Corporate 24
MEDICAL AID
Covering You in More Ways Than One

REQUIREMENTS
1. 1 Passport size photo for all
2. Copy of ID for adult members & dependants
3. Copy of birth certificate for all children

MEMBERSHIP, PERSONAL DECLARATION AND STOP ORDER AUTHORISATION FORM

ACCOUNT HOLDER DETAILS

Full Names: Title | First Name (As per ID Card) | Maiden Name | Surname

Date of Birth: dd | mth | yy   Nationality

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er   Sex: ☐ Male ☐ Female

Residential Address
(Please give full details: street, area names etc)

Postal Address
(If different from above)

Telephone Numbers
Home: Area Code | Number   Business: Area Code | Number   Mobile No.

Email/s

ID Number   Religion

Hobbies/Activities/ Interests   Occupation

Nature of Business   Work Area

Payment Method
☐ Cash ☐ Bank Stop Order ☐ Eco-cash ☐ Bank Transfers ☐ Telecash ☐ Onewallet ☐ SSB

Preferred Mode of Communication: ☐ Email ☐ Post ☐ SMS

Name of Employer   Income $

Bank Name   Acc. Number

Account Name   Branch Name

Branch Code   Registration Date: dd | mth | yy   Stop order deduction Date: dd | mth | yy

DETAILS OF DEPENDANTS

Name	Surname	Date of Birth	Sex	ID Number	Relationship
1.					
2.					
3.					
4.					
5.					
6.					

Total Premiums: $

PLAN AND FUNERAL OPTION (Please tick plan of choice)

*N.B Those above 50 years should apply for the Four Star & provide medical history

PLAN

☐ Two Star ☐ Three Star ☐ Four Star

NEXT OF KIN DETAILS

Name ______ ID Number ______

Address ______ Occupation ______

Cell ______ Email/s ______

Employment Details ______

Relationship to Member ______

MEDICAL HISTORY

Are you/your spouse/any of your dependants suffering from any of the following? (tick the applicable)

☐ Asthma ☐ Renal Disease ☐ Psychiatric Conditions ☐ Diabetes ☐ Leprosy ☐ HIV/Aids

☐ Hypertension ☐ Cardio-vascular ☐ Epilepsy ☐ Cancer ☐ Paying for Chronic Add-on

Other Specify ______

If any of the above applies, please give details of the condition, when it was diagnosed and current treatment being taken.

Indicate the member(s) on chronic (Names & Condition).

DECLARATION AND ACCEPTANCE

I hereby certify that the information given above is true in all aspects. I agree that the contract between myself and the Scheme shall be governed by the rules, regulations and benefits as amended from time to time by the Scheme. I accept that I have familiarised myself with the Corporate 24 Medical Aid Membership Guide and Benefit Schedule and I am aware of the benefits of my chosen package as well as the terms and conditions that I should abide by during the course of my membership. Every member shall upon joining the Scheme be deemed aware and in agreement of the rules and regulations that govern the relationship between Corporate 24 and its members.

I accept liability for any amount due from any benefit limit exceeded, abused or otherwise by myself and my dependents. I hereby authorise Corporate 24 Medical Aid to access my medical records from any service provider for any reason whatsoever related to the scope of our relationship.

Date dd | mth | yy Member's Signature ______

Date dd | mth | yy HR Head or Payroll Administrator ______

FOR OFFICE USE ONLY

Agent Name ______ Organisation ______

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13 Bath Road Belgravia Harare, Zimbabwe
Tel/Fax: +263 4 701 120 - 1, 701 113
info@corp24med.com
www.corp24med.com