BULAWAYO HEAD OFFICE
MASCA House, 2 Eleventh Avenue
P. O. Box 1776, Bulawayo
Tel: +263-9-63274, 880829-33. Fax: +263-9-63277
E-Mail: marketing@masca.co.zw
Website: www.masca.co.zw

masca

Medical Aid Society of Central Africa
Future Healthcare

HARARE OFFICE
MASCA House 119 Kwame Nkrumah Ave
P. O. Box A842, Avondale, Harare
Tel: +263-4-251741/3, 707904,
706920, 250945. Fax: +263-4-732663
E-Mail: marketing@hre.masca.co.zw
Website: www.masca.co.zw

APPLICATION FORM

(PLEASE COMPLETE ALL RELEVANT SECTIONS)

This form should be submitted with the monthly return for companies already registered with us.

NB: Persons over 60 years of age, not acceptable.

A) PERSONAL DETAILS (PLEASE PRINT) MEMBERSHIP START DATE

COMPANY NAME:

PRINCIPAL MEMBER: (EMPLOYEE) FIRST NAME(S): SURNAME: AGE:

POSTAL ADDRESS: TELEPHONE (W): (H):

HOME ADDRESS: EMAIL:

DATE OF BIRTH: SEX: M ☐ F ☐ MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

I. D. NUMBER: WEIGHT (KG): HEIGHT (CM):

HOME LANGUAGE: OCCUPATION: INDUSTRY (e.g; MINING)

ARE YOU COVERED BY ANY OTHER INSURANCE POLICIES:

PERSONAL ACCIDENT YES ☐ NO ☐ COMPANY'S NAME:.....
ROAD ACCIDENT:- YES ☐ NO ☐ COMPANY'S NAME:.....
i) FULL THIRD PARTY YES ☐ NO ☐ COMPANY'S NAME:.....
ii) FULLY COMPREHENSIVE YES ☐ NO ☐ COMPANY'S NAME:.....

NEXT OF KIN - NAME IN FULL: TELEPHONE (W): (H):

ADDRESS: EMAIL:

B. ELECTRONIC DATA: (F.C.A.) FOREIGN CURRENCY ACCOUNT (US$)

BANK: ACCOUNT NUMBER:

ACCOUNT NAME: SWIFT CODE: BRANCH CODE:

PREVIOUS MASCA MEMBERSHIP NUMBER (if any)..... NB; Have you been a member of any Medical Aid in the past?

YES ☐ NO ☐ (tick applicable) NAME..... NUMBER.....

Scheme applied for **CLASSIC SCHEME**: *(Written application only)

SUPERMASCA ☐ HOSPITAL & CLINIC ☐ HOSPITAL PLAN ONLY ☐ PRINCIPAL CHRONIC ☐
PRINCIPAL ☐ PRINCIPAL FAMILY ☐ STANDARD ☐ SELECT ☐

health INTERNATIONAL GROUP LIMITED
EXTERNAL COVER

SUPREMA/F ☐ PRIMA/F ☐

If you tick one of these boxes you will require a separate application form for HEALTH INTERNATIONAL (HI)

C. PLEASE ENTER BELOW DETAILS OF THE APPLICANT (PRINCIPAL MEMBER) AND ALL DEPENDANTS TO BE INCLUDED IN THIS APPLICATION FOR MEMBERSHIP

SURNAME	FIRST NAMES	DATE OF BIRTH	SEX	I. D. NUMBER	WEIGHT/ HEIGHT	DOCTOR'S NAME	RELATIONSHIP TO PRINCIPAL MEMBER
					/		
					/		
					/		
					/		
					/		
					/		
					/		
					/		
					/		