Medihelp application form 2020
Corporate

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

Thank you for choosing to join Medihelp medical scheme.

Important information

Please use this form only in the following cases- in all other cases, please complete Medihelp's Application Form - Corporate (form 4220):

- Membership must be obtained from the date of appointment as per the agreed group underwriting policy and;
- Enrolment must take effect from 1 January and there must be no break in the applicant's coverage at the previous scheme prior to joining Medihelp.
- **Please attach proof of current membership.**

1. Date from when membership is required

2	0	y	y	m	m	d	d

2. Details of applicant (person who requests membership)

ID/passport number ______________

Title

Mr	Mrs	Ms	Other (specify)

A copy of your passport must be attached if you use your passport number.

Surname ______________ Initials ______________

First names ______________ Gender

Male	Female

______________ Known as ______________

Marital status

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

Date of birth

y	y	y	y	m	m	d	d

Date of marriage

y	y	y	y	m	m	d	d

Income tax number ______________

Language

Afrikaans	English

3. Contact details of applicant

Residential address ______________

____

______________ Code ______

Tel: (W) Code ______ No. ______________

Tel: (H) Code ______ No. ______________

Fax: Code ______ No. ______________

Postal address ______________

____

______________ Code ______

Cell No. ______________

Email address ______________

May Medihelp use your/your dependant's(s') personal details to determine the quality of our service?

Yes	No

To improve the quality of our communication to you, please indicate if the following is applicable to you:

Visually impaired

Yes	No

Hearing impaired

Yes	No

4. Details of employer/institution responsible for paying your subscriptions

NB: Complete only if subscriptions are paid in full or partially by your employer or any other institution.

Name of employer/institution ______________

Campus/site ______________

Branch code/Employer group No. ______________

Payroll number ______________

Appointment date

y	y	y	y	m	m	d	d

Appointment

Permanent	Temporary

Pay area ______________

Office stamp of employer

5. Choice of benefit option (choose only one benefit option by marking with an "X" at 5.1)

5.1 Benefit options

Note: If you choose any of the savings options, please refer to section 5.2 and if you choose any of the network options (including Necesse), please refer to section 5.3.

- [ ] Prime 1 | Hospital plan
- [ ] Prime 1 Network | Hospital plan
- [ ] Prime 2 | Savings
- [ ] Prime 2 Network | Savings
- [ ] Prime 3 | Comprehensive
- [ ] Prime 3 Network | Comprehensive
- [ ] Elite | Comprehensive
- [ ] Plus | Comprehensive
- [ ] Necesse | Network
- [ ] Unify | Savings

5.2 Utilisation of savings account funds (Prime 2, Prime 2 Network and Unify)

Please indicate your preference. If you do not select an option, Medihelp will pay all qualifying medical expenses from your savings account.

- Pay all qualifying medical expenses from my savings account. ☐
- Pay only selective qualifying medical expenses from my savings account, excluding certain in-hospital expenses (e.g. tariff reductions, co-payments, amounts exceeding available benefits). ☐

5.3 Declaration by applicants who apply for enrolment on a network option (including Necesse)

I confirm that I am aware of the following:

1. I will be liable for co-payments if I do not use Medihelp's hospital network, designated service providers (DSPs) and formulary medicine.
2. I must register my prescribed minimum benefit (PMB) condition with Medihelp and my PMB chronic medicine must be pre-authorised by Medihelp. Medihelp uses a DSP for PMB chronic medicine and a formulary applies. I will be responsible for a co-payment* on my PMB chronic medicine should I fail to obtain this medicine from the DSP or deviate from the formulary for my benefit option.
3. My treating specialists should form part of Medihelp's DSP specialist network in order to prevent co-payments on PMB treatments.
4. I must use Medihelp's hospital network for all planned hospital admissions. If there is no network hospital available near my place of residence, I will need to travel to the nearest network hospital to obtain medical services. If I use a non-network hospital instead, I will be liable for a co-payment*.

*** Please refer to your benefit option's guide/brochure for all applicable co-payments.**

Signature of applicant		Date	2	0	y	y	m	m	d	d

6. Details of dependant(s) you wish to register

The following dependants of an applicant may be registered:

- Spouse/partner.
- Father/mother/brothers/sisters/grandchildren of the applicant and whose financial care is entrusted to the applicant (**PLEASE NOTE**: these dependants of the spouse/partner cannot be registered as dependants of the applicant, and grandchildren of the applicant pay the same subscription as that of an adult dependant, unless legally adopted).
- Dependent own children (of the applicant and spouse/partner).
- Dependent stepchildren (of the applicant and spouse/partner).
- Adopted children/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement (of the applicant 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 dependants only up to the age of 21 years in terms of legislation.
- In the case of dependants who are not South African citizens, a copy of their passport must be submitted with the completed application

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 No. | | | | | | | | | | |

Email address ______________________________

Relationship to applicant ______________________________

6. Details of dependant(s) you 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 No.

Email address ______

Relationship to applicant ______

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 No.

Email address ______

Relationship to applicant ______

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 No.

Email address ______

Relationship to applicant ______

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 No.

Email address ______

Relationship to applicant ______

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 No.

Email address ______

Relationship to applicant ______

7. Banking details for credit refunds and recovery of subscriptions

Bank ______________________________

Branch ______________________________

Branch code ☐☐☐☐☐☐☐☐☐☐☐

Type of account ______________________________

Name of account holder ______________________________

Account number ______________________________

This account will be used both for the recovery of subscriptions and for refunding credit amounts. In case of a trust, a copy of the trust deed must be submitted and the responsible trustee must sign.

Signature of account holder for credit refunds and recovery of subscriptions

8. Medical questionnaire

8.1 If you or any of your dependant(s) are **HIV positive or have AIDS**, it will be your responsibility to inform the Scheme and to enrol on Medihelp's HIV/AIDS programme within 21 days from your enrolment date by phoning LifeSense on 0860 50 60 80. If 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.

Should you need to obtain authorisation for chronic medicine, please phone Medihelp on 086 0100 678 once your 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 website at www.medihelp.co.za by logging on to the secured website for members.

9. Conditions of membership, declaration by applicant 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 membership, 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 your banking details, unless you instruct Medihelp otherwise.

Your responsibilities as a member 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.
8. I declare that the information provided in this application for membership 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 my health status or that of my dependants after my application for membership has been submitted but prior to my membership commencement date. I confirm that the residential address stated on page 1 is the address that I choose for the purpose of serving any legal documentation. I undertake to notify Medihelp in writing should there be any future changes in my personal details 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.**

9. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information (continued)

9. 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 60 days, whereafter the application form will be cancelled and I will be required to submit a new application form.

10. I confirm that neither my dependant(s) nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.

11. I take note that the monthly subscription fees will be due on the date selected by me at Section 7 of this application form or on the first workday after this date, and thereafter on the same day of every subsequent calendar month. Should my employer/institution, as my authorised agent, undertake to pay my subscriptions to Medihelp, I give permission to my employer/institution 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/institution 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.

12. I confirm that I am responsible to give advance notice of termination of membership, and that neither my dependant(s) nor I will be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

Medihelp's rights as a medical scheme:

13. I am aware that a three-month general waiting period and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on my membership and that of my registered dependant(s) in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise my membership without issuing a document containing the conditions of my membership in the event that no waiting period and/or late-joiner penalty is imposed.

14. 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.

15. 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.

16. 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.

17. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.

18. 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.

19. I am aware that Medihelp may increase its subscriptions annually at the beginning of the year.

Protection of information:

20. I hereby give permission, and declare that I have obtained the consent of all my dependant(s), that –

20.1 Medihelp may enquire about my health status or that 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 for the administration of my health plan;

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

20.3 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 for the purpose of proper administration and underwriting, except for my banking details;

20.4 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 dependants and to pay for such services; and

20.5 Medihelp may share my information for statistical analysis and academic research purposes.

21. I understand that the information contemplated in paragraph 20 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.

22. 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 for quality control purposes and to help detect and prevent fraud.

23. I agree that Medihelp may, for the purpose of considering my application for membership 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/institutions.

9. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information (continued)

24. 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 applicant

Date 2 0 y y m m d d

10. 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 applicant 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 applicant 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

For office use only

Lead reference number

M H

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 ______________________