



Cimas Medical Aid Society

Harare Head Office: Cimas House, Cnr. Jason Moyo Ave and Harare Street, P.O. Box 1243, Harare, Zimbabwe. Phone 263-04-777300-15. Fax 753567

Cimas Bulawayo: Suite 4 Medical Centre, Cnr. Josiah Tongogara Street and 8th Ave, P.O. Box 5, Bulawayo. Phone 263-09-64876, 72318

Cimas Gweru: No. 23 Sixth Street, P.O. Box 1402, Gweru. Phone 054-26178

Cimas Mutare: Cimas House, 98 Second Street, P.O. Box 712 or 2560, Mutare. Phone 020-67703, 67639 Fax 020-67795

TICK THE APPROPRIATE BOX WHERE YOU ARE AMENDING DETAILS

AMENDMENT FORM

For existing members only.

Please read the notes on the back of this form before completing

BLOCK A : EMPLOYER / ACCOUNT HOLDER DETAILS (To be completed by Account Holder only)

Name of Employer / Account Holder:		Date of Registration:
Employer / Account Holder Number:	Employer / Account Holder Authorisation:	

BLOCK B : MEMBER DETAILS

Quote your Membership No:

Surname:		First Name:		Initials:	Title:	Mr	Mrs	Ms	Dr	Prof
ID Number			Sex		Date of Birth			Race: eg African		
					DAY	MONTH	YEAR			
					M	F				
Residential Address:					Contact Telephone Nos:					
					Bus:	Code	No			
					Home:	Code	No			
					Cell:					

BLOCK C : PLEASE INDICATE THE PACKAGE YOU WISH TO JOIN UNDER TRADITIONAL OR MANAGED CARE

BASICARE	PRIMARY	GENERAL	PRIVATE HOSPITAL	MEDEXEC	OTHER <small>please specify eg. U.Z., Wankie</small>
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BLOCK D : FAMILY MEMBERS TO BE ADDED / REMOVED / DETAILS TO BE AMENDED (attach extra sheet if required)

PLEASE TICK WHERE APPLICABLE

Please write name of your doctor

First Name	Surname	Date of Birth	Sex	(✓) Add	(✓) Remove	(✓) Amend	Relationship to Member	Name of Doctor

BLOCK E : MEDICAL HISTORY : Have you/your spouse/any of your dependants suffered from any of the following:

Cancer	Psychiatric Conditions	Hypertension	Diabetes	Leprosy
Renal Disease	Cardio-vascular Problems	Epilepsy	Asthma	Other

If any of the above applies or if any other condition is present please give details of condition, when it was first diagnosed and any treatment being taken

Name and Address of Doctor:

BLOCK F : DECLARATION AND SIGNATURE

I hereby certify that the information given above is correct and true and in all respects. I agree that should this application for membership 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 authorise the deduction from my salary of the monthly subscriptions due in respect of myself and my dependants.

I further declare that these dependant(s) do not suffer from any condition, not declared.

NB. Please read notes on Block G overleaf before signing this form.

Date

Member's Signature