P. O. Box 1922, HARARE
Telephone 780437, 781078/9, 775144/5, 710142/4
Fax 775998
Email: emfmembership@neceng.co.zw

Membership Application Form

Please tick applicable	✓
Private	
SuperMed	
Primary	

FOR EMF USE ONLY

11	N		Day Month Year	$ c	
Delete inapplicable		Member No.	Date Effective	Member's Contribution	Employer's Code

M/F | Payment advice to Members (Y/N) | Type (A,C, R, Y) | N.E.C. Grading

COMPLETE THIS SECTION

(Mark X in Box)

Male / Female

Married / Single

MY DATE OF BIRTH

Day Month Year

ID Number

12 *(BLOCK CAPITALS PLEASE)*

MY SURNAME

MY OTHER NAMES

13 MY POSTAL ADDRESS

COMPLETE THIS SECTION FOR DEPENDANTS

FOR EMF USE ONLY

(BLOCK CAPITALS PLEASE)

13 Action	Dept. No.	Suffix	FULL NAME OF DEPENDANT	Relationship to Member	Date of Birth	Date of Marriage
N	1	1		wife		
N	2					
N	3					
N	4					
N	5					
N	6					
N	7					
N	8					
N	9					
N	A					

Note: Complete Declaration on Reverse.

Document No.: WebApp_____

MEMBERSHIP APPLICATION FORM

1

I AM EMPLOYED BY _____ Date commenced____/_____/_____

MY LAST EMPLOYER WAS_____ Date Left_____/_____/_____

ARE YOU SELF EMPLOYED? YES/NO_____ ARE YOU UNEMPLOYED? YES/NO_____

IF PREVIOUSLY COVERED BY MEDICAL AID, STATE NAME OF SOCIETY_____

DATE TO WHICH SUBSCRIPTION LAST PAID___/_____/____MEMEBERSHIP NUMBER_____

I REQUIRE MEDICAL COVER FROM DATE:_____/_____/_____

2

I AM EMPLOYED AS A_____(JOB TITLE)

*N.E.C. GRADING_____

VOLUNTARY (State nature of employment)_____

_____

_____

** Cross out which ever is inapplicable*

3

RETIRED PERSONS ONLY: Date retirement commenced_____/_____/____Membership No._____

Retired from (name of firm)_____

4

DECLARATIONS

Declaration by member

I declare the information given to be correct and that the dependent/s name is/are wholly dependant upon me. I authorize my employer to deduct from my wages/salary all subscriptions due to the Fund and any amount due, in full or in apart as agreed by the council, by Stop Order in terms of the Rules of the Fund and to pay such amounts to the council. I agree to be bound by the rules of the society

Date_____Signature_____

Employer's declaration (If applicable)
I confirm the above to be employed by me in the capacity stated and I acknowledge his/her authorisation as above.

Date commenced with firm_____ Employer's Signature_____

5

DECLARATION EMPLOYER OF COMPULSORY, SPECIAL VOLUTARY OR APPRENTICE MEMBER

This is an irrevocable undertaking that upon receipt of notification by the Fund I will make such deductions from the salary or wage of

_____ (name of applicant), add the employer's amount and transmit the total sum in the amount and in the manner required by the agreement and rules governing the Fund.

SIGNATURE_____DESIGNATION_____DATE_____

Contact Telephone;_____

Note: All membership forms to be sent to EMF, P.O. Box 1922, HARARE