Head Office
MASM House, Lower Sclatter Road
P.O. Box 1254 Blantyre Malawi.
Telephone: +265 (0) 0211 820 543 | +265 (0)0211 820 370 |
+265 (0) 0211 820 208 | +265 (0) 0211 820 064
Fax: +265 (0) 1 820 217

Lilongwe Branch
MASM Complex, Plot Number 11/59 Area 11 Behind Capital Hotel
P.O. Box 30381 Lilongwe 3
Telephone: +265 (0) 0211 776 427 | +265 (0) 0212 770 678

Mzuzu Branch
Grace Building, P.O. Box 973 Mzuzu
Telephone: +265 (0) 0211 311797

MASM Call Center: 4277

Email: infodesk@masm.mw

AMENDMENT FORM

For Existing Members Only

All fields marked with asterisks (*) are required fields and should be completed. Failure to complete these fields will lead to the Amendment Form not being processed.

Block A / Gawo A Premium Payer / Account Holder

Block A to be completed by the account holder only

Premium Payer Name: _____ **Premium Payer Number** _____

Block B / Gawo B Principle Member Details

Title: Mr ◯ Mrs ◯ Ms ◯ Dr ◯ Prof ◯ Other ◯ _____ **Gender :** M ◯ F ◯

First Name: Dzina Loyamba _____ **Middle Name** Dzina Lochiwiri _____ **Surname** Dzina La Makolo _____

Identity Type: National ID ◯ Passport ◯ Drivers's License ◯ Birth Certificate ◯ For minors **ID NO** _____

Date of Birth D D M M Y Y Y Y _____ **MASM ID Number** _____

Cell Number*: _____ **Telephone Number** _____

Physical Residential Address*: Komwe Mukukhala District | Township | Village

Postal Address*: _____

Email Address*: _____

Block C / Gawo C Change of Product (Scheme)

Please indicate the scheme you wish to change to / Sankhani sikimu yomwe mukufuna

Econoplan ◯ **Executive** ◯ **VIP** ◯ **Other** _____

BLOCK D / GAWO D Electronic Funds Transfer

Please provide banking details to which refunds can be made / Perekani akaunti yanu komwe tingatumize ndalama zokubwezerani

Name of Bank / Dzina la Banki _____

Account Number / Nambala ya akaunti _____

Account Type / Mtundu wa akaunti **Current** ◯ **Savings** ◯ **Other** ◯

Branch / Nthambi _____

BLOCK E / GAWO E Dependants

Please provide the right ID as follows: for adults National ID(NI), for minors Birth Certificate(BC)and for foreigners Passport (PP)

	First Name Dzina Loyamba	Middle Name Dzina Lachiwili	Surname Dzina Lamakolo	Date of Birth Tsiku Lobadwa DDMMYYYY	Gender M	 F	Add	Delete	Upgrade/ Downgrade	Product Sikimu	ID Number	ID Type (NI, BC, PP)
1												
2												
3												
4												
5												
6												

BLOCK F / GAWO F Confidential Medical History (for dependants only)

Please circle the actual disease" / "Zingulizani matenda amene mumadwala"
You are encouraged to fill this section with assistance of a Medical Practitioner

		Dependant One	Dependant Two	Dependant Three	Dependant Four	Dependant Five	Dependant Six
1	**Medication** Are you, your spouse and dependant or any other, currently taking any Chronic medication? Please detail the name, dosage and frequency in the medication section G page 3	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
2	**Cardiovascular** Chest pain/angina, heart attack, heart failure, heart valve disease, high blood pressure, high cholesterol deep vein thrombosis (DVT), or any other heart or circulatory problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
3	**Respiratory & Breathing** Difficulty with breathing, tuberculosis (TB), emphysema, chronic bronchitis, asthma, or any other breathing problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Have you ever been hospitalized for asthma?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
4	**Bladder & Kidneys** Kidney failure, polycystic kidneys, removal of kidney (nephrectomy), kidney stones, abnormal kidneys, any other kidney problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
5	**Reproductive & Gynaecological** Endometriosis, infertility, ovarian cysts, fibroids, hysterectomy, abnormal PAP smear, Fibroadenosis of the breast, hormone replacement therapy, prostate infections or surgery, prostate enlargement or any other reproductive problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6	**Digestive System or any other digestive problems** Ulcers, pancreatitis, hiatus hernia, colon problems, Crohn's disease, ulcerative colitis, gall bladder diseases, liver problems, colonoscopy, or endoscopy.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

7	**Ear, Nose & Throat** Deafness, nasal surgery, throat surgery.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
8	**Dental** Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, or other surgery or any other such surgery or problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
9	**Eyes** Blindness (partial or full), eye surgery, cataracts, glaucoma, retinitis pigmentosa or any other problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
10	**Endocrine** Diabetes, thyroid surgery or another glandular problem.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
11	**Joint Disease** Rheumatoid arthritis, osteo-arthritis or any other joint disease.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
12	**Musculoskeletal Disorders** Neck, back, knee or shoulder problems or operations, recurrent back pain, osteoporosis, spondylitis or any other bone, skeletal or muscle disorders.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
13	**Neurological** Epilepsy, stroke (CVA), brain or head injuries, spinal code injuries, paralysis, mental retardation, Parkinson's disease, Alzheimer's disease or any other neurological disease.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
14	**Psychological** Psychosis, suicide attempts, bipolar disorders, schizophrenia, counselling or hospitalization for alcohol or drug abuse or any other psychological conditions.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
15	**Tumours and Growths** Lymph gland cancer, leukaemia, breast cancer or any other tumours, growths and cancers.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
16	**Blood** Blood or bleeding disorders, platelet or any other blood clotting disorders, or have you ever had blood transfusion.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
17	**Skin** Eczema, psoriasis, skin cancer or any other skin disorders.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
18	**Hereditary Disorders / Family History** Are you aware of any family history of Cancer, High cholesterol, Heart attacks or any other hereditary conditions or predispositions.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
19	**Other** Are there any other diseases/conditions related to you or your spouse or any other dependant's health that are not disclosed or listed above?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

BLOCK G / GAWO G Current Medication Details

If you answered YES to any Question in the Confidential Medical History Section F you are required to give us more information for each instance in the table below. If the space is insufficient, please attach a separate sheet with complete information. Please attach relevant medical reports. **Full disclosure is necessary to prevent future invalidation of memberships.**

Question #	Name of Applicant/Dependant	Condition being Treated	Dosage, Name & frequency of prescribed medication	Date treatment commenced

BLOCK H / GAWO H Payment of Subscriptions

CANCELLATION/TERMINATION OF MEMBERSHIP

An insured person's cover under this policy will automatically terminate if there is non-payment of monthly contributions for 90 (ninety) consecutive days (three months).

SUSPENSION OF MEMBERSHIP

Subscriptions become due in respect of, and benefits accrue to member and his/her dependents on the 1st (first) day of each month. Failure to pay in full the membership fee (monthly contribution) as required under this policy shall result in automatic suspension of the membership.

BLOCK I / GAWO I Declaration and Signature

I hereby declare that the information given is correct and true in all respects. I agree that should this application be accepted, the contract between myself and the Society shall be strictly governed by the terms and conditions, as amended from time to time by the Society. I hereby authorize **MASM** to access my medical records from any health service provider for the purpose of confirming access to service.

Ine ndikutsimikiza kuti ndapereka umboni woona okhaokha. Ndikuvomereza kuti ndidzatsata malamulo onse a bungwe la **MASM**. Ndikupelekanso chilolezo ku bungwe la **MASM** kuti pa nthawi ili yonse litha kufufuza za umoyo wanga ngakhale ine ndisakudziwa ndi cholinga chotsimikiza kuti ndinalandila chithandizo choyenera.

Date/Tsiku D D M M Y Y Y Y

Member's Signature/ Posainira Membala _____