FAXED APPLICATION FORMS ARE NOT ACCEPTABLE



Namibia Medical Care
P.O. Box 24792
Windhoek, Namibia
Tel. (061) 287 6000
Email: membership@methealth.com.na

APPLICATION FOR MEMBERSHIP

(Read addendum notes before completing the form)

PLEASE COMPLETE ALL THE API	PLIC.	ABL	E SE	CTIC	ONS	IN F	ULL																						
Applicant's Status			Pri	incipa	ıl Mer	nber						Ad	dition	al De	pend	ant						S	pecia	l Dep	endar	nt			
A. BENEFIT OPTION																													
Topaz Plus			1	Topaz	Plus	Stude	ent				Opal	l			Jade	!				Ruby				Si	apphii	re			
Diamond		meral								ald Plu							Ambe			Amber Plus (Hospital cover with optional									
(Hos	pital	cover	r only))			(H			er with ay ben		onal			(F	łospit	al cov	er on	ly)			(Ho			r with y bene		nal		
Indicate with an X:							١	VOLU	JNT	ARY (CON	TRII	BUTI	ONS	5														
Monthly Voluntary Contribution		N\$	\$300					N\$60	0					\\$90	0				N	\\$1, 20	10				N	I\$1,50	0		
Extended Benefit Per Year		N\$3	3,600					N\$7,20	00				N:	\$10,8	00				N	\$14,4	00			N\$18,000					
Membership Start Date	М	М	Υ	Υ			Are	you a	ıpplyi	ng as i			al (Pri	vate					Or				an Em lete S		er Gro n K)	up?			
B. PARTICULARS OF PRINCIPAL MEME	·																												
TITLE (Prof/Dr/Mr/Mrs etc.)						SURNAME																							
FIRST NAME																													
DATE OF BIRTH	D	D	М	М	Υ	Υ		GENDE	ER	М	F	ID/I	PASSP	ORT I	NO.														
NATIONALITY													МА	RITAL	_ STAT	US		S	INGL	.E	М	ARRI	ED	W	IDOWI	ED	DIV	ORCE	ED
OCCUPATION (Indicate if you are a Pensioner)													_				ILY IN												
POSTAL ADDRESS			Т										STF	EET	T ADDRESS														
		_																											
POSTAL CODE		<u></u>		1																		1			Ш				
TEL (HOME)		Ļ	<u>_</u>												TEL. (WORK	<)								Ш				
CELL NO.															F	AX:													
EMAIL ADDRESS (Principal Member)													_			ADDRI appli	ESS cable)))											
FOR OFFICE USE ONLY																													
UNDERWRITING DECISIONS																											ı		
																				PRORATED BENEFITS					Υє	Yes		No	0
															CONFINEN		NEN	NE		V.	05	[KI.	0					
EXCLUSIONS																		RIOD		16	Yes No								
MEMBERSHIP NUMBER														OPTION			N				EGIST ATE:	RATI	ON	D	D	М	М	Υ	Υ
PREMIUM (N\$)										PAYM	ENT N	1ETH	OD.		C4	\SH		D	EBIT	ORDF	R		FI	FT			GRO	UP	

BENEFIT DATE ON D	DAY-TO-DAY	MEMBERSHIP CODE N													ROUF AME:														
PROCESSING DATE		D	D	М	М	Υ	Υ		LERK NITIA	LS)								NIOR / IITIALS											
C. EMPLOYER D	PETAILS																												
COMPANY NAME																													
ADDRESS																													
TEL.]											FAX													
D. PARTICULARS	S OF PREVIOUS MEDIC	CAL CO	OVER																										
	mber/dependant of a edical aid fund (a mem							d fund	for th	e pas	st two	years	s? If 'y	es', ple	ease atta	ch a	a cer	rtificate	(s) (of me	mbers	hip f	rom	your		Yes			No
NAME OF CURRENT	MEDICAL AID FUND												MEMB	ERSHI	P NO.														
PERIOD OF MEMBER	RSHIP: FR	ОМ	D	D	М	М	Υ	Υ		TO:	D	D	М	М	ΥΥ														
NAME OF PREVIOUS	S MEDICAL AID FUND												MEMB	ERSHI	P NO.														
PERIOD OF MEMBER	RSHIP: FR	ОМ	D	D	М	М	Υ	Υ		TO:	D	D	М	М	Y														
Was membership su	bject to any restriction	ns/exc	lusion	ns?				Υe	es		N	lo		If yes,	state pa	rticı	ulars	of res	ricti	ions	_								
								.11			ela mara		4- 25.			-1	والمماد	6 Ala a								المامات	+:		*1441*
provide documentar	stration. Please attach ry proof of relationship ional institution as per First Name	n a list p.	t for n	nore	than f	ive (5) chil	dren. (ed, ple		ttach 1	the nece	ssar		cumen					er fro	m th	at of I		pal M		
Attach proof of regi provide documental *Recognised educat	stration. Please attach ry proof of relationship ional institution as per	n a list p.	t for n	nore	than f	Tive (5) chil cal Ca urnar	dren. ((If leg	ally a		ed, ple	ease a	ttach 1	the nece	ssar	y do	cumen				diffe	er fro	m th	port !	Princi	pal M		
Attach proof of regi provide documental *Recognised educat	stration. Please attach ry proof of relationship ional institution as per	n a list p.	t for n	nore	than f	Tive (5) chil cal Ca urnar	dren. (are. ne	(If leg	ally a		ed, ple	ease a	ttach 1	the nece	ssar	y do	cumen			names	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regi provide documentar *Recognised educat Dependants Spouse 1* Child	stration. Please attach ry proof of relationship ional institution as per	n a list p.	t for n	nore	than f	Tive (5) chil cal Ca urnar	dren. (are. ne	(If leg	ally a		ed, ple	ease a	ttach 1	the nece	ssar	y do	cumen			names	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regi provide documentar *Recognised educat Dependants Spouse	stration. Please attach ry proof of relationship ional institution as per	n a list p.	t for n	nore	than f	Tive (5) chil cal Ca urnar	dren. (are. ne	(If leg	ally a		ed, ple	ease a	ttach 1	the nece	ssar	y do	cumen			names	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regi provide documentar 'Recognised educat Dependants Spouse 1st Child 2nd Child	stration. Please attach ry proof of relationship ional institution as per	n a list p.	t for n	nore	than f	Tive (5) chil cal Ca urnar	dren. (are. ne	(If leg	ally a		ed, ple	ease a	ttach 1	the nece	ssar	y do	cumen			names	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regi provide documentar *Recognised educat Dependants Spouse 1st Child 2nd Child 3rd Child	stration. Please attach ry proof of relationship ional institution as per	n a list p.	t for n	nore	than f	Tive (5) chil cal Ca urnar	dren. (are. ne	(If leg	ally a		ed, ple	ease a	ttach 1	the nece	ssar	y do	cumen			names	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2std Child 3std Child 4std Child 5std Child F. STATE OF HE. TO BE SUPPLIED BY	ALTH MEMBER/APPLICANT	n a list	ules o	ore (if d	nibia liffere	Media S nt fro) chil cal Ca urnar m pri	me	If leg	ber)	adopte	(Gende M/F	er	(Occu	y do	on			names	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2std Child 3std Child 4std Child 5std Child F. STATE OF HE. TO BE SUPPLIED BY	istration. Please attact ry proof of relationship ional institution as per First Name	n a list	ules o	ore (if d	nibia liffere	Media S nt fro) chil cal Ca urnar m pri	ne ncipal	If leg	ber)	adopte	(Gende M/F	er	(Occu	y do	on .	ts). I		D.O.	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2nd Child 3rd Child 4th Child 5th Child F. STATE OF HE. TO BE SUPPLIED BY Please provide the region of the state of th	ALTH MEMBER/APPLICANT	n a list	ules o	ore (if d	nibia liffere	Media S nt fro) chil cal Ca urnar m pri	are. (ne ncipal as wel	If leg	ber)	adopte	(Gende M/F	er	(Occu	y do	on S	ts). I	if suri	D.O.	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2nd Child 4st Child 5st Child F. STATE OF HE. TO BE SUPPLIED BY Please provide the recognised and the the recognise	ALTH MEMBER/APPLICANT	n a list	IPULS:	ore (if d	tiffere	Media S nt fro) chill cal Ca urnar m pri ntist, Doc Tel.	me ncipal	If leg.	ber)	eciali	()	Gende M/F	er	(Occu	y do	on S	pec	if suri	D.O.	diffe	er fro	m th	port !	Princi	pal M	lembe	
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2nd Child 4st Child 5st Child F. STATE OF HE. TO BE SUPPLIED BY Please provide the recognised the recognised educat Tel. Please complete the Have you, your spouse	ALTH MEMBER/APPLICANT name and address of y e questionnaire by pla	(COM our ge	iPULS:	ORY) L prace	mibia liffere answe	Media S nt fro) chill cal Ca urnar m pri mntist, Doc Tel. that	as wel	. mem	ber)	eciali:	sst you	Gende M/F	er anave c	onsulted	rec	y do	on y.	pec el.	ialist	D.O.	B	ID,	m th	port !	Princi	pal M	lembe	
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2nd Child 4st Child 5st Child F. STATE OF HE. TO BE SUPPLIED BY Please provide the recognised the recognised educat Tel. Please complete the Have you, your spouse	ALTH MEMBER/APPLICANT mame and address of y e questionnaire by pla use or any dependants of the heart (e.g. angi	(COM our ge	iPULS:	ORY) L prace	mibia liffere answe	Media S nt fro) chill cal Ca urnar m pri mntist, Doc Tel. that	as wel	. mem	ber)	eciali:	sst you	Gende M/F	er anave c	onsulted	rec	y do	on y.	pec el.	ialist	D.O.	B	ID,	m th	port !	Numb ID/Pa	pal M	lembe	
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2nd Child 3rd Child 4th Child 5th Child F. STATE OF HE. TO BE SUPPLIED BY Please provide the recognised the recognised educated the recognised educated the recognised educated e	ALTH MEMBER/APPLICANT mame and address of y e questionnaire by pla use or any dependants of the heart (e.g. angi	(COM) (COM) (COM) (COM)	IPULS:	ORY) L prace	than finibia difference di supporte di sun	Media S nt fro er, de murr) chill cal Ca urnar m pri mntist, Doc Tel.	as wel corres corres	mem ll as a	ber)	eciali:	sst you	Gende M/F	nave c	onsulted	rec	y do	on y. stress o	pec el.	ialist	D.O.	B	ID,	m the	port !	Numb ID/Pa	pal M	lembe	r, please
Attach proof of regiprovide documentar *Recognised educat Dependants Spouse 1st Child 2std Child 4std Child 5std Child F. STATE OF HE. TO BE SUPPLIED BY Please provide the recognised to the recognised educated	ALTH MEMBER/APPLICANT name and address of y e questionnaire by pla use or any dependants of the heart (e.g. angi	(COM our ge	IPULS an X ir experi	ORY) I prace	mibia iiffere answe d any heart	Media S nt fro er, de murr) chill cal Ca urnar m pri m pri Tel. that	as wel corres corres heuma	mem ll as a	ber)	ecialis	ed, ple	Gended M/F	nave c	onsulted	rec	y do	on y. stress o	pec el.	ialist	D.O.	B	ID,	m the	port !	Numb ID/Pa	pal M er asspo	lembe	No.

 $Disease \ or \ disorder \ of \ the \ kidney, bladder \ or \ reproductive \ or gans \ (e.g. \ protein \ in \ the \ urine, kidney \ stones, nephritis, prostatitis, cystitis \ or \ sexually \ transmitted \ disease)?$

6.	Diabetes, thyroid or other glandular or blood disorders (e.g. anaemia or bleedin	g disorders, leuka	aemia, haemophilia)?			Yes	No
7.	Eye, ear, nose or throat disorder (e.g. defective vision, hearing loss, ear discharge	e, recurrent tonsi	llitis, hoarseness, retinitis pigmen	tosa, glauc	oma)?	Yes	No
8.	Nervous or mental complaint (e.g. epilepsy, blackout, paralysis, anxiety state or	depression, chro	nic headaches, fits, fainting, multi	ple scleros	is, brain impairment)?	Yes	No
9.	Disorder or disease of the skin eruption, (e.g. porphyria, psoriasis, dermatitis, nother back condition)?	nuscles, bones, jo	oints, limbs or spine, e.g. rheuma	tism, arthri	tis, gout, slipped disc or	Yes	No
10.	Any tropical disease (e.g. bilharzia, malaria, brucellosis)?					Yes	No
11.	Cancer, a growth or tumor of any kind?					Yes	No
12.	Any other illness, disorder or operation, disability or accident, (INCLUDING MOTinvestigations, or have you ever been hospitalised?	OR VEHICLE ACC	IDENTS) which required medical,	radiologica	al, surgical, pathological	Yes	No
13.	Do you or any of your dependants have any physical (including dental), abnorm disease or some other cause? For dental system (poor closure of jaws, implants,				s a result of an accident,	Yes	No
14.	Are you or your dependants currently undergoing or expecting to undergo any r	nedical, dental, o	r surgical treatment?			Yes	No
15.	Are you or any of your dependants pregnant? If yes, state expected date of deliv	ery.				Yes	No
	If the answer to question 15 is YES, please answer the following questions:						
	15.1. Did you or any of your immediate family e.g. mother, dependants, sister e	xperience any co	mplications with previous pregn	ancies?		Yes	No
	15.2. Are there any complications or health problems detected in you or your i	mmediate family	's current pregnancy or that of t	he unborn l	baby?	Yes	No
16.	Does any member of your (or your spouse's) immediate family e.g. parents, brother mental disease, porphyria or any other disease?	ers or sisters suffe	r from diabetes, heart disease, hig	th blood pre	essure, raised cholesterol,	Yes	No
17.	Did you experience any health problems or show signs and symptoms of health	problems in the	ast 3-months before applying for	membersh	nip?	Yes	No
18.	Has your weight or the weight of your spouse/dependant changed more that 5k	g in the last 12 m	onths? If so, why?			Yes	No
19.	Are you or your dependants smokers?					Yes	No
20.	Are there any addictions we should be aware of?					Yes	No
21.	Height & weight (Principal member)	Height			Weight		
	Height & weight (Spouse)	Height			Weight		
	Height & weight (child 1)	Height			Weight		
	Height & weight (child 2)	Height			Weight		
	Height & weight (child 3)	Height			Weight		
	Height & weight (child 4)	Height			Weight		
	Height & weight (child 5)	Height			Weight		
If you	have answered 'yes' to any of the above questions please provide the full details	below:	Data and the second				

Question No.	Beneficiary (Name of Person)	Illness or condition	Date and duration of the illness or condition	Date and nature of treatment received medical or surgical result of treatment	Name of doctor, hospital or institution	Treatment recommended: likely date and duration of treatment

If more space is needed, please attach list.

Declaration of the Applicant's Famil I confirm that the information suppl			pplic	ant ir	ı Secti	on F,	State	of He	alth, is	true	and c	orrect																	
DOCTOR'S FULL NAMES																			PRACTICE	NUM	BER								
SIGNATURE																				0	ATE								
G. CHRONIC MEDICATION																													
Do you or any of your dependent	dants (use ch	nroni	c med	licatio	in?		Υ	es		N	lo	be	nefit o	an be	erec		(Form	HRONIC N obtainab										
Beneficiary				D	iagno	sis				Presc	ribed	Medic	ation			Str	ength		Do	sage			Per	riod	Medic	cation	ı User		
																						From		D	D	М	М	Υ	Υ
																						То		D	D	М	М	Υ	Υ
																						From		D	D	М	М	Υ	Υ
																						То		D	D	М	М	Υ	Υ
																						From	_	D	D	М	М	Υ	Υ
																						То		D	D	М	М	Υ	Υ
																						From		D	D	М	М	Y	Υ
																						To	_	D D	D D	M M	M M	Y	Y
																						From		D	D	М	M	Y	Y
																						From		D	D	М	М	Y	Y
																						То	+	D	D	М	М	Υ	Υ
																						From		D	D	М	М	Υ	Υ
																						То		D	D	М	М	Υ	Υ
																						From		D	D	М	М	Υ	Υ
																						То	_	D	D	М	М	Υ	Υ
																						From		D	D	М	М	Υ	Υ
																						То		D	D	М	М	Υ	Υ
																						From	_	D D	D	M M	M M	Y	Y
																						To From	_	D	D D	M	M	Y	Y
																						То		D	D	М	М	Y	Y
																						From		D	D	М	М	Υ	Υ
																						То		D	D	М	М	Υ	Υ
Declaration of the Applicant's Famil I confirm that the information supp DOCTOR'S FULL NAMES SIGNATURE	lied by	the a											orrect						PRACTICE		BER ATE								
H. YOUR BANKING ACCOUNT D	ETAILS	(Req	uired	d for r	efund	s to b	e dep	osited	direc	tly in	to acc	ount)																	
ACCOUNT HOLDER'S NAME																								\perp					
ACCOUNT NO.																													
BANK]	TYP	E OF A	ACCOUNT	:	C	URREN	г			SA	AVING	s	
BRANCH NAME																	BRA	NCH	CODE										
Please note: a bank account confirmation no post office savings account	letter nts are	is req allow	quired ved	d; and																									
NAME										S	IGNA	TURE (OF AC	COUN	NT HC	DLDE	ER								DAT	ГЕ			
I. DEBIT ORDER (Required for a	authori	isatio	n of o	deduc	tion o	f mor	nthly o	contril	oution	s fron	n banl	k acco	unt) (ONLY	FOR	INDI	IVIDUA	L ME	MBERSHIP	- - -									_
ACCOUNT HOLDER'S NAME																							$\underline{\underline{\mathbf{I}}}$						
ACCOUNT NO.																													
BANK																	TYP	E OF A	ACCOUNT	:	C	URREN	г			SÆ	AVING	is [

BRANCH NAME																	BR	ANC	Н СО	DE												
ID NUMBER							I												DATE (OF LA	ST [DEDU	TIO	N		D	D	N	4 1	1	Υ	Υ
I authorise Namibia Med my bank to effect payme is to remain in force until	nt of such inc	rease	d amou	unt u	ıpon r	eceipt	of wi	ritten no	tice fr	om Na																						
I agree that I am not ent	tled to recov	er an	ny amou	ınt d	lebite	d from	my a	account	by me	ans of	this	debit	order a	nd tl	hat s	hou	d my	ban	k reve	rse ar	ny s	uch a	nou	nt, I	will	refun	d Na	mibi	a Me	dical	Care	s. I
undertake to notify Nami	bia Medical C	are o	of any c	hang	ges to	my add	dress	or banl	к detai	ils.																						
																				_			-									_
	NAME									51	GNA	UKE	OF ACC	OUN	II HO	JLDI	:K											DATE				_
J. UNDERTAKING BY	THE APPLICA	NT																														
I, the undersigned Care's opinion, are membership shall benefits paid shall My membership si	relevant to t be void if any immediately nall not comm	the ri info be p	sk and rmation ayable unless	which sho to Na Nan	ch are ould b amibi mibia	signed e inacc ia Medi Medica	or water cal Cal	vill be si e or inco Care. re specif	igned I omplet fically	by me, te, in w notifie	shall hich s me	be th event in wri	e basis all the ting of	of mon	ny money p	emb aid t epta	ership oward	and ds th	that e mer risk; a	they some	shal hip ny d	l be v shall eteric	arra oe fo	nted orfeit on or	d as ted t	true a to Nar ange o	nd c nibia	omp Med	lete; dical e of r	and t Care	hat n and a	ny all or
the health of my o by the Namibia M new terms of acce shall be forfeited t by Act 23 of 1995	edical Care, o ptance or to d o Namibia Me	r the lecla edica	date of re the n Il Care a	f reconnemiand b	eipt o bersh	f the fir ip null a	rst su and v	bscripti oid, in v	on wh	icheve event a	r is th	ne late e mon	est date ey paid	, sha tow	ıll giv ards	e Nathis	amibia memb	a Me ersl	dical	Care ore N	the am	right ibia M	o re edic	cons	ide are	r the a receiv	ppli es no	catio otice	n and of su	l to p	ropo chan	se ge
I irrevocably give in to disclose this inf											osse	ss, or i	may co	me ir	n pos	sess	ion of	any	inforr	natio	ı re	gardii	g m	y hea	alth	or the	hea	lth o	f my	depe	ndan	ts,
3. I give my consent	o my employ	er in	the cas	e of	group	memb	bersh				y sala	ary and	d pay N	amil	bia M	1edi	al Ca	re a	l amo	unts t	hat	may	e d	ue to	Na	mibia	Med	lical	Care.	l cor	nmit	to
familiarise myself 4. I commit to famili								to ther	m																							
4. Fedimine to familia	mise myseti w		ic rune	1314	ites ui	ia to ac	mer e	to then																								
Signed at								on the					_	day	of												20					
	WITNESS											DA	TE								_			AF	PPLI	CANT	'S SIC	NAT	URE			_
K. EMPLOYER'S DECI	ARATION CO	NCEF	RNING (GRO	UP SC	HEME	APPL	ICANT													_											_
I/We declare that																																
was appointed as a full-	ime employe	e on				D D)	ИМ	Υ	Υ		and	d is ent	tled	to m	emb	ership	p of	the gr	oup s	che	me nı	mbe	er								
from D D	ММ	Υ	Υ	1	The m	onthly	subs	cription	of N\$											W	rill b	e pai	d fro	m		D	D	N	1 1	1	Υ	Υ
Payroll Number																																
													-																			
							_										_															
COMPANY OFFIC											DA	TE											ı	MPL	LOY	ER'S S	TAM	Р				
	IAL'S SIGNAT	TURE																														
	IAL'S SIGNAT	TURE		DDE	MDIII	M TO N	AMI	NA MED	ICAL (ADE A	DDI I	CATIO	N EOP	MEM	IDED	CUIE	EODI	M (Fe	r all a	nnlic	ante	۸									int th	at
Thank you for applying for you comply with the follo	r membershij	p witl	A h our Fu					BIA MED															regi	strati	ion	as a m	emb	er, it	is im	porta		
	r membership wing require rm must be C	p witl ment	A h our Fu	und. ¹	To en	sure you	ur re	lationsh	nip witl	h Nam	bia N	1edica	al Care	rema	ains s	atisi	actory	y for	the d	ıratio	n of	your									oplyii	ng
you comply with the followard. The application for	r membership wing required rm must be C nation. plication is in	p with ment OMP	A h our Fu is: PLETED	und. T	To en: ULL, i. Il requ	sure you e. all re	ur re	lationsh	nip with	h Nam on mu	ibia N	1edica	al Care	rema ase	ains s do no	atisi	actory	y for	the di	uratio olank	n of	your	sec	tions	wit	thout f	irst ı	eadi	ng ar	d su		
you comply with the following the required information of the required information of the apart REPERCUSSIONS in the second of t	r membership wing required rm must be C nation. plication is in n your future nations, etc., a	p with ment OMP nport associ	Ah our Futs: PLETED tant; thuciation	und. I IN Fl us, al with	To ensult, i.	e. all re uired inf und.	ur re eques form	lationsh sted info ation mi	ormations be	n Nam on mus provid	ibia N st be ed. A enco	1edica provid NY INI urage	el Care ded. Ple FORMA you to	ase o	do no	atisfot le	actory ave ar DED TH	y for ny sp HAT	the dipaces	uratio olank TTRU	n of or o	your delete	sec	tions ΓΕ/N	wit	thout f	irst i	eadi	ng ar	d su		
you comply with the following the required information of the required information of the approximation of the app	r membershi wing requirer rm must be C nation. plication is in n your future nations, etc., a	p with ment OMP nport associ are no	h our Fuss: PLETED tant; thuciation	und. I IN Fl us, al with ry at t	To ensult required the F this stry B) f	e. all re uired inf und. tage of	ur re eques form your nbers	lationsh sted info ation mo applica s joining	nip with ormation ust be ation, b	on mus provid out we dividua	ibia N st be ed. A enco ls wil	nrovic NY INI urage Il be p	el Care ded. Ple FORMA you to ro-rate	ase of TION subrided for	do no	atisfoot le	actory ave ar DED The s of you	y for ny sp HAT our n	the dipaces land	uratio olank TTRU	or o	your delete	sec PLE	tions ΓΕ/Ν t you	o wit	thout f	irst i	eadi O cou	ng ar	d su ve SI	ERIOL	JS
you comply with the following the required information of the required information of the apart REPERCUSSIONS in the second of t	or membership wing requirer rm must be C nation. plication is in n your future nations, etc., a ll day-to-day l pulate that a	p with ment OMP nport associate no bene mem	h our Fuis: PLETED tant; thu ciation ecessar fits (Can	und. T IN Fl us, al with ry at r tegoi	To ensult requirements the First this start ry B) for a class	e. all re uired inf und. tage of for men	ur re eques form your nbers a m	lationsh sted info ation mo applica spoining sember of	ust be ation, by as income	on must provide out we dividua	ibia N st be ed. A enco ls wil	nrovid NY INI urage Il be p	ded. Plate FORMA you to ro-rate JP" if h	remarase (TION subrated for is/he	do no N PRO mit co the	atisi	actory ave ar DED THE s of you three	y for ny sp HAT mor is d	the dicates library and the di	uratio olank TRU I repo	or of E/IN	your delete NCOM to su	sec	tions ΓΕ/Ν t you	or ap	thout f	OSEI	readi O cou	ng ar ild ha	d su ve SI	ERIOL	JS
you comply with the following the required information of the required information of the approximation of the app	or membership wing requirer rm must be C nation. plication is in n your future nations, etc., a ll day-to-day l pulate that a wenty EMPLO	p with ment OMP nport associ are no bene mem YEES	h our Fusis: PLETED tant; thu ciation ecessar fits (Cal	IN FUUS, all us, all tegonal t	To ensult requirements the F this straight ry B) for class	e. all re uired inf und. tage of for men ified as GROUF	ur re eques form your nbers a m P" wi	lationsh sted info ation mi applica s joining nember of ll be cla	ust be ation, by as income of an "assified	on must provide out we dividual EMPLO di as a v	ed. A enco ls wil	nrovid NY INI urage Il be p	ded. Plate FORMA you to ro-rate JP" if h	remarase (TION subrated for is/he	do no N PRO mit co the	atisi	actory ave ar DED THE s of you three	y for ny sp HAT mor is d	the dicates library and the di	uratio olank TRU I repo	or of E/IN	your delete NCOM to su	sec	tions ΓΕ/Ν t you	or ap	thout f	OSEI	readi O cou	ng ar ild ha	d su ve SI	ERIOL	JS
you comply with the following the required information of the required information of the appearance o	or membership wing requirer rm must be Conation. plication is in a your future nations, etc., a ll day-to-day loulate that a wenty EMPLO sing the Fund vailable for a	p with ment OMP of the control of th	h our Futs: PLETED tant; thuciation recessar fits (Car hber will 5. An "El	IN Fluss, all us, all with tegorial be MPLC	ULL, i. ULL, i. ULL, i. ULL, i. UL requ the F this st ry B) f class OYER u will	e. all re uired inf und. tage of for men ified as GROUF have P	ur re eques form your nbers a m P" wi	lationsh sted info ation mi applica s joining tember of ll be cla RATA da on the	ust be ation, by of an "assified princip	on mustore provide but we dividual (EMPLO) as a vector ay ben	efits.	nrovid NY INI urage Il be p GROU tary g	ded. Ple FORMA you to ro-rate JP" if h	ase (TION subrid for is/he at le	do no N PRO mit co	atisfort le OVIE oppie first embo 70%	actory ave ar DED The s of you three ership of the	HAT mour r mor is d	the divaces linedicanths.	uratio blank TTRU l repo from	or of E/IN orts the the	your delete NCOM to su part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the following the required information of	or membership wing requirer rm must be Conation. plication is in a your future nations, etc., a ll day-to-day loulate that a wenty EMPLO sing the Fund railable for a the principal	p with ment OMP nport associate no bene mem YEES on 1 ny ex mem	A h our Function of the control of t	und. The state of	ULL, i. ULL	e. all re uired inf und. tage of for men iffied as GROUF	ur re eques form your nbers a m P" wi PRO-F	lationsh sted info ation mi applica s joining tember of ll be cla RATA da on the egistrati	ust be ust of an " assification, but g as income assification, but principal income assification, but ust be ust b	n Nam provid provid dividua fEMPL(d as a v pal me	enco ls will DYER volun	Medica provid NY INI urage Il be p GROU tary g	ded. Place FORMA you to ro-rate JP" if h roup if	ase of TION subride for is/he at le	do no N PRO mit co the er mee east 7	atisi ot le OVIE opie first embe 70%	actory ave ar ED TH s of you three ership of the	HAT more is december and the	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the following the required information of the required information of the appearance o	r membership wing required run must be Conation. plication is in a your future nations, etc., all day-to-day local that a wenty EMPLO thing the Fund railable for a the principal ROM YOUR P.	p withment OMP nport associate ne bene mem YEES on 1 ny ex mem RESE	A h our Fusicistics: LETED A tant; thu ciation a ecessar fits (Car sheer will Januar kclusior kclu	und. The state of	To ensity of the Figure 1 to 1 t	e. all re uired inf und. tage of for men iffied as GROUF have P ions pla ce prior	ur re eques form your nbers a m P" wi PRO-F acced r to r until	lationsh sted info ation mo applica s joining sember o ll be cla RATA da on the egistrati you rec	ust be ust of an " assification, but g as income assification, but principal income assification, but ust be ust b	n Nam provid provid dividua fEMPL(d as a v pal me	enco ls will DYER volun	Medica provid NY INI urage Il be p GROU tary g	ded. Place FORMA you to ro-rate JP" if h roup if	ase of TION subride for is/he at le	do no N PRO mit co the er mee east 7	atisi ot le OVIE opie first embe 70%	actory ave ar ED TH s of you three ership of the	HAT more is december and the	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the following the required information of the repeat of	r membership wing required run must be Conation. plication is in a your future nations, etc., all day-to-day local that a wenty EMPLO thing the Fund railable for a the principal ROM YOUR P.	p withment OMP nport associate ne bene mem YEES on 1 ny ex mem RESE	A h our Fusicistics: LETED A tant; thu ciation a ecessar fits (Car sheer will Januar kclusior kclu	und. The state of	To ensity of the Figure 1 to 1 t	e. all re uired inf und. tage of for men iffied as GROUF have P ions pla ce prior	ur re eques form your nbers a m P" wi PRO-F acced r to r until	lationsh sted info ation mo applica s joining sember o ll be cla RATA da on the egistrati you rec	ust be ust of an " assification, but g as income assification, but principal income assification, but ust be ust b	n Nam provid provid dividua fEMPL(d as a v pal me	enco ls will DYER volun	Medica provid NY INI urage Il be p GROU tary g	ded. Place FORMA you to ro-rate JP" if h roup if	ase of TION subride for is/he at le	do no N PRO mit co the er mee east 7	atisi ot le OVIE opie first embe 70%	actory ave ar ED TH s of you three ership of the	HAT more is december and the	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the following the required information of the required information of the required information of the required information of the appearance	or membership wing requirer must be Conation. plication is in a your future nations, etc., a coll day-to-day loulate that a wenty EMPLO sing the Fund railable for a the principal ROM YOUR Ponts (all photon)	p withment OMP nport associate ne bene mem YEES on 1 ny ex mem RESE	A h our Fusicistics: LETED A tant; thu ciation a ecessar fits (Car sheer will Januar kclusior kclu	und. The state of	To ensity of the Figure 1 to 1 t	e. all re uired inf und. tage of for men iffied as GROUF have P ions pla ce prior	ur re eques form your nbers a m P" wi PRO-F acced r to r until	lationsh sted info ation mo applica s joining sember o ll be cla RATA da on the egistrati you rec	ust be ust of an " assification, but g as income assification, but principal income assification, but ust be ust b	n Nam provid provid dividua fEMPL(d as a v pal me	enco ls will DYER volun	Medica provid NY INI urage Il be p GROU tary g	ded. Place FORMA you to ro-rate JP" if h roup if	ase of TION subride for is/he at le	do no N PRO mit co the er mee east 7	atisi ot le OVIE opie first embe 70%	actory ave ar ED TH s of you three ership of the	HAT more is december and the	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the following the required information of the required and the representation of the required	or membership wing requirer must be Conation. plication is in nyour future nations, etc., a bull day-to-day loulate that a wenty EMPLO sing the Fund vailable for a the principal ROM YOUR Pots (all photos ate	p with ment OMP nport associ bene mem ny EES on 1 ny ex mem RESE	Ah our Fu tant; thu ciation ecessar ecessar sher will Januar sclusion sclusion with the full scanning and search with the full scanning and scanning and search scanning and scanning and search scanning and scanning and scanning scanning and scanning and scanning and scanning and scanning scanning and scanning and scanning and scanning and scanning scanning and scanning and scanning and scanning and scanning and scanning scanning and scanning and scan	IN FU IS, al with y at the tegor II be MPLO INSTREE ACCE DICA be c	To en: ULL, i. Il requ the F this si ry B) f class OYER u will estricti eptano	e. all re e. all re inired infi und. tage of for men fified as GROUF have P FUND legions pla	ur re eques form your nbers s a m P" wi PRO-F aced r to r until	lationsh sted info ation mi applica s joining ll be cla RATA da on the egistrati	ust be ust of an " assification, but g as income assification, but principal income assification, but ust be ust b	n Nam provid provid dividua fEMPL(d as a v pal me	enco ls will DYER volun	Medica provid NY INI urage Il be p GROU tary g	ded. Place FORMA you to ro-rate JP" if h roup if	ase of TION subride for is/he at le	do no N PRO mit co the er mee east 7	atisi ot le OVIE opie first embe 70%	actory ave ar ED TH s of you three ership of the	HAT more is december and the	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the folion The application for the required inform Section F of the application of the required inform Section F of the application F of	or membership wing requirer rm must be Conation. plication is in nyour future nations, etc., a coll day-to-day loulate that a wenty EMPLO sing the Fund vailable for a the principal ROM YOUR Pints (all photos ate ate	p with ment of the	A h our Fu tests: **LETED **LE	IN FU us, al with y at the median	To en: ULL, i. Il requithe F this st try B) f class OYER uu will eptane LL AID	e. all re e. all re irred infi und. tage of for men ified as GROUF have P FUND ind legi	ur re eques form your nbers s a m P" wi PRO-F aced r to r until	lationsh sted info ation mi applica s joining ll be cla RATA da on the egistrati	ust be ust of an " assification, but g as income assification, but principal income assification, but ust be ust b	n Nam provid provid dividua fEMPL(d as a v pal me	enco ls will DYER volun	Medica provid NY INI urage Il be p GROU tary g	ded. Place FORMA you to ro-rate JP" if h roup if	ase of TION subride for is/he at le	do no N PRO mit co the er mee east 7	atisi ot le OVIE opie first embe 70%	actory ave ar ED TH s of you three ership of the	HAT more is december and the	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the folion the required information of the required of the require	or membership wing requirer rm must be Conation. plication is in a your future nations, etc., a ll day-to-day loulate that a wenty EMPLO sing the Fund vailable for a the principal ROM YOUR Pints (all photos ate ate	p with ment OMP north associate no bene mem yees on 1 ny ex mem RESE copies	A h our Fu ties: "LETED tant; thu ciation; ecessar fits (Calaber will 5. An "El Januar cclusion; ber for NT MEI ess must	IN FU us, all with y at tegor tegor MPLC ACCE ACCE ACCE ACCE ACCE ACCE ACCE A	To en: ULL, i. Il requ the F this si ry B) f class OYER u will eptano L AID lear of	e. all re e. all re inired infi und. tage of ior men ified as GROUF have P tions pla ce prior FUND of the prior and legit	ur re eques form your nbers a a m P" wi PRO-F aced r to r until ible):	lationsh sted info ation m applica s joining sember r ll be cla RATA da on the egistrati you rec	nip with with the control of an "assified principion.	n Nam provid provid ut we dividua if as a v pal me	enco ls wil DYER volun efits.	providence of the providence o	Il Care ded. Ple FORMA you to ro-rate JP" if h roup if	ase of TION submits of the submits o	do no N PRO mit co the east 7	atisfoot le DVIE Dpie first embo 70%	actory ave ar ED TH s of you three ership of the atts fro attion	y formy sp HAT mour mon is determined the em	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid
you comply with the folion the required information of the required set of the required of the req	or membership wing requirer rm must be Conation. plication is in a your future nations, etc., a ll day-to-day loulate that a wenty EMPLO sing the Fund vailable for a the principal ROM YOUR Pints (all photos ate ate	p with ment OMP north associate no bene mem yees on 1 ny ex mem RESE copies	A h our Fu ties: "LETED tant; thu ciation; ecessar fits (Calaber will 5. An "El Januar cclusion; ber for NT MEI ess must	IN FU us, all with y at tegor tegor MPLC ACCE ACCE ACCE ACCE ACCE ACCE ACCE A	To en: ULL, i. Il requ the F this si ry B) f class OYER u will eptano L AID lear of	e. all re e. all re inired infi und. tage of ior men ified as GROUF have P tions pla ce prior FUND of the prior and legit	ur re eques form your nbers a a m P" wi PRO-F aced r to r until ible):	lationsh sted info ation m applica s joining sember r ll be cla RATA da on the egistrati you rec	nip with with the control of an "assified principion.	n Nam provid provid ut we dividua if as a v pal me	enco ls wil DYER volun efits.	providence of the providence o	Il Care ded. Ple FORMA you to ro-rate JP" if h roup if	ase of TION submits of the submits o	do no N PRO mit co the east 7	atisfoot le DVIE Dpie first embo 70%	actory ave ar ED TH s of you three ership of the atts fro attion	y formy sp HAT mour mon is determined the em	the drawaces IS NO medica iths. erived	ratio	or of E/IN orts the she s	your delete NCOM to sup e part	sec PLE ⁻ opor cipa who	ΓΕ/N t you ation	owit OT ur ap in t	thout f	OSEI tion.	of an	ng ar ıld ha ı EMF to a	d su ve Si LOYI med	ERIOL ER wh	JS ho hid

SIGNATURE OF ACCOUNT HOLDER

DATE

NAME