PHOTO

Eight Dimensions
Medical Aid Society

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inquires@8dmedicalaid.co.zw
19Baines Avenue, Court 17Mimosa,
The Avenues, Harare, Zimbabwe

MEMBER APPLICATION FORM

New application ☐ Change of signatories ☐ Change of Bank ☐ Change of contact person ☐ Account termination ☐

SECTION 1 PACKAGE SELECTION (Please indicate the package you wish to join)

SCHOOL PACKAGE ☐ GROUP PACKAGE ☐ POOL PACKAGE ☐ CORPORATE PACKAGE ☐ ASSOCIATION PACKAGE ☐

SECTION 2 FOR ORGANIZATIONS (For companies, Associations, Families, Clubs etc) BP Number

Name of Organization: _____ Physical Address: _____

Organizational website: _____ Organizational email: _____

Organizational Representative

Full name: _____ Designation: _____ National ID number: _____

Cell Number: _____ E-mail: _____ Postal Address: _____

_____ Fund name: _____

Signature: _____

FOR OFFICIAL USE ONLY

FUND NO.

SECTION 3 REGISTRATION OR ADDITION OF SIGNATORIES

NAME	ID NUMBER	PHYSICAL ADDRESS	PHONE NUMBER	DESIGNATION	EMAIL	SIGNING RULES	SIGNATURE	
								PHOTO
								PHOTO
								PHOTO

SECTION 4 GROUP DEFINITIONS

Group name: _____ Description: _____

Group name: _____ Description: _____

Group name: _____ Description: _____

Group name: _____ Description: _____

Group name: _____ Description: _____

Group name: _____ Description: _____

Group name: _____ Description: _____

SECTION 5 BANK DETAILS (Refund of claims)

I/We hereby instruct Eight Dimensions Medical Aid Society to deposit claim refunds using the information provided below and authorize the Society to reverse any erroneous transactions and/or rectify any electronic fund transfer errors without prior notice.

USE THIS ACCOUNT FOR CLAIMS REFUNDS

Bank name: _____

or Mobile Banking details: _____

Branch name: _____ **Branch code:** _____

Bank account number: _____

SECTION 6 EIGHT DIMENSIONS ACCOUNT MANAGER DETAILS

Name: _____ **ID Number:** _____

Employee number: _____ **Contact number(s):** _____

Email Address: _____

TERMS AND CONDITIONS

By submitting this form, you agree to the following terms and conditions:

- ŸYou agree that the data you provide on this form will be used for the all Eight Dimensions Medical Aid Society related processes and communiction.
- ŸYou agree that we may store and use your data in accordance with our privacy policy.
- ŸYou agree that you are responsible for ensuring that the information you provide on this form is accurate and complete.
- ŸYou agree that we are not liable for any damages that may arise from the use of this form.
- ŸIf you have any questions about our terms and conditions, please contact us at **inquires@8dmedicalaid.co.zw**

Acknowledgement

As a member, I undertake to familiarize myself with the Eight Dimensions Medical Aid Society Constitution together with the Eight Dimensions Medical Aid Society Membership Rules and regulations. I will ensure that I am familiar with the benefits of my chosen package and fully understand the terms and conditions of enjoying or accessing those benefits BEFORE signing this form. As the Eight Dimensions Medical Aid Society constitution, Eight Dimensions Medical Aid Society Membership Rules and regulations, package benefits and the terms and conditions of accessing these packages change from time to time, it is my responsibility as a member to constantly track and understand these changes throughout my membership period. Every member on joining the Society is deemed to be aware and in agreement with the Eight Dimensions Medical Aid Society Constitution, Eight Dimensions Medical Aid Society Membership Rules and regulations, package benefits and attending terms and conditions of accessing the same.

Declaration and Signature

I hereby certify that the information given above is correct in all aspects. I agree that should this application be accepted, the contract between myself and the Society shall be strictly governed by the Eight Dimensions Medical Aid Society Constitution and the Eight Dimensions Medical Aid Society Membership Rules, and Regulations, as amended from time to time by the Society. I have familiarized myself with all these documents and make this application in light thereof. I also confirm that I have fully familiarized myself with the benefits that I am entitled to in my chosen package together with the terms and conditions of accessing the same. I authorize Eight Dimensions Medical Aid Society to access my medical records from any health service provider for any reason whatsoever. I further declare that these dependents do not suffer from any conditions not declared.

Name(1): _____ **Signature:** _____ **Date:** _____/_____/_____

Name(2): _____ **Signature:** _____ **Date:** _____/_____/_____

Witness(1): _____ **Signature:** _____ **Date:** _____/_____/_____

Witness(2): _____ **Signature:** _____ **Date:** _____/_____/_____