Membership No…….

Business Application Form

Business to Complete	Business Name			Type of Business	
	First of Contact:			Tel No.	
	Employee Amount			WCA Number	
	Complex Name			Complex Number	
	Street Name			Street Number	
	Suburb			Town	
	Postal Code		Province		Country
	Type of Business			Type of Package	
I wish to pay by card as an annual payment		Amount	R	Receipt No.	A representative will be in contact

Employee Details

Name	Surname	ID Number	Medical Aid		Name
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	

I …….. appointed as ……. at company ……. hereby agree that the details supplied above are true to my knowledge. I also understand the terms and conditions and understand that I may view the terms and conditions on the www.nationalparamedics.co.za website and/or request the terms and conditions by emailing: members@nationalparamedics.co.za

Name	Signature	Date

CLIENT NO…… **HOUSEHOLD APPLICATION FORM**

Type of Address			OTHER:	
Client Address	Unit Number		Complex Name:	
	Road Name:		Closest Crossing	
	Suburb		Postal Code	
	Postal Address		Postal Code	

Telephone Numbers:	Cell		Landline		Other	
Email Address:					

I wish to pay by card as an annual payment	Amount	R	Receipt No.	A Representative will be in contact

Households to Complete

1	Title		Initials		First Name		Surname	
ID No.					DOB	/ /	Age	
Medical Aid			Medical Aid No.		Dependant Code			
Doctor Name			Tel Number		Other:			
NOTES:								
2	Title		Initials		First Name		Surname	
ID No.					DOB	/ /	Age	
Medical Aid			Medical Aid No.		Dependant Code			
Doctor Name			Tel Number		Other:			
NOTES:								
3	Title		Initials		First Name		Surname	
ID No.					DOB	/ /	Age	
Medical Aid			Medical Aid No.		Dependant Code			
Doctor Name			Tel Number		Other:			
NOTES:								
1	Title		Initials		First Name		Surname	
ID No.					DOB	/ /	Age	

Medical Aid		Medical Aid No.		Dependant Code	
Doctor Name		Tel Number		Other:	
NOTES:					

4	Title		Initials		First Name		Surname	
ID No.							DOB	/ /	Age	
Medical Aid		Medical Aid No.		Dependant Code	
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Doctor Name		Tel Number		Other:	
NOTES:					

5	Title		Initials		First Name		Surname	
ID No.							DOB	/ /	Age	
Medical Aid		Medical Aid No.		Dependant Code	
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Doctor Name		Tel Number		Other:	
NOTES:					