

ATTACH PASSPORT SIZE
PHOTO

Write name, surname,
date of birth and ID
number at the back of
each photo.



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MEMBERSHIP APPLICATION FORM (PLEASE COMPLETE IN CAPITAL LETTERS)

FOR ADMINISTRATIVE USE ONLY

MEMBERSHIP NO							
ACCOUNT HOLDER NO							
COMPANY NAME							

FIELD 1. CHOICE OF PLAN (Please tick)

Lemon		Banana		Pear		Nuts		Pawpaw		Students	
Apple		Avocado		Mango		Lentil		Grapes		General	

FIELD 2. INTERMEDIARY – This section MUST be completed by Broker/Agent where possible.

Agent/ Broker Code			
Name of Agent/Broker			
Address			
Cell		Phone	
E-mail			
Signature		Date	

FIELD 3. DETAILS OF PRINCIPAL MEMBER

TITLE (Tick)	MR		MRS		MS		DR	
FIRST NAME				SECOND NAME				
SURNAME								
MARITAL STATUS (Tick)	SINGLE		MARRIED		DIVORCED		SEPARATED	
RACE	AFRICAN		ASIAN			EUROPEAN		
ID NUMBER				GENDER	M		F	
TELEPHONE				CELL				
EMAIL ADDRESS								
PHYISCAL ADDRESS								
POSTAL ADDRESS								
I WISH TO JOIN THE SOCIETY/FUND FROM...	DAY			MONTH			YEAR	

FIELD 4. DEPENDANTS YOU WISH TO REGISTER

Adult rates apply to any dependant who is 18 years or older. Child rates apply from newly born babies to full-time students aged between 18-24 years provided that proof of education for the current year is attached to the application form. Please attach copies of ID or the Birth certificate for all beneficiaries. Acceptance of the dependants will be in accordance with the rules of the fund.

SURNAME	FIRST NAME AND INITIALS	DATE OF BIRTH	RELATIONSHIP	GENDER (Tick)		ID NUMBER
				M	F	

FIELD 5. DECLARATION OF MEDICAL HISTORY

Do you or any of your dependants suffer from any of the following medical conditions? If YES tick the appropriate box and provide details below.

CONDITION	YES	NO	CONDITION	YES	NO
Hypertension			Diabetes		
Cancer			Bone problems		
Heart problems			Arthritis		
Asthma			Orthodontics		
Renal/kidney diseases			Abdominal problems		
Other (Specify)					

Name of Beneficiary	Name of condition	Name of medication	Are you currently receiving medication (Tick)		Date diagnosed	Name of doctor
			YES	NO		

Are you or any of your dependents pregnant? If YES provide the details.

Name of Dependant	Expected Delivery Date	Attending Doctor

FIELD 6. PREVIOUS MEDICAL INSURANCE INFORMATION (Please attach certificate of membership with the termination date)

Name of Medical Aid	Plan/ package	Membership Number	Date of Registration	Date of Termination

Are you changing your medical aid due to a change of employer? If yes, provide a letter from previous employer confirming termination of employment and date.

FIELD 7. EMPLOYER ACCOUNT HOLDER INFORMATION.

This section **MUST** be completed and signed for by Employer/Account Holder. No application form will be processed without the Employer/ Account Holder's Authorisation or Stamp.

Name of Employer/ Account Holder		COMPANY STAMP
Employer Account Holder		
Employee/ E.C. Number		
Medical Aid start date		
Employment Date		
Employer Telephone Number		
Signature of Employer		

FIELD 8. BANKNG DETAILS FOR REFUNDS

BANK NAME	
BRANCH NAME	
BRANCH CODE	
NAME OF ACCOUNT HOLDER	
BANK ACCOUNT NUMBER	

TERMS AND CONDITIONS OF MEMBERSHIP

This form should be completed by the first time applicants to the WMAS or if you are a dependant and now wish to be a member in your own right. If you are a member of WMAS and wish to add or remove a dependant or change from one plan to another, complete Membership Update Form.

Please complete all sections of the form of the application form as this forms the basis of your registration.

FIELD 1 Choice of Plan

The WMAS offers a variety of plans . Please tick the appropriate box for the plan you wish to join.Your employer should approve the Plan of your choice if joining through a company.

FIELD 2 Intermediary

This section should be completed by the Agent / Broker.

FIELD 3 Details of Principal Member

The personal details of the principal member should be entered here. Settlement advice slips and cheque refunds will be made out to this person . Please enter the personal details as they appear on your ID card as you may be asked to produce this along with your membership card when you see providers of health services.

FIELD 4 Dependants

May include your spouse,children, or in certain circumstances, other dependants the member wishes to benefit from WMAS. WMAS may request a medical report before accepting other family members as dependants. Relationships to member describes the relationship of the dependant to the the principal member. Spouse and child are normal dependants and anyone else e.g. parents, in-laws etc are considered to be an "other dependant". A child aged between 18 and 24 years may be classified as a student provided they are studying full-time and proof of education for the current year is attached to the registration form. Otherwise such a child will be classified as an "other dependant."

FIELD 5 Declaration of Medical History

You need to inform WMAS ,if you, or any of your dependants you are registering, is currently udergoing, or likely to require medical treatment. It is very important that you disclose all information as failure to do so will be a breach of contract leading to failure to have claims settled.

Section 6 Previous Medical Insurance

Please provide a membership certificate with termination date if you are moving from another medical aid fund. If you are changing employer. Please provide a letter confirming your termination of your employment and date.

Section 7 Employer/Account Holder Information

This section should be completed by the person who will be responsible for remitting your contributions to WMAS either the individual account or employer designated officer. Employer needs to stamp the form and sign as authorisation for the applicant to be on the WMAS. The account holder number is the number which appears on the billing invoice. If you are applying for membership without Employer affiliation you should submit a completed Employer/Individual Account Holder application. The Employer account number is automatically generated by WMAS, please remember to quote the number each time you remit your contributions.

Start date is the effective date from which the membership wants to be registered and benefit. Membership runs from the first day of the month to the last day of the month. Applications must be received before the 25th day of the month for registration to be effective for the following month.

Section 8 Banking Details of the Principal Member

Please provide WMAS with your banking details to enable the payment of claims refunds, savings pot or cash back through Electronic Funds Transfer (EFT).

Contributions Payments:

Please note that contributions are paid a month in advance. If contributions are not received for a period of ninety (90) days, the membership will be terminated.

DECLARATION

I declare that the information contained in this form is materially true in all respects. I agree that should my application for membership be accepted, I will abide by the Rules, Benefits and Regulations set by the WMAS from time to time. I certify that none of my dependants suffer from any condition/s not declared. I authorise the deduction from my salary of the monthly contributions due in respect of my dependants and myself. Signing this application form, forms the basis of a contract between myself and WMAS.

Signature of Principal Member: _____ Date: _____/_____/20____

YOUR CHECKLIST

IMPORTANT: WE WILL NOT PROCESS YOUR APPLICATION FORM IF IT IS not signed/stamped by employer/Account Holder, Incomplete, Incorrect or if you have not attached the correct documents. **PLEASE USE THIS CHECKLIST TO MAKE SURE YOU HAVE COMPLETED YOUR APPLICATION IN FULL:**

	Have you completed all fields on the application form?
	Have you provided us with correct contact details, telephone and e-mail?
	Have you provided us with your banking details?
	Have you ticked the Plan you wish to be registered on ?
	Have you attached your previous membership certificate with the termination date?
	Have you signed the form? (Unsigned forms will not be processed and returned to you for signature)
	Has Your/Account Holder signed or stamped your application form?