masca

Reliable. Efficient. Dependable

APPLICATION FOR MEMBERSHIP

(COMPLETE ALL SECTIONS)

PLEASE SEE PRE-BENEFIT WAITING PERIOD SCHEDULE

NB:Applications from persons over 60 years of age will not be accepted.

A. PERSONAL DETAILS (PLEASE PRINT)

MEMBERSHIP START DATE DAY MONTH YEAR

COMPANY NAME:

PRINCIPAL MEMBER(EMPLOYEE):

FIRST NAME(S): SURNAME: AGE:

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

HOME ADDRESS: EMAIL:

DATE OF BIRTH: DAY MONTH YEAR 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$)

Without your banking details, your claims will not be paid.

BANK: BRANCH NAME: 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?

NAME OF MED AID NUMBER

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

SUPER MASCA ☐ PRINCIPAL CHRONIC ☐ PRINCIPAL FAMILY ☐ PRINCIPAL ☐

STANDARD ☐ SELECT ☐ HOSPITAL AND CLINIC ☐ ESSENTIAL CORE ☐

health INTERNATIONAL GROUP LIMITED

EXTERNAL COVER

COMBO SUPREMA PACKAGE ☐ COMBO PRIMA PACKAGE ☐ DWALA ☐

If you tick one of these boxes you will require a separate application form for HEALTH INTERNATIONAL (HI) & G.P. NETWORK

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
					/		
					/		
					/		
					/		
					/		
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					/		
					/		

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MEDICAL HISTORY (To be completed for all applicants)

(Pre-existing conditions may be excluded from foreign travel emergency assistance)
Please read carefully and complete all the required information by placing a tick in the correct box. If the answer to any of the questions is "YES", please provide details in the space provided below in respect of the member or dependants applicable. Failure to disclose material information or the provision of incorrect information can result in immediate cancellation of your membership and benefits.

Have you, your spouse or any of your dependents experienced or are presently experiencing any of the following?	**Please Specify** YES	NO
1. Heart (Cardiac) Diseases: Heart attack, Rheumatic fever, Congenital heart abnormalities, Angina, Embolism, High Blood Pressure.	☐	☐
2. Circulatory Disorders: Varicose veins/Thrombosis, Blood disorders (eg. anaemia, leukemia).	☐	☐
3. Diseases of the Liver: Jaundice, Gall bladder diseases, Liver cirrhosis.	☐	☐
4. Diseases of the Airway/Lungs: Asthma, Chronic bronchitis, Tuberculosis, Emphysema, Cystic Fibrosis, Interstitial Fibrosis of any cause.	☐	☐
5. Diseases of the Digestive System: Gastric/Duodenal ulcers, Hiatus hernia, severe recurring diarrhoea.	☐	☐
6. Diseases of the Bladder/Kidney: Kidney stone, Congenital kidney disorder, Nephritis, bladder infections.	☐	☐
7. Neurological Disorders: Migraine, Stroke, Epilepsy.	☐	☐
8. Diseases of the Bone, Joints & Muscles: Rheumatic Arthritis, Gout, Back, Neck, Joint problems.	☐	☐
9. Endocrine Disorders: Diabetes mellitus, Thyroid disease (e.g; goitre).	☐	☐
10. Mental Health Disorders: Psychotic disorders (e.g; schizophrenia), Mood disorders, Anxiety disorders (e.g; Panic disorders).	☐	☐
11. Are you currently taking medication for any permanent or recurring condition? If so, please detail name, dosage & frequency?	☐	☐
12. Is there any illness or factor not mentioned on this questionnaire that might affect your health in the next 12 months	☐	☐
13. Have you ever undergone surgery?	☐	☐
14. Are you pregnant? If so what is the expected date of delivery?	☐	☐
15. Any condition not mentioned above?	☐	☐

16. **IF YOU HAVE TICKED YES FOR ANY OF THE ABOVE, PLEASE COMPLETE THE SECTION BELOW. PLEASE NOTE ALL IMPORTANT INFORMATION MUST BE DISCLOSED. THE FOLLOWING SECTION IS FOR DETAILS OF 1-15 ABOVE.**

QUEST No	NAME	DATE	PLEASE SUPPLY FULL DETAILS OF DISORDER, DATE, DURATION OF TREATMENT AND MEDICATION (IF ANY)

If there is insufficient space above, please attach a separate sheet with additional information.

NB: IF YOU OR YOUR FAMILY SUFFER FROM ANY CHRONIC ILLNESSES, (ie, DIABETES, ASTHMA, ETC) PLEASE COMPLETE THE CHRONIC REGISTRATION FORM IN ORDER TO RECEIVE SPECIAL CHRONIC DRUGS, SECTION 15 ABOVE MUST ALSO BE COMPLETED

DECLARATION BY PRINCIPAL MEMBER - ON BEHALF OF HIMSELF AND ALL HIS DEPENDENTS

I declare that any false information in this application form, or the non disclosure of any material information will render the membership entirely null and void.

1. As the Principal Member, I confirm that the information provided in this application form, concerning both myself and my dependents, is accurate and complete.
2. I understand that any condition, including related emergencies, for which I or my dependents have received medical advice or treatment prior to the date of joining, is excluded from benefits under the scheme until the applicable waiting periods have been fully served.
3. I understand that I or any of my dependants may be required to obtain a medical report or undergo a medical examination to provide further information on any of the conditions declared above.
4. I authorise MASCA to have unrestricted access to my medical records but require their confidentiality to be maintained.
5. I have completed the medical history for myself and all my dependants declared in this application.
6. I understand that MASCA reserves the right to withhold benefits for conditions or emergencies that arise as a direct result of reckless, negligent, or intentionally endangering behavior or habits. This includes, but is not limited to, actions such as jumping from a moving vehicle, excessive smoking, and the abuse of alcohol or other substances.
7. I acknowledge that it is my responsibility to familiarize myself and my dependents with all relevant rules, procedures, and requirements of the Society, and to seek clarification where necessary.
8. I understand that MASCA reserves the right to amend its terms at any time and will provide members with reasonable notice of such changes.

PRINCIPAL MEMBER'S SIGNATURE

DATE

LIAISON OFFICER SIGNATURE AUTHORIZING COVER

DATE OF COMMENCEMENT