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P.O. Box 30381 Lilongwe 3
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Mzuzu Branch
Grace Building, P.O. Box 973 Mzuzu
Telephone: +265 (0) 1 311 797, +265 (0) 999 957 523
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APPLICATION FOR MEMBERSHIP

Only new members can complete this form (Oyankha mafunso pa pepalali ndi okhao akufuna kukhala ma membala a MASM kwanthawi yoyamba)

** All fields to be Completed **

Block A / Gawo A Member's Details

Title: Mr ◯ Mrs ◯ Ms ◯ Dr ◯ Prof ◯ Others ◯ Premium Payer Name: Firm/Company

First Name * Dzina loyamba | Middle Name Dzina lachiwiri | Surname * Dzina la Makolo

Identity Type: * Passport ◯ National ID ◯ Driver's License ◯ Other ID ◯ ID No:

Marital Status: Single ◯ Married ◯ Divorced ◯ Widowed ◯ Gender: * M ◯ F ◯

Date of Birth: Tsiku lobadwa (D D M M Y Y Y Y) | MASM ID Number: *

Telephone Number: | Cell Number: *

Physical Address: *

Postal Address: *

Doctor's name/Service Provider: | Email Address: *

*All fields marked with an asterisk * are required fields and should be completed. Failure to complete these fields will lead to the application not be accepted.

Block B / Gawo B Product (Scheme)

Please indicate the Scheme you wish to join / Sankhani sikimu yomwe mukufuna

Econoplan ◯	Executive ◯	VIP ◯

Block C/ Gawo C Electronic Funds Transfer

Provide bank details to which claims refund will be made/Pelekani akaunti yomwe tidzalipilire claim yanu

Name of Bank/Dzina la Banki:

Account Number/Nambala ya akaunti:

Account Type/Mtundu wa akaunti: Current ◯ Savings ◯ Branch/Nthambi:

Block D / Gawo D Dependants

	First Name Dzina loyamba	Middle Name Dzina lachiwili	Surname Dzina lamakolo	Date of Birth Tsiku lobadwa D D M M Y Y Y Y	Gender F		Relationship Pali ubale wanji ndi membala	Product(Scheme) Sikimu
1					◯	◯		
2					◯	◯		
3					◯	◯		
4					◯	◯		
5					◯	◯		

Block E / Gawo E Previous Medical Insurer

Name of Medical Insurer Dzina la Bungwe	Product(Scheme) Sikimu	Effective Date Kuchokera	Termination Date Mpaka

Block F/ Gawo F 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 surgery.	◯ 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, schizo-phrenia, 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 transfu-sion.	◯ 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 G/ Gawo G 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 H / Gawo H Additional Medical History Information

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 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

Block I / Gawo I Declaration And Signature

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 authorise MASM to access my medical records from any health service provider for purpose of confirming access to service.

Ine ndikutsimikiza kuti ndapereka umboni woona okhaokha. Ndikulonjeza kuti ndikaloredwa kukhala membala 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.

Termination Clause

A member can cancel their scheme by giving 90 days advance notice in writing to MASM. The cover on all insured persons will cease on the date the policy is cancelled.

Date/Tsiku D D M M Y Y Y Y

Member's Signature/ Posainira Membala.....