Ordinary Membership Form

Please type or write in CAPITAL LETTERS

For office use	
REG NO#	

NAME OF EMPLOYER								
BENEFICIARY SURNAME	Mr	Mrs	Miss					
FIRST NAMES								
ADDRESS								
OCCUPATION				Day	Mth	Year		
TELEPHONE NO			DATE OF BIRTH				SEX	
EMAIL ADDRESS								

BANK DETAILS

ACCOUNT HOLDER	
ACCOUNT NUMBER	
BANK NAME	

COVERS CHOSEN:

	COVERS	PREMIUM			
1.			2.		
			3.		

	D D M M Y Y Y Y
Date joined company	
Date confirmed by company	
Waiting period purchase	

Tick if applicable.

ID NO.

(This is limited to 3 months and to beneficiaries joining the scheme at the same time as the Employer)

DEPENDANTS' DETAILS

If you elect to cover your dependants, ALL OF THEM must apply for registration, unless they are already covered elsewhere. You must submit to your Employer evidence of their respective birth dates.

	PERSON 1	PERSON 2	PERSON 3	PERSON 4
SURNAME				
FIRST NAMES				
DATE OF BIRTH				
RELATION TO MEMBER				
SEX				
PLANS CHOSEN+ PREMIUM				

If any of the dependants named above is engaged in regular work, please state the nature of work:

DECLARATION

I declare that the information given above is true and hereby apply to be a member of the Association with effect from the _____ I hereby agree to be bound by the Rules of the Association and by the **Bye-Laws/Terms and Conditions** of the Medical Aid scheme and accept to regularly pay to my Employer the contribution due by me (if applicable).

Signature: _____ Date: _____

A copy of the **Bye-Laws/Terms and Conditions** has been remitted to the Employer and may be examined on request.

Once completed, please send this form to: Medscheme (Mtius) Limited, 1st Floor, Tower A, 1Cybercity, Ebene.
Kindly write NEW MOSANTE MEMBERSHIP FORM on the top RHS of the envelope.
This proposal will not take effect until it has been accepted by Mosanté.