Membership Application Form

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East Block, Borrowdale Office Park
P.O. Box 1243, Harare, Zimbabwe

Personal Details

New member application
Complete All Sections ☐

Change of personal details
Complete Section 1,2,3,4,5,6 ☐

Change of banking details
Complete Section 1,2,3,5,6 ☐

Dependent termination
Complete Section 1,2,3,4,5 ☐

Change of Package
Complete Section 1,2,3,4,5,8 ☐

Change of marital status
Complete Section1,2,3 ☐

Dependent registration
Complete Section 1,2,3,4,5,8 ☐

Change of Employer
Complete Section 1,2,3,4,5,8 ☐

Passport size photo

Section 1: Package Selection | Please Indicate The Package you wish to join

Health Save ☐ | Secure Primary ☐ | Secure Essential ☐ | Secure Private ☐

Secure Premium ☐ | Secure Prime ☐ | Other (Specify)

Section 2: Employer Information | This section must be completed by the employer or account holder

Name of Employer/Account Holder

Employer/Account Number

Payroll/Employee Number

Registration Start Date

No of Dependants	Adult	Child	Other	Total
Plan Contributions				

Company Stamp

We confirm that the applicant is employed by us and contributions are being deducted according to the Society Rules and plan chosen. All sections of the application form have been completed.

Name of Salary Administrator

Signature of Salary Administrator

Date Signed

Section 3: Details Of Principal Member | This section is mandatory

Title

Surname

First Name

Date of Birth

Ethnic Group

I.D Number

Membership N.o

Telephone (H)

Cell Number

Telephone (W)

Email

Physical Address

Postal Address

GP Nomination

Name

Contact Details

Section 4: Registration Or Addition Of Dependents Spouse/Child/New-born/Adult dependent

Adult rates apply to any dependent who is 18 years and older. Child rates apply to full time students aged between 18-25 years provided proof is attached to the application form for the current academic studies. Acceptance of the dependants will be in accordance with the rules of the Society.

First Name	Surname	Date Of Birth							Relationship	Gender		I.D Number	Contact Number
		D	D	M	M	Y	Y	Y		M	F		
										M	F		
										M	F		
										M	F		
										M	F		
										M	F		

Section 5: Banking Details

Use This Account For Claims Refunds ☐

Name of Bank

1 Bank Account Number (RTGS)

or

2 Bank Account Number (FCA)

Branch

Source of funds

Branch Code

Branch Code

Mobile Banking Details

Section 6: Account for Contribution Rates Payments

Use This Account For Claims Refunds ☐

*Complete this section if details are different from the details provided in Section 5

Name of Bank

Bank Account Number (RTGS)

Bank Account Number (FCA)

Branch

Employer

Branch Code

Mobile Banking Details

I hereby instruct Cimas Medical Aid Society to deposit claim refunds using the information provided above and authorize the Society to reverse any erroneous transactions and/or rectify any electronic fund transfer errors without prior notice.

Section 7: Amendment Of Dependants | Change of details or Termination of Dependants

Please attach certified copies of Marriage Certificate/ ID for change of surname or DOB. Attach a copy of death certificate if termination is due to death.

Full Name	Date Of Birth								Amend	Remove	Deletion Date							
	D	D	M	M	Y	Y	Y	Y			D	D	M	M	Y	Y	Y	Y

Reason for Amendment/Termination

Section 8: Details Of Previous Medical Aid | Please attach certificate of last medical aid if any.

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on the member or dependent on application for membership of any other medical aid scheme.

Name of Medical Aid Insurance	Scheme/Package	Membership Number	Date Joined								Date Left							
			D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y

Medical History

Please note: It is compulsory to answer each question. Failure to disclose medical conditions could limit and/or exclude you or your dependents from receiving certain benefits or result in termination of your membership.

1 Any Chronic illnesses. Cardio and Vascular conditions, Obstructive lung diseases, Diabetes, High or Low blood pressure, Raised Cholesterol Asthma, Depression, Anxiety, Systematic lupus erythematosus, Epilepsy, Thyroid disorders? If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Treatment	Name Of Medication	Attending GP/Specialist

2 Digestive system or Stomach disorders? Liver failure, Gall bladder or pancreas, Stomach or duodenal ulcer, Hiatus hernia, Crohn's disease, Irritable bowel syndrome, Rectal bleeding, Hepatitis. If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Treatment	Name Of Medication	Attending GP/Specialist

3 Muscle, Bone, Dental, Orthodontic condition, Skin or nerve illness or disorders. Acne, Eczema or psoriasis, Multiple sclerosis, Back injury/neck or joint problems or replacements, Arthritis, Prosthetic limbs, Gout, Stroke, Blackouts, Migraine, Alzheimer's etc. If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Treatment	Name Of Medication	Attending GP/Specialist

4 Urinary tract, genital /Gynaecological disorders? e.g. UTI, Kidney stones, Kidney Failure, Prostatitis, Ovarian cysts, Fibroids, etc., If yes please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Treatment	Name Of Medication	Attending GP/Specialist

5 Any Chronic illnesses. Cardio and Vascular conditions, Obstructive lung diseases, Diabetes, High or Low blood pressure, Raised Cholesterol Asthma, Depression, Anxiety, Systematic lupus erythematosus, Epilepsy, Thyroid disorders? If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Treatment	Name Of Medication	Attending GP/Specialist

6 Ear, Nose, Throat or Eye disorders? Defective vision, Cataracts, Glaucoma, Blindness, Retinitis, wear spectacles or contact lenses, Hearing loss, Ear discharge, Allergies, recurrent Tonsillitis, etc. If yes, please provide details. Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Treatment	Name Of Medication	Attending GP/Specialist

7 Are you or any of your dependants pregnant? If yes, please provide details Y N

Name Of Beneficiary	Expected Date Of Delivery	Attending Doctor

8 Have you or any of your dependants had surgery in the past 12 months, or are you planning to have surgical procedure in the next 12 months? Or any other condition not stated above? If yes, please provide details Y N

Name Of Beneficiary	Name Of Condition And Date Diagnosed	Are You Currently Receiving Treatments?	Date Of Last Treatment	Name Of Medication	Attending GP/Specialist

TERMS & CONDITIONS

This form should be completed by applicants (i) joining Cimas Medical Aid Society for the first time, (ii) adding or terminating dependants, (iii) changing personal details, marital status, banking details, migrating or switching to new packages. Please note, all sections are mandatory for new applicants.

Section 1: Package Selection
Cimas offers a variety of packages. Please tick the appropriate package you wish to join. This should be approved by employer if joining through an employer.

Section 2: Employer /Account Holder Information
This section should be completed by the person who will be responsible for paying contributions either the account holder or your employer. Designated officer or person responsible for remitting contributions to Cimas Medical Aid. Employer or member firms need to check filled-in details, sign and stamp to authorise the form for applicant to be registered on Cimas.

Section 3: Details Of Principal Members
The details of the Principal member must be entered here. Settlement Advice statements and refunds will be made out to the principal member only. Please enter these details as they appear on your identity document. Please note, you may be asked to produce this together with membership card when accessing treatment by providers of health services. Ethnic group is required for statistical purposes only. State e.g. African, Asian, European, etc.

Section 4: Registration Of Dependants
You can add people who rely on you for financial support to your medical aid, especially a family member (i.e. spouse, children, in certain circumstances Other/Adult dependants. The Society may request a medical report before accepting other family members as dependants. Relationship to members describes the relationship of the dependent to the principal member, Spouse or child are normal dependants. Other/Adult Dependent" refers to anyone who is not a direct dependent e.g. mother, father etc. Adult rates apply to any dependent who is 18 years and older. Child rates apply to full time students aged between 18-25 years provided proof is attached to the application form.

Section 5: Member Banking Details
The Society has an Electronic Funds Transfer facility that allows members claims refunds to be paid directly into their bank account or mobile bank account. Refunds will be made out only to the principal member.

Section 6: Account for Contribution Rates Payments
This section must be completed entering the correct details for the bank account responsible for the principal members contribution rates.

Section 7: Amendment Of Dependants
This section must be completed when terminating dependants from Cimas or when changing details of dependent such as names e.g. due to marriage, certified copies of ID, marriage certificate etc. should be attached.

Section 8: Details Of Previous Medical Aid
If you have been a member of another medical aid society or was on another health insurance cover, please provide details

Section 9: Medical History
You need to inform the Society, if you or any of the family members you are registering are currently undergoing or likely to require medical treatment. It is very important that you disclose all information here as failure to do so may result in your membership being terminated. Nomination of a Family Practitioner is important so that we can register their details for Managed Care purposes.

Compliance with Anti-Money Laundering laws and polices
Cimas is subject to and complies with applicable regulations relating to Anti-money laundering in Zimbabwe. These include client due diligence obligations and has implemented procedures and internal control mechanisms in order to ensure compliance with such laws and regulations. By signing this form, you agree to comply with these laws and policies and that, you agree not to involve the organisation in any money laundering activities of any nature.

Acknowledgement
I undertake to familiarize myself with the Cimas Constitution, Cimas Membership Rules and regulations. I will ensure that I am familiar with the benefits of my chosen package and fully understand the terms and conditions of enjoying or accessing those benefits BEFORE signing this form. As the Cimas constitution, Cimas Membership Rules and regulations, package benefits and the terms and conditions of accessing these packages change from time to time, it is my responsibility as a member to constantly track and understand these changes throughout my membership period. Every member on joining the Society is deemed to be aware and in agreement with the Cimas Constitution, Cimas Membership Rules and regulations, package benefits and attending terms and conditions of accessing the same.

Declaration and Signature
I hereby certify that the information given above is correct in all aspects. I agree that should this application be accepted, the contract between myself and the Society shall be strictly governed by the Cimas Constitution and the Cimas Membership Rules, and Regulations, as amended from time to time by the Society. I have familiarized myself with all these documents and make this application in light thereof. I also confirm that I have fully familiarized myself with the benefits that I am entitled to in my chosen package together with the terms and conditions of accessing the same. I authorize monthly deduction of subscriptions from my salary due in respect of myself and my dependants. I also authorize Cimas to access my medical records from any health service provider for any reason whatsoever. I further declare that these dependants do not suffer from any conditions not declared. NB: Please read the notes on section 8 and acknowledgement above before signing this form.

Signature of Principal Member

Date Signed

To avoid delays in processing your application, please provide the following documents where applicable and use the check list to make sure you have completed your application form in full.	Please Tick
Have you completed all fields on the application form?	Y
Has your employer signed or stamped your application form?	Y
Have you provided us with your banking details?	Y
Have you ticked the Plan you wish to be registered on?	Y
Have you signed the form? (Unsigned forms will not be processed and may be returned for your signature)	Y
Have you attach copy of marriage certificate/Affidavit for change of Surname?	Y
Have you attached proof of Studentship for child dependants above 18?	Y
Have you attached proof of previous medical insurance? (Certificate of membership with end date)	Y
Attach photos for all beneficiaries. (Write full names of beneficiary at the back of the passport size photo)	Y

For Office Use:

1) Documents provided:

Certified copy of National ID

Certified copy of Passport

Certified copy of Birth Certificate (for minors)

Cimas Representative's Name

Signature

Date Signed