MUTUAL BENEFIT FUND
PILOTS

**It is essential that you are honest, truthful and thorough when you complete the following Health Declaration Form.**

**This is to avoid a possible future claim being declined.**

**Note the declaration and warrantees at the end of the form - these are very important.**

MUTUAL BENEFIT FUND
PILOTS

Reset Form

# 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: 0 _____ 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: _____

_____

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**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: $ 0 _____ _____

Certificate Issued: _____ COVER TO COMMENCE: _____



Unit 4, Level 6, 204 Thorndon Quay, WELLINGTON; Telephone (04) 478-3632; Email: office@pilotsmbf.org.nz; Web: www.pilotsmbf.org.nz

**Health Declaration Form**
**Have you experienced or are you currently experiencing any of the following:**

# Health Declaration

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



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# Health Declaration Form

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

| | | | Comments |
|---|---|---|---|
| Diagnosed depression: | Yes:☐ | No:☐ | _____ |
| Anxiety disorder/panic disorder: | Yes:☐ | No:☐ | _____ |
| Learning difficulty: | Yes:☐ | No:☐ | _____ |
| Attention Deficit or hyperactivity disorder: | Yes:☐ | No:☐ | _____ |
| Post Traumatic Stress Disorder: | Yes:☐ | No:☐ | _____ |
| Suicide Attempt: | Yes:☐ | No:☐ | _____ |
| Any other Mental illness: | Yes:☐ | No:☐ | _____ |
| Do you drink alcohol? If yes, how much do you drink per week? (be specific): | Yes:☐ | No:☐ | _____ |
| Has your use of alcohol ever caused conflict in your current or past relationships?: | Yes:☐ | No:☐ | _____ |
| 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:☐ | No:☐ | _____ |
| Has a health professional ever expressed concern at your level of drinking?: | Yes:☐ | No:☐ | _____ |
| 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:☐ | No:☐ | _____ |
| Have you ever received a conviction or formal caution for any alcohol related behaviour including drink driving, public intoxication, or disorderly conduct?: | Yes:☐ | No:☐ | _____ |
| 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:☐ | No:☐ | _____ |
| Is any action against you pending, whether by the police or your employer, in respect of any alcohol or drug related issue?: | Yes:☐ | No:☐ | _____ |
| Use of legal or illegal recreational drugs or substances: | Yes:☐ | No:☐ | _____ |
| Substance dependence or substance abuse: | Yes:☐ | No:☐ | _____ |
| Muscle, bone or joint injury: | Yes:☐ | No:☐ | _____ |
| Any complications arising from any treatment or surgery: | Yes:☐ | No:☐ | _____ |
| Back pain, injury or "back trouble": | Yes:☐ | No:☐ | _____ |
| Swollen or painful joints: | Yes:☐ | No:☐ | _____ |
| Suffered any pain severe enough to be disabling: | Yes:☐ | No:☐ | _____ |
| Passed blood with or in urine or faeces: | Yes:☐ | No:☐ | _____ |



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# Health Declaration Form

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

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



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**Health Declaration Form**
**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:☐ | No:☐ | _____ |
| Has any assessment been deferred?: | Yes:☐ | No:☐ | _____ |
| Have you ever been convicted or any alcohol or drug-related offence including a drink driving offence, or is any action pending for such an offence?: | Yes:☐ | No:☐ | _____ |
| Have you received any Notice under Section 27I of the Civil Aviation Act ? (suspension, restriction, endorsements, etc): | Yes:☐ | No:☐ | _____ |
| Have you received any Notice under Subpart 67C of the Civil Aviation Safety Regulations (CASA) 1998? (suspension, restriction, endorsements, etc): | Yes:☐ | No:☐ | _____ |
| 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:☐ | No:☐ | _____ |
| Have you ever had any exclusions placed on an Insurance Policy related to your health? | Yes:☐ | No:☐ | _____ |
| Is there any other history of illness or health concern which might influence the acceptance of this application?: | Yes:☐ | No:☐ | _____ |
| 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:☐ | No:☐ | _____ |
| 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:☐ | No:☐ | _____ |



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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 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. 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.



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# Additional Comments



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