Central Health Medical Aid
Lilongwe Area 47/3/138
P.O Box 2739
Lilongwe
www.centralhealthmw.org

All Communication to **Managing Director:**
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MEMBERSHIP APPLICATION FORM

PART A: APPLICANT'S DETAILS

Member Name: Mr/Mrs/Ms/Dr/Prof/Rev/H.E _____ **Gender**: Male ☐ Female ☐

Date of Birth: _____ Nationality: _____ ID Number: _____ Marital Status: _____

Phone Number(s): _____ Email Address: _____

Profession: _____

Govt Dept: _____ Ministry: _____

Duty Station: _____

Position: _____ Employment Number: _____ Location: _____

PART B: MEDICAL AID PLAN

CisMed: ☐ **Others:** Silver ☐ Gold ☐ Diamond ☐ Diamond-Plus ☐ Emerald ☐

PART C: MODE OF PAYMENT

Monthly: ☐

By:

☐ Source Deduction

PART D: DEPENDANTS

Surname	First Name	Gender	Date of Birth	Relationship to Member	Doctor/Hospital

PART E: MEDICAL HISTORY

Member ☐ / Dependant ☐ **Name:** _____

Disease ☐ / Condition ☐ **Name:** _____

Year of Diagnosis Treatments Received

Doctor /Hospital Name

I hereby agree to the truth of the information given above and hence this membership application form be accepted in accordance with the rules, regulations and policies of Central Health Medical Aid and I grant Central Health Medical Aid access to my medical record.

Signature _____ Date _____

MOST PREFERRED HOSPITAL

In our quest to provide you with quality medical aid services please kindly list down your three (3) preferred hospitals where you would like to access medical services from time to time.

1 .....

2 .....

3 .....

FOR OFFICIAL USE ONLY

Approved Plan:

CisMed ☐ Silver ☐ Gold ☐

Diamond ☐ Diamond-Plus ☐ Emerald ☐

Reason for Approval: .....

.....

Approved by Name .....

Signature: .....

Date of Approval: .....