zb for you

BANKING | INVESTMENTS | INSURANCE

Head Office
21 Natal Road, Belgravia, Harare
Application for the
ZB HOSPITAL CASH PLAN WITH ACE EMERGENCY RESCUE SERVICES

Please tick (√) appropriate box

NEW APPLICATION ☐ AMENDMENT APPLICATION ☐

Policy No. _____

1. **PERSONAL DETAILS OF APPLICANT (PRINCIPAL MEMBER)**

FORENAMES: _____ *SURNAME:* _____

MAIDEN NAME (where applicable): _____

TITLE (Mr. /Mrs/ Ms/ Miss/Other): _____ *OCCUPATION:* _____ *MONTHLY SALARY* _____

NATIONAL REGISTRATION NUMBER | | | | | | | | | | | | | | | *(Submit copy of national Identity Card)*

DATE OF BIRTH: D D M M Y Y Y Y

MARITAL STATUS: | *Single* | *Married* | *Widowed* | *Divorced* |

RESIDENTIAL ADDRESS: _____

_____

POSTAL ADDRESS (if different)

_____

NAME AND ADDRESS OF EMPLOYER:

_____

EMAIL ADDRESS _____ *MOBILE (CELL) NUMBER* _____

HOME PHONE NO. _____ *BUSINESS PHONE NUMBER* _____

FULL NAMES & ADDRESS OF NEXT OF KIN: _____

_____

_____

2. **DETAILS OF DEPENDANTS TO BE COVERED UNDER THIS APPLICATION UP TO A MAXIMUM OF 8 (EIGHT) DEPENDANTS.**

NOTES

(a) A Dependent is a person who is related to and is wholly or almost wholly dependent on the Principal Member for support and maintenance.
(b) The Daily Hospital Cash Benefit per person should not exceed the maximum amount set by the Company from time to time, including any similar cover that has already been issued by ZB Life Assurance Limited under any other policy or contract.
(c) The Daily Hospital Cash and Emergency Rescue Benefit for a Dependent should not exceed that of the Principal Member.
(d) Proof of identity of a Dependent will be required before settlement of a claim. We recommend that you supply this proof NOW.

2.1 ZB HOSPITAL CASH BENEFIT

Surname	Forename(s)	Date of Birth	Sex (M/F	Relationship to Principal Member	National ID Number	Daily Hospital Cash	Premium (USD)	
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					Principal Member			
					PREMIUM			

2.2 ACE EMERGENCY RESCUE SERVICE BENEFIT

Surname	Forename(s)	Date of Birth	Sex (M/F)	Emergency medical rescue packages		Premium (USD)	
				Road Ambulance	Road and Air Ambulance	$	C
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		Principal Member					
				PREMIUM			
				GROSS PREMIUM			

Preferred Commencement Date D D M M Y Y Y Y

3. HEALTH DECLARATION

3.1 Have you or any of your selected dependents been hospitalized for five or more days in the past 24 months? Yes No

3.2 Are you or any of your selected dependents scheduled for any medical or surgical treatment within the next 24 months? Yes No

3.3 Are you or any of your selected dependents on prescribed medication for any ailment? Yes No

If you have answered "Yes" to any question above, please provide the relevant details below plus space on last page: -

Question No.	Full Names of Person(s) Hospitalized or Scheduled For Treatment.	Date(s)	Exact nature and details of Investigations, Test, Counselling Treatments or Consultations, duration of treatment, etc.	Name and Address of attending Doctor, Hospital, Clinic or Laboratory	Results of Examinations, Details of treatments given and, date of last symptoms.

4. DECLARATION (VERY IMPORTANT - PLEASE READ CAREFULLY)

I, the Applicant, hereby agree that this application and declaration together with any other statements and/or declaration made by me shall be the basis and form part of the contract between me and ZB Life Assurance Limited (hereinafter called "the Company"). I apply for and agree to accept a membership certificate in the form and containing the provisions ordinarily adopted by ZB Life Assurance Limited for the benefits stated in this application.

I, the Applicant, understand that the Company may vary the benefits, or increase the premiums or contributions payable to respond to inflation or morbidity or other conditions such as laws imposed in the Country.

I, the Applicant, declare that I understand and agree that the Company shall not be liable for any claims if hospitalization or life-threatening condition of the insured occurs due to natural causes before the expiry of a period of three (3) consecutive months from the date of registration of the insured, or the date of registration of a dependent if later.

I, the Applicant declare that all the answers to the questions concerning me and the above-named Dependent(s) in this application and/or any other relevant statements made by me, whether in my handwriting or not, are true and correct and that no material information has been withheld, misstated, or concealed by me. I further agree that if any material information has been withheld or any material information supplied proves to be incorrect, the contract will be invalid, and all premiums paid will be forfeited.

*APPLICANT'S SIGNATURE:*_____ *DATE:* _____

5. DECLARATION BY APPLICANT FOR ZB BANK PREMIUM DEDUCTION

I_____authorize ZB Bank to deduct the premiums stated above each month from my account when funded.

Account holder's Name_____Account Number_____

Accountholder's National Registration Number_____

ACCOUNT HOLDER'S SIGNATURE_____DATE_____

6. **Agent/Broker**

Date_____Signature of Agent _____

Name		*Agency No.*	

7. **ANY OTHER INFORMATION OR DECLARATIONS**:

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8. FOR OFFICE USE ONLY

Processed by_____Signature_____Date_____

*Reviewed by_____Signature_____Date_*

Underwritten by

zb Life Assurance Limited