

# Membership Application Form

## cfb Membership



www.cfbmedic.com.zm  
 membership@cfbmedic.com.zm  
 T +260 211 255728, C +260 979 700 100  
 4192, Addis Ababa Drive, Lusaka, Zambia

### MAIN APPLICANT DETAILS

Title	<input type="text"/>	Surname	<input type="text"/>
First Name	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/> NRC Number <input type="text"/>
Passport Number	<input type="text"/>		
Residential Address	<input type="text"/>		
Postal Address	<input type="text"/>		
Telephone No	<input type="text"/>	Cellphone Number	<input type="text"/>
Email	<input type="text"/>		
Next of Kin Name	<input type="text"/>	Cellphone Number	<input type="text"/>
Relationship	<input type="text"/>		

### DEPENDENT 1

Title	<input type="text"/>	Surname	<input type="text"/>
First Name	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	Relationship <input type="text"/>
Email	<input type="text"/>		
Cellphone No.	<input type="text"/>	NRC Number	<input type="text"/>

### DEPENDENT 2

Title	<input type="text"/>	Surname	<input type="text"/>
First Name	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	Relationship <input type="text"/>
Email	<input type="text"/>		
Cellphone No.	<input type="text"/>	NRC Number	<input type="text"/>

### DEPENDENT 3

Title	<input type="text"/>	Surname	<input type="text"/>
First Name	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	Relationship <input type="text"/>
Email	<input type="text"/>		
Cellphone No.	<input type="text"/>	NRC Number	<input type="text"/>

### DEPENDENT 4

Title	<input type="text"/>	Surname	<input type="text"/>
First Name	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	Relationship <input type="text"/>
Email	<input type="text"/>		
Cellphone No.	<input type="text"/>	NRC Number	<input type="text"/>

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### DEPENDENT 5

Title	<input type="text"/>	Surname	<input type="text"/>
First Name	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	Relationship <input type="text"/>
Email	<input type="text"/>		
Cellphone No.	<input type="text"/>	NRC Number	<input type="text"/>

### DEPENDENT 6

Title	<input type="text"/>	Surname	<input type="text"/>
First Name	<input type="text"/>		
Date of birth	<input type="text"/>	<input type="text"/>	Relationship <input type="text"/>
Email	<input type="text"/>		
Cellphone No.	<input type="text"/>	NRC Number	<input type="text"/>

### DECLARATION BY APPLICANT

The Board of Directors of CFB Medical Centre reserve the right to accept any applicant and his/her dependents for Membership.

The Membership terms and conditions have been read and understood.

The Exclusion Policy has been explained and understood.

Membership cover for Hospital admission requires the applicant and each registered dependent to undergo a full medical check-up, within the first fourteen days of acceptance for Membership.

The member must notify the Membership office in writing, of any changes in the details contained in this application form.

Membership Subscriptions are payable in advance. Subscription not paid within thirty days of due date will result in termination of membership. Once membership has been terminated, the member will be required to join as a new member.

Renewal of Membership is the member's responsibility and although cfb Medical Centre will make every reasonable effort to deliver subscription invoices to the member on time, cfb Medical Centre cannot be held responsible for the member not receiving reminders.

The Board of Directors reserve the right to change, amend, modify or terminate this Membership at any time without notice.

I hereby acknowledge that I/We have read and understood the terms and conditions mentioned above and agree to it all.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

Membership No: \_\_\_\_\_ Subscription Fee: \_\_\_\_\_

Policy Start Date: \_\_\_\_\_ Policy End Date: \_\_\_\_\_

PMO File No: \_\_\_\_\_ Signature: \_\_\_\_\_

Payment Date: \_\_\_\_\_ Signature: \_\_\_\_\_