September 2017

registration of my dependant(s)

For office use only							
Membership number							
	M	H					

Enquiries: 086 0100 678
Fax: 012 336 9534 **Email:** newbusiness@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007

For use by corporate clients

Payroll number

Employer's office stamp

How to complete this form:

1. Please complete in print using black ink and email, fax or post all pages of the form to Medihelp.
2. Please complete all sections in full and sign the application form.
3. Never sign a blank application form.

1. Details of member

Member number | Initials | Title: Mr | Mrs | Ms | Other (specify)

First names

Surname

Cell No. | Tel: (W) Code | No.

Tel: (H) Code | No.

Email address

Marital status

Married in community of property	Married out of community of property	Single	Divorced	Widow	Widower	Other (specify)

Date of marriage y y y y m m d d

2. Date on which my dependant(s) should be registered 2 0 y y m m d d

3. Details of dependant(s) I wish to register

The following dependants of a member may be registered:

- Spouse/partner.
- Father/mother/brothers/sisters/grandchildren of the member and whose financial care is entrusted to the member (**PLEASE NOTE:** these dependant(s) of the spouse/partner cannot be registered as dependant(s) of the member, and grandchildren of the member pay the same subscription as that of an adult dependant, unless legally adopted).
- Dependent own children (of the member and spouse/partner).
- Dependent stepchildren (of the member and spouse/partner).
- Adopted children/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement (of the member and spouse/partner). Official proof of the Court/clerk of the Court/appointed social worker must be provided in terms of the set criteria determined by Medihelp – foster children and children in temporary safe care may be registered as dependant(s) only up to the age of 21 years in terms of legislation.
- In the case of dependant(s) who are not South African citizens, a copy of their passport must be submitted with the completed application form.

Dependant (spouse/partner)

Surname

First names in full

Known as

ID/passport number | Gender: Male | Female

Date of birth y y y y m m d d | Cell number

Email address

Relationship to member

3. Details of dependant(s) I wish to register (continued)

Dependant

Surname

First names in full

Known as

ID/passport number Gender Male Female

Date of birth y y y y m m d d Cell number

Email address

Relationship to member

Dependant

Surname

First names in full

Known as

ID/passport number Gender Male Female

Date of birth y y y y m m d d Cell number

Email address

Relationship to member

Dependant

Surname

First names in full

Known as

ID/passport number Gender Male Female

Date of birth y y y y m m d d Cell number

Email address

Relationship to member

4. Gross monthly income – Necesse only

Gross monthly income of member Occupation of member

Gross monthly income of spouse/partner Occupation of spouse/partner

For the purpose of the Necesse benefit option, "monthly income" means the gross monthly income before any deductions.

Proof of income must only be provided if the monthly income of both the member and the registered spouse/partner is less than the highest income category, since Medihelp will use the highest of the incomes declared to determine the subscription category.

Acceptable proof of income

Income from investments:
This income must be declared by all individuals, if applicable, and includes interest, dividends and rental income.
- Letter from an auditor/accountant/income tax adviser
- Latest tax assessment – ITA34
- IT3(a) and past **three** months' bank statements
- Rental income – rental agreement and past **three** months' bank statements

Income from full-time employment:
Gross monthly income includes all forms of remuneration, such as basic salary, overtime, commission, bonuses, allowances, fringe benefits and one-off payments.
- Past **three** months' official payslips
- Latest tax assessment – ITA34
- IRP5 of the previous tax year
- Past **three** months' commission and bank statements

4. Gross monthly income – Necesse only (continued)

Pensioners: (Pension, annuity)
- Latest tax assessment – ITA34
- Past three months' pension payment advices and additional proof

Own business: (Income from vocation/profession, total income from business, irregular income)
- Latest tax assessment – ITA34
- Letter from an auditor/accountant/income tax adviser

Unemployed:
Individuals who receive no income from a vocation/profession/business, who are unemployed or receive an allowance.
- UIF payments

Employer groups:
- Any proof of income applicable to individuals as indicated above

Full-time students:
- A notice or letter on an official letterhead from the tertiary institution where you are registered as a full-time student, confirming your registration
- Proof of income applicable to individuals

Important:
- If no acceptable proof of income can be provided, your subscription will be calculated according to the highest income category.
- Medihelp may require additional proof other than the above.
- Only official bank statements on which the account holder's initials and surname are indicated, are acceptable. Please indicate clearly on the bank statements which payment(s) refer to your income.

5. My dependant's(s') previous/current membership of medical scheme(s)

5.1 Has this application been necessitated by a change in employment which resulted in the cancellation of your dependant's(s') membership of a previous medical scheme? (Not applicable to employees who have retired and are entitled to remain at their previous/current medical scheme.)

Yes	No

Who was the member of the previous scheme? Name and surname

5.2 **Please provide details of ALL the medical schemes where your dependant(s) are currently or have previously been enrolled:**

NB:
- The date joined and date ended is important to place your dependant(s) in the correct enrolment category.
- Indicate "current" if your dependant's(s') membership of the particular scheme is still active.
- Ensure that the dates of your dependant's(s') membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated separately for each of your dependant(s).

Name of medical scheme*	Name and surname*	Membership number	Date joined*	Date ended*

* This information is compulsory. If not completed, your application to register your dependant(s) cannot be finalised.

5. My dependant's(s') previous/current membership of medical scheme(s) (continued)

5.3 Did your dependant's(s') previous medical scheme apply any late-joiner penalty?

Yes	No

If "Yes", please provide the following details:

Name of dependant(s)	Late-joiner penalty			
	5%	25%	50%	75%
	5%	25%	50%	75%
	5%	25%	50%	75%

5.4 Did your dependant's(s') previous medical scheme apply any condition-specific waiting period and was it still active at the time of termination of membership? (The treatment of a specific condition was excluded from benefits for a certain period.)

Yes	No

If "Yes", please provide the following details:

Name of dependant(s)	Condition-specific waiting period (CSW)	End date of CSW							
		y	y	y	y	m	m	d	d
		y	y	y	y	m	m	d	d
		y	y	y	y	m	m	d	d

If the space provided is insufficient, please provide additional information on a separate page.

6. Medical questionnaire

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **If the space provided is insufficient, please provide additional information on a separate page.**

NB: Please complete the following questionnaire to indicate whether your dependant(s) mentioned on this application form have a history of any of the following medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

Mark with an "X"

1. Muscle and skeletal/bone system, brain, nerve and skin conditions (e.g. back and neck problems, including injuries, arthritis, gout, multiple sclerosis, hip and knee problems, osteoporosis, dermatitis, stroke, epilepsy, paralysis, tremors)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

2. Gastrointestinal system (e.g. gastro-oesophageal reflux, heartburn, ulcer, Crohn's disease, ulcerative colitis, diverticulitis, spastic colon, liver conditions, hernias, piles)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

6. Medial questionnaire (continued)

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **If the space provided is insufficient, please provide additional information on a separate page.**

NB: Please complete the following questionnaire to indicate whether your dependant(s) mentioned on this application form have a history of any of the following medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

Mark with an "X"

3. Urinary tract system and/or genital disorders (e.g. kidney stones, renal failure, dialysis, prostate disorders, endometriosis, ovarian cysts, menstrual disorders, pelvic inflammatory conditions, miscarriages)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

4. Chronic illness (e.g. elevated cholesterol, chest pain, heart diseases, pacemaker, diabetes, high blood pressure, asthma, bronchitis, obstructive lung disease, emphysema, systemic lupus erythematosus, thyroid, porphyria)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

5. Is any female beneficiary indicated in this application currently pregnant or is pregnancy suspected?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

6. Blood conditions/disorders and/or any type of cancer (e.g. haemophilia, leukaemia, lymphoma, tissue-specific cancers)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

6. Medical questionnaire (continued)

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **If the space provided is insufficient, please provide additional information on a separate page.**

NB: Please complete the following questionnaire to indicate whether your dependant(s) mentioned on this application form have a history of any of the following medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

Mark with an "X"

7. Psychiatric conditions and/or any substance dependency (e.g. depression, bipolar mood disorder, stress, panic attacks, alcohol and/or drug abuse)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

8. Any disorder of the ears, nose, throat, eyes and/or teeth (e.g. glaucoma, cataracts, glasses or contact lenses, deafness, retinal conditions, orthodontics, crowns and bridges, maxillofacial and oral surgery)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

9. If your dependant(s) are **HIV positive or have Aids**, you must phone Medihelp on **086 014 3258** within 21 days from your dependant's(s') enrolment date to register them on Medihelp's HIV/Aids programme. Should you fail to adhere to this condition, it will be considered as the non-disclosure of information, which may result in the termination of your membership. On receipt of this request, Medihelp will determine whether underwriting conditions should be applied and if so, you will receive an amended Proof of membership document.

10. Are your dependant(s) planning to have any examination, treatment and/or procedure done in the next 12 months?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

11. Has any person indicated in this application ever been examined (e.g. medical tests, X-rays, scans), diagnosed and/or treated (with/without procedures) for any condition or disorder **not** mentioned in the medical questionnaire (including medicine bought without prescription) that could potentially result in a medical claim in the next 12 months?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

Please note that this medical questionnaire does not constitute an application to register or authorise chronic medicine/PMB services/planned procedures/ treatment for benefits. Should you need to obtain authorisation for chronic medicine, please phone Medihelp on 086 0100 678 once your dependant's(s') membership of Medihelp has been finalised, to obtain an application form for chronic medicine benefits. Alternatively, you can download an application form from the Medihelp secured website for members at www.medihelp.co.za.

7. Conditions of membership, declaration by member/dependant and consent for Medihelp to process personal information

Medihelp confirms that –

1. your and your registered dependant's(s') personal and medical information will be treated confidentially and will not be sold to a third party or used for commercial or related purposes;
2. security measures have been implemented to protect your data and that Medihelp staff and contracted parties have access to your data to process and pay claims, among other things, and that they have signed a confidentiality agreement in terms of which they undertake not to disclose your personal information to any unauthorised parties;
3. your personal information will only be used for purposes such as processing your application for the registration of your dependant(s), paying your medical claims, determining whether you are entitled to benefits, managing risks, and for any communication purposes;
4. the Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy; and
5. should you make use of a Medihelp contracted brokerage's services, then relevant membership information will be made available to the appointed brokerage in order to render a service to you, and any authorised person at the brokerage may instruct Medihelp to change any of your personal information, except for banking details, unless you instruct Medihelp otherwise.

Your responsibilities as a member/dependant of Medihelp:

6. I will ensure that I know all the provisions of Medihelp's Rules and will read all the correspondence from Medihelp, such as newsletters and statements, and I will study my benefit guide and familiarise myself with the coverage offered by the benefit option that I have chosen.
7. I undertake to abide by the Rules, as amended from time to time and available at www.medihelp.co.za on the secured website for members, and to not submit any fraudulent claims or commit any fraudulent acts. I understand that on approval of my application for the registration of my dependant(s), the Rules of Medihelp will be binding on my registered dependant(s), as the Rules are binding on me.
8. By signing this application I confirm that I have the right to apply for the registration of my dependant(s) and to act for those that I apply for, in any matter relating to this application.
9. I declare that the information provided in this application for the registration of my dependant(s) is accurate and complete. I understand that any false declaration or omission of information may result in the termination of my membership and that of my registered dependant(s) or any other measures which Medihelp, in its sole discretion, may decide to take, subject to appeal procedures. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependant(s), even if this application was completed by my financial adviser, or any other third party on my behalf. **I undertake to notify Medihelp in writing should there be any changes in the health status of my dependant(s) after my application for the registration of my dependant(s) has been submitted but prior to their membership commencement date. I undertake to notify Medihelp in writing should there be any future changes in my personal and/or banking details and I understand that any non-adherence hereto may result in my membership being terminated in accordance with provisions of the Medical Schemes Act and Medihelp's registered Rules.**
10. I understand that this application form is valid for a period of 30 days from the date of signature. The period may be further extended, subject to Medihelp's discretion, up to a maximum of 90 days, whereafter the application form will be cancelled and I will be required to submit a new application form.
11. I confirm that my dependant(s) will not be registered as beneficiaries of another registered medical scheme on the date on which I request their registration at Medihelp.
12. I take note that the monthly subscription fees will be due as per arrangement with Medihelp and thereafter on the same day of every subsequent calendar month. Should my employer, as my authorised agent, undertake to pay my subscriptions to Medihelp, I give permission to my employer to deduct the amount payable to Medihelp from my salary and pay such amount over to Medihelp. I furthermore give permission that Medihelp may provide the following information to my employer in order to pay subscriptions: my identity number, my tax certificate information, as well as my dependant's(s') dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account should I terminate my membership of Medihelp.
13. I confirm that I am responsible to give advance notice of termination of membership, and that my dependant(s) will not be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

7. Conditions of membership, declaration by member/dependant and consent for Medihelp to process personal information (continued)

Medihelp's rights as a medical scheme:

14. I am aware that a 3-month general and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on the membership of my registered dependant(s) in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise their membership without issuing a document containing the conditions of their membership in the event that no waiting period and/or late-joiner penalty is imposed.
15. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid in respect of particular services, for example by enforcing co-payments and exclusions.
16. Medihelp's Rules may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and designated service providers.
17. Medihelp may also restrict interchanges between benefit options to the beginning of a year, and require a notice period as set out in the Rules.
18. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
19. I am further aware that my membership may be suspended should I not pay my contributions or debt in full for a period of one month, and that my membership may be terminated should I be in arrears for a period of two months, and that my account will be handed over for collection.
20. I am aware that Medihelp may increase its subscriptions annually at the beginning of the year.

Protection of information:

21. By signing this form, I give permission for Medihelp to share personal information, as defined in the Protection of Personal Information Act 4 of 2013, with any third party as nominated by Medihelp.
22. I hereby give permission, and declare that I have obtained the consent of my dependant(s), that –

22.1 Medihelp may enquire about the health status of my dependant(s) at any medical doctor or any person who is in possession of such information,and give permission for the doctor or person concerned to make such information available to Medihelp and its contracted third parties;

22.2 my dependant(s) may enquire about my personal and medical information and that of any of my dependant(s) at Medihelp's disposal;

22.3 an adviser in the service of a Medihelp contracted brokerage, should I make such an appointment and use their services, may have access to my personal and medical information and that of any of my registered dependant(s) at Medihelp's disposal, and that such adviser or an authorised person at the brokerage may instruct Medihelp to change any of my personal information except for my banking details; and

22.4 Medihelp may disclose my and my dependant's(s') medical and personal information to medical service providers for the purpose of delivering medical services to me and my dependant(s) and to pay for such services.

23. I understand that the information contemplated in paragraph 22 will only be used for the purposes as set out in Medihelp's confidentiality statement (on this application form) and that any deviation will be regarded as a breach of confidence. Should Medihelp wish to use the information for any other purpose, Medihelp must first obtain my approval.
24. I agree that all my telephone conversations and/or that of my dependant(s) with Medihelp and/or its contracted third parties may be recorded.
25. I agree that Medihelp may, for the purpose of considering my application for the registration of my dependant(s) or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependant(s) from medical practitioners, financial advisers, industry regulatory bodies or employers.

7. Conditions of membership, declaration by member/dependant and consent for Medihelp to process personal information (continued)

26. I further consent, and declare that I have obtained the consent of my dependant(s), that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependant's(s') consumer credit record, including and not limited to information about my/my dependant's(s') credit history, financial history, personal information (excluding medical information) and judgment or default history.

Signature of member

Date 2 0 y y m m d d

Should you be applying on behalf of another person as guardian or curator, please complete the following:

In your capacity as Member Guardian Curator

ID/passport number

Title Mr Mrs Ms Other (specify)

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator, must accompany this application.

First name

Surname

Tel: Code No.

Fax: Code No.

Cell number

8. Undertaking and declaration by adviser

NB: If this section is not completed in full by the adviser, no commission will be paid.

I declare that –

1. the member has appointed me as his/her adviser and is entitled to cancel my services at any time;
2. I have signed a valid contract with my Medihelp contracted brokerage; and
3. the member has signed the application in person.

I take note that the adviser/brokerage indemnifies Medihelp against any non-adherence to the legal requirements as quoted above.

Name of brokerage

Brokerage code A

Adviser code

Name and surname of adviser

Tel: Code No.

Fax: Code No.

Email address

Signature of adviser

Date 2 0 y y m m d d

Lead reference number

In case of a dispute, the registered Rules of Medihelp will apply.

Additional information (if necessary)

Membership number								Title	Mr	Mrs	Ms	Other (specify)

Initials		Surname	

Additional information (if necessary)

Medihelp
Enquiries: 086 0100 678
Fax: 012 336 9534
Email: newbusiness@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007
Website: www.medihelp.co.za

Council for Medical Schemes
Enquiries: 086 1123 267
Website: www.medicalschemes.com

Medihelp is an authorised financial services provider (FSP No 15738)

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