick √):

SasaGuard	☐	SmartGuard	☐	ExcelGuard	☐
SupremeGuard	☐	StarGuard	☐	ConnectGuard	☐
VandiGuard	☐				

SECTION 2: Principal Member Details

Title

First Name

Surname

Identity Number | Date of Birth | Gender

Passport Number | Marital Status

Physical Address

Postal Address

Cellphone | Telephone-Home | Telephone-Work

Email

I wish to join the Fund as from

Section 2.1: Spouse/Partner Details

Title

First Name

Surname

Identity Number | Date of Birth | Gender

Passport Number | Marital Status

Physical Address

Postal Address

Cellphone | Telephone-Home | Telephone-Work

Email

Section 2.2: Dependant Details

First Name	Surname	Gender	Date of Birth	Identity Number	Relationship	Plan Option

Section 3: Employer Details

Name of Employer

Employee Number | Employment start date

Department | Position Held

Physical Address

Telephone

Email

NB: *For Members joining under Corporates and SMEs, the employer must sign and stamp this section.*

Signature of employer representative: _____ Date _____ _____ _____

Section 4: Previous Medical Aid Information

Please provide full details and attach certificate of previous medical aid, if applicable.

Name of member	Name of Scheme	Membership Number	Date Joined	Termination date

Section 5: Bank Details (Also to be used for refunds)

Please provide your full banking details below.

Bank Name

Branch Name | Branch Code

Account Number | Account Type

Name of Account Holder

Section 6: Medical Details Questionnaire

Please disclose all pre-existing conditions or illnesses, as failure to disclose could limit and/or exclude you or your dependants from receiving certain benefits or result in the termination of your membership.

Please complete the table below. All questions must be answered with a **YES** or **NO (Please tick √)**.

Have you or any of your dependants suffered from Chronic illnesses, such as Raised Cholesterol, Diabetes, Cardio and Vascular conditions, Obstructive lung diseases, High or Low blood pressure, Asthma, Depression, Anxiety, Systematic Lupus Erythematosus (SLE), Epilepsy and or Thyroid disorders etc?	YES / NO	Have you or any of your dependants suffered from any gastro-intestinal disorders, such as gastro-oesophageal reflux, Heart-burn, Liver failure, Gall bladder or pancreas disorders, Stomach or duodenal ulcer, Ulcerative colitis, Diverticulitis, Hiatus hernia, Crohn's disease, Irritable bowel syndrome, Rectal bleeding, Hepatitis and or Spastic colon etc?	YES / NO	Have you or any of your dependants suffered from Muscle, Bone, Dental, Orthodontic condition, Skin or nerve illness or disorders, such as back and neck related conditions, Arthritis, knee or hip problems, Motor Neuron diseases, Osteoporosis, Dermatitis, Acne, Eczema or Psoriasis, Multiple sclerosis, or joint problems or replacements, Prosthetic limbs, Gout, Stroke, Blackouts, Migraine, Alzheimer's etc?	YES / NO
Have you or any of your dependants suffered from Urinary tract or genital disorders, such as Urinary Tract Infections (UTI), Kidney stones, Kidney Failure, Prostatitis, Endometriosis, Ovarian cysts, Fibroids, Irregular menstrual cycle, Dysmenorrhea etc?	YES / NO	Have you or any of your dependants suffered from Ear, Nose, Throat, (ENT), Mouth (teeth or gums) or Eye disorders, such as Glaucoma, AMD, Defective vision, Cataracts, Blindness, Retinitis, Sinusitis, Visual disorders, deafness, Rhinitis, Ear discharge, Allergies, recurrent Tonsillitis, etc?	YES / NO	Have you or any of your dependants suffered from Blood disorders and or Cancer, such as Anaemia, Leukaemia, Lymphomas, Haemophilia etc?	YES / NO
Are you or any of your dependants pregnant, or planning a pregnancy within the next 12 months?	YES / NO	Have you or any of your dependants been hospitalised or had surgery in the past 12 months, or are you planning to have surgical procedure in the next 12 months?	YES / NO	Is there any other condition not stated above for which medical advice, diagonosis, care or treatment has been recommended or received, that could potentially lead to a medical claim?	YES / NO

If the answer to any of the above questions is **YES**, please provide the necessary full details in table below.

Name of Applicant	Condition and date of diagnosis	Name of Medication	Are you currently receiving treatment and or medication?	Date of last treatment	Name of doctor

Section 7: Method of Contrubution Payments

Method of Payment (Please tick √)

Cash ☐ Debit Order ☐

Bank Transfer ☐ Mobile Money Transfer ☐

Section 8: Declaration by the Principal Member

Acknowledgement:

As a member, I undertake to familiarise myself with the Investmed Health Fund Constitution, membership Rules and regulations. I also undertake to familiarise myself with the chosen benefit plan in order to fully appreciate the terms and conditions thereof. It is my responsibility as a member to constantly track changes in the Constitution, Rules and regulations, benefit plans as well as terms and conditions that my happen from time to time.

Declaration:

I, the undersigned, apply to be accepted as Investmed Health Fund member and I agree to follow the Fund rules. I declare that the information contained in this application form is correct in all material terms and that any false information will result in my membership being cancelled and any money paid to the Fund will be forfeited.

I agree that should this application be accepted, the contract between myself and the Fund shall be strictly governed by its Constitution, Fund Rules and Regulations, as amended from time to time. I have fully familiarised myself with the chosen benefit plan together with its terms and conditions. I undertake to make monthly contributions and authorise Investmed to make deduction from my monthly salary in respect of myself and my dependants.

Signature of Principal Member _____ **Date** _____ _____ _____

Document Checklist

	Please Tick
Have you completed all section on this application form?	
Have you chosen and ticked the Plan you wish to be registered on?	
Have you provided us with the correct personal details, that is (ID, phone number, email and address)	
Has your employer signed or stamped your application form?	
Have you signed the form? (Unsigned forms will not be processed and may be returned for your signature)	
Have you provided us with your banking details?	
Have you attached proof of Studentship for child dependants above 18?	
Have you attached proof of previous medical scheme? (certificate of membership with end date)	
Attach photos & relevant documentation for all beneficiaries. (Write full names of beneficiary at the back of the passport size photo)	

Name of Broker/ Agent/ Officer _____ **Reg/Code** _____

Signature _____