

Generation Health
P.O. Box 10130,
2nd. Floor, Zimnat House
Nelson Mandela Ave./ 3rd. Street
HARARE
Website: www.sovhealth.co.zw



Administered by:
Sovereign Health (Pvt) Ltd.
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APPLICATION FOR MEMBERSHIP

All questions to be answered in full (please print)

1. Applicant's Details

Title: Mr Mrs Miss Ms Dr Prof Marital status: Single Married Divorced Widow(er)

Applicant's Surname:	First Name(s)
Date of birth:	National I.D. number: (This will be included on your membership card)
Have you ever been a member of a Fund administered by Sovereign Health? Yes No	If you answered yes, please provide your previous membership number:

2. Details of Immediate Family Members To Be Covered On Medical Aid. (Please use a separate sheet if necessary)

Surname	First Name(s)	Sex	Date of Birth	National I.D. Number	Relationship

3. Details of Other Dependents To Be Covered On Medical Aid.

Surname	First Name(s)	Sex	Date of Birth	National I.D. Number	Relationship

4. Contact Details.

Postal address					
Home address					
Telephone Numbers	Work:			Home:	
Cellphone Number					E-mail address:

5. Generation Health Medical Fund Plan Option (Please tick desired option).

Green Plan (No MSA Option)	Please indicate your Medical Savings Account contribution option for Ivory and Mahogany.				
Ebony Plan	Low	Medium	High	Super High	
Ivory Plan	Low	Medium	High	Super High	
Mahogany Plan	Low	Medium	High	Super High	

6. Effective date of Generation Health Membership: _____

7. Applicant's Signature: _____ Date: _____

PLEASE TURN OVER

8. Waiting Periods

- 8.1. Subject to the Fund Rules, applicants who are transferring direct from a Association of Healthcare Funders (AFHoZ) affiliated medical aid society may be admitted without waiting periods. Proof of previous medical aid membership must be submitted with this application.
- 8.2. Applicants joining medical aid for the first time will be subject to a general 3 month waiting period. The following condition specific waiting periods will also apply:

Six (6) Months	Nine (9) Months	Twelve (12) Months	Twenty-four (24) Months
Anti-Retroviral Therapy Programme Chronic Medication CT Scans & MRI Scans Chemotherapy Hospitalisation of a non-emergency nature Spectacles and contact lenses Specialist treatment Special appliances – nebulisers, glucometers, hearings aids, ostomy bags, etc. Planned or elective surgery.	Maternity benefits	Surgery involving internal prosthesis ARVs	Haemodialysis Chemotherapy

9. Previous medical aid membership

Name of medical aid society	Scheme/Plan	Membership number	Joining date	Termination date

10. Banking Deals

Generation Health claim refunds are deposited direct into members bank accounts using Electronic Fund Transfer (E.F.T.). Please provide your bank details to enable us to deposit your refunds into your bank account.

Name of Account Holder	Name of Bank	Branch	Branch Sort Code	Account Number

EMPLOYER INFORMATION (TO BE COMPLETED BY EMPLOYER REPRESENTATIVE)

Name of Employer:	Employer Generation Health Group Number: (if already registered with Generation Health)
Applicant's employee number:	Applicant's Employment Date:
Effective Date of Generation Health Membership:	Name of Employer Representative:
Signed on Behalf of Employer:	Date:

OFFICIAL COMPANY STAMP

FOR SOVEREIGN USE ONLY

Actioned By:	Date:
Membership Number:	Comments: