



MBF Membership Application

- You can apply for cover of up to \$800,000.
- Cover amount cannot exceed 5 times your salary.
- The Fund's Medical Adviser will generally review your health declaration.
- Payment of membership contributions by salary deduction is available for Air New Zealand pilots, please provide your employee ID where indicated.

Please Note:

- **The declaration and warranties at the end of the form - these are very important.**
- **It is essential that you are honest, truthful and thorough when you complete the following Health Declaration Form about the medical issues you have had in the past.**
- **Non-disclosure may result in no disability payments being made and the member asked to leave the Fund, or the amount of capital benefit payable reduced under the Rules.**
- **A prior health issue may not be subject to an exclusion once reviewed by the Fund's medical advisor.**



Application Summary

What are you applying for: New Membership Increase in Cover

Date: _____ Title: _____

First Name: _____ Surname: _____

Postal Address 1: _____

City: _____ Post Code: _____

Mobile Phone Number: _____

Email Address: _____

Date of Birth: _____ Age: _____

Current Employer: _____ Commencement Date: _____
(If Air NZ, please include fleet)

Gross Salary: _____ Rank: _____

Total Cover Available is five times salary (max \$800k) Amount of Cover Requested: _____

Licence Type: _____ Licence Number: _____

ALPA Membership Number: _____ ALPA Joining Date: _____

Previous Pilot Employment History: (please include dates)

Air NZ employees **only**.

Please tick if you wish to pay contributions via salary deduction and advise your employee ID number.

Air NZ Employee ID: _____



Health Declaration Form

Have you experienced or are you currently experiencing any of the following:

Health Declaration

			Comments
Eye or Vision Trouble: (includes needing glasses/lenses)	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Eye or Corneal Surgery:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Hay Fever:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Middle Ear infection:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Sinusitis:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Hearing Trouble:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Problems with Balance:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any other Ears, Nose & Throat problems or surgery:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Asthma or Wheezing:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Chronic Cough:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any Other Lung Problems:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Shortness of Breath:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Coughed or vomited blood:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Pulmonary embolism or deep vein thrombosis:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any Severe Allergy:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Heart problem:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Vascular problem:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Suffered any chest pain:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Rheumatic fever:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
High or low blood pressure:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Severe abdominal pain:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Hernia:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Oesophagus, Stomach, liver gall bladder or intestinal trouble:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Anaemia or blood disease:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Diagnosed or treated for cancer, tumour, growth or malignancy (including skin cancer):	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Headaches/migraines which have interfered in any way with daily living?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Headaches/migraines requiring medication?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Dizziness or fainting spell:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Unconsciousness for any reason:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Head injury:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Seizures or fits:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Stroke:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Paralysis:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any other neurological disorder:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____



Health Declaration Form

Have you experienced or are you currently experiencing any of the following:

			Comments
Diagnosed depression:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Anxiety disorder/panic disorder:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Learning difficulty:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Attention Deficit or hyperactivity disorder:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Post Traumatic Stress Disorder:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Suicide Attempt:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any other Mental illness:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Do you drink alcohol? If yes, how much do you drink per week? (be specific):	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Has your use of alcohol ever caused conflict in your current or past relationships?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Have you ever been identified by a health professional as having a drinking problem, which might include the use of terms such as alcohol abuse, or alcohol dependence?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Has a health professional ever expressed concern at your level of drinking?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Has a health professional ever expressed concern at your use of prescription or over the counter medications such as, but not limited to, those for pain relief, stress or sleep problems comments:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Have you ever received a conviction or formal caution for any alcohol related behaviour including drink driving, public intoxication, or disorderly conduct?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Has your alcohol consumption, or behaviour while under the influence of alcohol, ever led to a formal warning or other disciplinary procedure by your current or any past employer?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Is any action against you pending, whether by the police or your employer, in respect of any alcohol or drug related issue?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Use of legal or illegal recreational drugs or substances:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Substance dependence or substance abuse:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Muscle, bone or joint injury:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any complications arising from any treatment or surgery:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Back pain, injury or "back trouble":	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Swollen or painful joints:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Suffered any pain severe enough to be disabling:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Passed blood with or in urine or faeces:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____



Health Declaration Form

Have you experienced or are you currently experiencing any of the following:

			Comments
Kidney, bladder or prostatic disease:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Easy fatigue-ability or sleep in the day:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Have you ever been diagnosed with a sleep disorder such as obstructive sleep apnoea syndrome:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Do you snore loudly or have you ever been told you stop breathing in your sleep?:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Investigations for abnormal glucose tolerance, high blood sugar, or diabetes:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Medical Certificate for absence of 7 days or more from work:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Rejection or premium loading for life, health or loss of licence insurance:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Rejection or retirement from employment on medical grounds:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Admission to hospital, psychiatric or in patient facility:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Taken or used any type of medicine or medication or alternative medicine for more than 2 weeks:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Had a positive laboratory test for HIV infection, or have you suffered from AIDS:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Sexually transmitted disease:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Investigation for any disorder:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any major medical or surgical procedure:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Day surgery:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any other illness, disability, debility, infirmity treatment or surgery:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Breast lump or other breast problem:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Are you Male or Female:	M: <input type="checkbox"/>	F: <input type="checkbox"/>	_____
Any troubling menstrual problems:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Other gynaecological problem:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____
Any obstetric problem:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	_____



Have you experienced or are you currently experiencing any of the following:

Certification Declaration

		Comments
Has any medical certificate ever been denied, suspended or revoked within or outside of New Zealand?:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Has any assessment been deferred?:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Have you ever been convicted of any alcohol or drug-related offence including a drink driving offence, or is any action pending for such an offence?:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Have you received any Notice under Section 271 of the Civil Aviation Act? (suspension, restriction, endorsements, etc):	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Have you received any Notice under Subpart 67C of the Civil Aviation Safety Regulations (CASA) 1998? (suspension, restriction, endorsements, etc):	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Have you at any time been in receipt of a benefit from a loss of licence policy or other disability policy? If so please supply details:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Have you ever had any exclusions placed on an Insurance Policy related to your health?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Is there any other history of illness or health concern which might influence the acceptance of this application?:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____
Have you visited a health professional within the last 3 years (other than for a routine CAA medical or consultation with your certifying ME)?:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____

Family History: Have any members of your family had vascular disease, cancer, hypertension, diabetes, heart disease, psychiatric disease or neurological disease? (Please mention age):	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	_____

General Practitioner Name and Address:

GP Phone Number: _____ GP Fax Number: _____

GP Email address: _____



Declaration

I hereby declare and warrant

1. That the answers given above are in every respect true, correct and complete.
2. That I have not sustained any bodily injury or suffered from any illness which may result in the permanent or temporary loss or cancellation of my licence, medical validity certificate or other document that I am required to hold to enable me to exercise the privileges of my New Zealand Civil Aviation/CASA Certificate.
3. That I am not at the present time afflicted by any sickness disease, deafness or deterioration in health and that I have not withheld any information regarding my health and medical history.

I authorise any Medical Adviser to the New Zealand Air Line Pilots' Mutual Benefit Fund is authorised to see this application and to obtain such information as he/she shall require from the Principal Medical Officer of any Civil Aviation Licencing Authority or any medical practitioner I have consulted regarding my health.

I acknowledge and authorise that the information given in my application for membership or obtained pursuant to the above authority can be disclosed to such parties as the Trustees of the Fund or their medical adviser considers necessary to assess my entitlement to any benefit or right to continued membership of the Fund.

I understand any information obtained pursuant to this authority will be held at the office of the New Zealand Airline Pilots' Mutual Benefit Fund and I understand that I have the right of access to and correction of any information held about me.

I have read and accept the conditions above.

I, _____ HEREBY APPLY to, become a Member of OR Increase my Cover with, The New Zealand Airline Pilots' Mutual Benefit Fund.

I agree to be bound by the Rules of the Fund, and understand that reduced benefits may be applicable as specified in the Rules and that an exclusion can be applied.

Signature: _____

Date: _____

I hereby authorise my employer (if applicable) for the time being to pay direct to the Fund such sum as I am entitled to as an employer's contribution towards loss of licence Cover.

Signed: _____ Date: _____

Please send this completed form and a copy of the front and back of your medical certificate to the MBF Office at office@pilotsmbf.org.nz



Additional Comments



Office Use

Application Received: _____ Refer to Doctors: Yes No

Amount of Cover Requested: \$ _____ Doctor Exclusion Recommended: _____

Less current cover: \$ _____

Cover Available: \$ _____ COVER TO COMMENCE: _____

Subject to Rules: 2(b) 4(c) 8(e) 8(ab)

Special Conditions: 10-year abatement 80% Disability 59-year rule Rate: \$ _____

Membership Number: # _____ Accepted by Trustees: _____