MUTUAL BENEFIT FUND
AIR TRAFFIC CONTROLLERS

Level 6, 204 Thorndon Quay
Pipitea
Wellington 6011
Telephone: 04 478 3632
Email: office@atcmbf.org.nz
Website: www.atcmbf.org.nz

Fund Membership No …….....

APPLICATION FOR MEMBERSHIP
To Provide Compensation for
LOSS OF CLASS 3 MEDICAL CERTIFICATE

Surname .....…..…..… Given Names .....……..... Title ……..

Address ..... Post Code …….

Contact Details: Home Ph: ……. Home Fax: ……..……..……..

Mob: ……..……..…… Email: ..……..…..……

Current Work Location ..... Current Position.…….....

ATC Licence Number .....…….. Date of Birth ..... Age ……..... (Refer Rule 3)

Work History

1. Date of issue of first ATC Licence .....…….....
2. Name of first ATC employer ….....…….....
3. Do you have broken service as an operational air traffic controller in NZ? YES/NO
4. If the answer to #3 above is yes, when did you most recently revalidate your NZ ATC Licence? .....…….....
5. If the answer to #3 above is yes, then how many years in total did you contribute to the old Loss of Licence insurance scheme and/or the MBF-ATC in NZ? .....…….....

I am/am not (delete one) a member of the NZ Air Line Pilots' Assn. My membership number is ……..

I have completed the Health Declaration attached to this application form.

I attach a copy of my Medical Certificate and endorsements (both sides please).

I hereby apply to become a full/associate (delete one) member of the New Zealand Air Line Pilots Mutual Benefit Fund - Air Traffic Controllers, and hereby agree to be bound by the Rules of the Fund.

I declare that the information provided in this application is, to the best of my knowledge, true, complete and correct.

Signed ..... **Date** ..…..….....

This will authorise payment by salary deduction from the date of acceptance direct to the Trustees of the New Zealand Air Line Pilots' Mutual Benefit Fund - Air Traffic Controllers by my employer of the sum of up to 1.50% of gross salary on my behalf for my membership of the Fund or at such other rate as may be fixed by the Trustees.

I hereby authorise the disclosure to the MBF-ATC of personal information held by any person or organisation which may be relevant to my membership or to any claim.

This authority will remain in force for the period of my membership.

Name ..... **Signature** ..... **Date** ..….....

FOR OFFICE USE ONLY

Application received.....

Accepted by Trustees .....

Type of membership Full/Associate

Referred to Medical Advisor Yes/No

Exclusions recommended by Medical Advisor

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Exclusions applied by Trustees

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Notification of exclusion to applicant.....

Commencement of cover.....