

cfb Medical Centre

APPLICATION FORM

Clinic Membership Annual
 Clinic Membership 6 Monthly
 Hospital Membership 3 Monthly
 Category _____
 Date of joining _____

	Surname	First Names	Date of Birth	Sex F/M	Relationship	NRC / Passport
Principal						
Spouse						
Child 1						
Child 2						
Child 3						
Child 4						
Child 5						
Child 6						

Residential Address: _____ Telephone No. (Home): _____

_____ Telephone No. (Cell): _____

Postal Address: _____ Fax No.: _____

_____ e-mail: _____

Work Address: _____ Tel: _____

Next of Kin Name: _____ Relationship: _____

Next of Kin Address: _____ Tel: _____

Do you have any evacuation cover? Yes / No. If Yes give Membership No.: _____

Company & contact details _____

Declaration by Applicant:

I/we understand that the Board of Directors reserves the right of membership of Care For Business Medical Centre. I/we are not aware of any reason for the above cover to be cancelled or curtailed and I/we have not withheld any material facts. I/we understand that non-disclosure or misinterpretation of a material fact will entitle the Board of Directors to void this membership. I/we declare that I/we have been provided with a copy of the cover wording and have read it myself and on behalf of those for whom I/we seek cover. I/we agree that if I/we wish to terminate my/our membership that I/we should do so in writing delivering the notice to the Centre. I/we understand that cover starts from the first day of the month of issue & therefore no refund of fees will be allowed if this cover is cancelled. I/we agree to abide by the rules and directives issued by the Board of Directors as set out in the booklet "Guidelines for Members".

Signed: _____

Date: _____

For office use only

Subscription Fees: _____ Receipt No.: _____ Account No.: _____