



Application Summary

What are you applying For: ☐ New Membership ☐ Increase in Cover

Date: _____ Full Name: _____

Title: _____ Given Name Initials: _____

Postal Address 1: _____ Postal Address 2: _____

City: _____ Post Code: _____

Home Phone Number: _____ Home Fax Number: _____

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: _____ Amount of Cover Requested: _____

Licence Type: _____ Licence Number: _____

ALPA Membership Number: _____ ALPA Joining Date: _____

Previous Employment History: _____ Previous Employer Cover Allowance?: _____

Previous Employer Cover Details: _____

Office Use

Application Received: _____ Refer to Doctors: ☐ Yes ☐ No

Membership Number # _____ Accepted by Office: _____

Amount of Cover Requested: \$ _____ Accepted by Trustees: _____

Less current cover: \$ _____ Doctor Exclusion Recommended: _____

Cover Available: \$ _____

Certificate Issued: _____ COVER TO COMMENCE: _____



Health Declaration

			Comments
Eye or Vision Trouble:	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"/>	



			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"/>	



			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"/>	
Are you Male or Female:	M: <input type="checkbox"/>	F: <input type="checkbox"/>	
Breast lump or other breast problem:	Yes: <input type="checkbox"/>	No: <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"/>	



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: _____

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

Please email a copy of the front and back of your medical certificate to the MBF Office. The email address is office@pilotsmbf.org.nz

☐ I have read and accept the conditions above. Before this application is accepted I will sign the page that is emailed to me.



Additional Comments