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Mzuzu Branch
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AMENDMENT FORM

For Existing Members Only

A. Premium Payer/ Account Holder

Block A to be completed by the Account Holder only

Premium Payer Name: (Firm/company) _____ Premium Payer Number: _____

B. Member's Details

*Only tick against the field with an asterisk when you are changing the Member details

Change of Member Details: * ◯ Title: Mr ◯ Mrs ◯ Ms ◯ Dr ◯ Prof ◯ Others ◯ Gender: M ◯ F ◯

First Name: _____ Middle Name: _____ Surname: _____

Identity Type: Passport: ◯ National ID: ◯ Driver's License: ◯ Other ID: ◯ ID Number: _____

Date of Birth: D D M M Y Y Y Y Masm Number: _____

Telephone Number: * _____ Cellphone Number: * _____

Email Address:* _____ Postal Address:* _____

Physical Address:* _____

C. Product (Scheme)

Please Indicate the Scheme you wish to join

*Only tick against the field with an asterisk when you are changing the Product

Change of Product(Scheme)* ◯

Econoplan ◯	Executive ◯	VIP ◯

D. Electronic Funds Transfer

* Provide banking details to which claims will be made

Change of Bank Details:* ◯

Name of Bank: _____ Branch: _____

Account Number: _____ Account Type: Savings ◯ Current ◯

E. Dependants

First Name	Middle Name	Surname	Date of Birth							Gender		Add	Amend	Remove	Product(Scheme)	Service Provider
			D	D	M	M	Y	Y	Y	M	F					
										○	○	○	○	○		
										○	○	○	○	○		
										○	○	○	○	○		
										○	○	○	○	○		

F. Previous Medical Insurer

Name of Medical Insurer	Product(Scheme)	Effective Date	Termination Date

G. Confidential Medical History

		Principal Applicant	Dependant One	Dependant Two	Dependant Three	Dependant Four	Dependant Five
1	**Medication** Are you, your spouse and dependant or any other, currently taking any 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 hospitalised 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, fibro-adonesis of the breast, hormone replacement therapy, prostate infenctions or surgery, prostate enlargement or any other reproductive problems.	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
6	**Digestive System** Ulcers, pancreatitis, hiatus hernia,colon problems, crohns disease, ulcerative colitis, gall bladder diseases, liver problems, colonyscopy or endoscopy.	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
7	**Ear, Nose & Throat** Deafness, nasal surgery, throat	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

8	**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
9	**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
10	**Eyes** Blindness (partial or full), eye surgery, cataracts, glaucoma, retinitis pigmentosa or any other eyelid problems.	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
11	**Endocrine** Diabetes, thyroid surgery or an other glandular problems.	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
12	**Joint Disease** Rheumatoid arthritis, osteo-arthritis or any other joint disease.	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
13	**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
14	**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
15	**Psychological** Psychosis, suicide attempts, bipolar disorders, schizophrenia, counselling or hospitalisation for alcohol or drug abuse or any other psychological conditions.	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
16	**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
17	**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
18	**Skin** Eczema, psoriasis, skin cancer or any other skin disorders.	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
19	**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

Block H/ Gawo H Current Medication Details

if you answered YES to Question 1 in the Confidential Medical History Section kindly complete full details below

Name of Applicant	Condition being Treated	Dosage, Name & frequency of prescribed medication	Date treatment commenced

Block I / Gawo I Additional Medical History Information

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

Question #	Names	Date of Diagnosis/ Treament	Details of disorder, duration of treatment, medication and dosage

J. Declaration

I hereby declare that the infomation 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 rules, regulations and benefits, as amended from time to time by the Society. I hereby authorize **MASM** to access my medical records from any health service provider for purpose of confirming access to service.

	D	D	M	M	Y	Y	Y	Y
Date/Tsiku								

Member's Signature.....