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 65 years should apply for the Four Star & provide medical history

PLAN

☐ One Star ☐ Two Star ☐ Three Star ☐ Four Star ☐ Five Star ☐ Star College

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).

NAME AND ADDRESS OF GENERAL PRACTITIONER / SPECIALIST IF NOT INCLUDED ON OUR NETWORK

DECLARATION AND ACCEPTANCE

I hereby certify and the information given is correct and 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 liability for any amount due from any benefit limit abused, exceeded or otherwise by myself and my dependants.

I hereby authorize 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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