Registration of my dependants

Enquiries: 086 0100 678
Email: newbusiness@medihelp.co.za
www.medihelp.co.za

For use by corporate clients

Payroll number

Employer's office stamp

How to complete this form

- You can use the editable PDF form and add your signature electronically before you email it to us. Printed forms must be completed in print using black ink. Please make sure to email or post all pages of the form to Medihelp. For your convenience, you can complete the form on the Member Zone at https://toolbox.medihelp.co.za/login.
- Please complete all sections in full and sign the application form. Incomplete information may delay the application process.
- Never sign a blank application form.

The next steps after we receive your application

- Medihelp will contact you should any details be omitted on the application form or if additional information is required.
- If we offer your dependants membership under the standard terms, their membership will be activated without issuing enrolment conditions.
- If we offer your dependants membership under any non-standard terms (waiting periods and/or late-joiner penalties) we will notify you and/or your adviser by letter and stipulate the conditions that will apply. If you accept these terms, you must sign the letter and return it to us, after which we will activate your dependants' membership.
- You will be notified when your application has been finalised.

1. Your information (member that registers dependant)

Member number

ID/passport number

Title: Mr | Mrs | Ms | Other (specify)

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

First names in full

Surname

Telephone number (W) Telephone number (H)

Cell phone number*

Personal email address*

* This information is compulsory and is required to communicate important information to you about your rights, benefits, and duties as a member. If not completed, your application for membership cannot be finalised.

Marital status	Married in community of property/ customary marriage	Married out of community of property	Single/ not married	Engaged/ cohabitant/ life partner	Divorced	Widow/ widower	Other (specify)

Date of marriage y y y y m m d d

Please indicate your race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

2. Date on which my dependants' cover should start

2 0 y y m m d d

Please note that no person may be enrolled as a member/dependant of Medihelp while such person is a beneficiary of another medical scheme. Refer to paragraph 11 of Section 6 of this application form.

3. Details of dependants I wish to register

You may register the following persons as dependants:

- Spouse/partner
- Own children of the applicant and spouse/partner
- Stepchildren of the applicant and spouse/partner
- Adopted children or in the process of adoption/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner

If any of the following persons are dependent on the applicant for family care and support, they may be registered as dependants:

- Father/mother/brother/sister of the applicant
- Grandchildren of the applicant

PLEASE NOTE

- Grandchildren of the applicant pay the same contribution as that of an adult dependant, unless legally adopted.
- 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.

The following persons may not be registered as dependants of the applicant:

- Stepbrothers and stepsisters
- Step-grandchildren
- Stepparents
- Grandchildren of the applicant's partner
- In-laws
- Godchildren
- Cousins

We require the following supporting documents to ensure your quick enrolment:*

Dependants	Document required
• Adopted children or children in the process of adoption/ foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner.	• Legal documentation confirming that the child was adopted or in the process of adoption/placed in foster care/temporary safe care of the applicant. • Official proof of the Court, clerk of the Court or appointed social worker must be provided in terms of the set criteria determined by Medihelp.
• Child (if surname differs from the applicant's surname).	• Unabridged birth certificate confirming the birth parents of the child.

* This information is compulsory. If not submitted, your application for membership cannot be finalised.

Spouse/partner (complete only if applying for registration as a dependant)

Surname ______________________ Title | Mr | Mrs | Ms | Other (specify) |

First names in full ______________________

Known as ______________________

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

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

Email address ______________________

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired | Yes | No | Hearing impaired | Yes | No |

* If "Yes", refer to the medical questionnaire in Section 5.2 for more details.

Relationship to applicant (please select **one** by marking with an X) Spouse ☐ Partner ☐

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", provide your dependant's residential address.

House/unit number and building name ______________________ House/building number and street name ______________________

Suburb ______________________ City ______________________

Province ______________________ Postal code | | | | |

3. Details of dependants I wish to register (continued)

Dependant 2

Surname ____________ Title: Mr | Mrs | Ms | Other (specify)

First names in full ____________

Known as ____________

ID/passport number ____________ Gender: Male | Female

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

Email address ____________

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired: Yes | No Hearing impaired: Yes | No

* If "Yes", refer to the medical questionnaire in Section 5.2 for more details.

Relationship to applicant (please select **one** by marking with an X)

Child dependant: Own child; Child born in terms of a surrogate motherhood agreement; Adopted child; Stepchild; Foster child; Child in temporary safe care

Other relative: Grandchild; Brother; Mother; Sister; Father

If you have marked one of the options at **"Other relative"** and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), indicate the following:

Married? Yes | No Financially dependent on you? Yes | No

Does the dependant earn an income? Yes | No If so, how much does the dependant earn per month? R ____________

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

Black; Coloured; Indian/Asian; White; Other

Is this dependant's residential address the same as the principal member's residential address? Yes | No

If "No", provide your dependant's residential address.

House/unit number and building name ____________ House/building number and street name ____________

Suburb ____________ City ____________

Province ____________ Postal code ____________

Dependant 3

Surname ____________ Title: Mr | Mrs | Ms | Other (specify)

First names in full ____________

Known as ____________

ID/passport number ____________ Gender: Male | Female

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

Email address ____________

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired: Yes | No Hearing impaired: Yes | No

* If "Yes", refer to the medical questionnaire in Section 5.2 for more details.

Relationship to applicant (please select **one** by marking with an X)

Child dependant: Own child; Child born in terms of a surrogate motherhood agreement; Adopted child; Stepchild; Foster child; Child in temporary safe care

Other relative: Grandchild; Brother; Mother; Sister; Father

3. Details of dependants I wish to register (continued)

Dependant 3 (continued)

If you have marked one of the options at **"Other relative"** and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), indicate the following:

Married? Yes No Financially dependent on you? Yes No

Does the dependant earn an income? Yes No If so, how much does the dependant earn per month? R

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

Is this dependant's residential address the same as the principal member's residential address? Yes No

If "No", provide your dependant's residential address.

House/unit number and building name House/building number and street name

Suburb City

Province Postal code

Dependant 4

Surname Title Mr Mrs Ms Other (specify)

First names in full

Known as

ID/passport number Gender Male Female

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

Email address

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired Yes No Hearing impaired Yes No

* If "Yes", refer to the medical questionnaire in Section 5.2 for more details.

Relationship to applicant (please select **one** by marking with an X)

Child dependant

- Own child
- Child born in terms of a surrogate motherhood agreement
- Adopted child
- Stepchild
- Foster child
- Child in temporary safe care

Other relative

- Grandchild
- Brother
- Mother
- Sister
- Father

If you have marked one of the options at **"Other relative"** and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), indicate the following:

Married? Yes No Financially dependent on you? Yes No

Does the dependant earn an income? Yes No If so, how much does the dependant earn per month? R

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

Is this dependant's residential address the same as the principal member's residential address? Yes No

If "No", provide your dependant's residential address.

House/unit number and building name House/building number and street name

Suburb City

Province Postal code

4. Previous and/or current membership of medical schemes

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

Yes	No

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

4.2 Please provide details of ALL the medical schemes where your dependants are currently or have previously been enrolled:

NB:
- The date joined and date ended are important to place your dependants in the correct enrolment category.
- Indicate "current" if your dependants' membership of the particular scheme is still active
- Ensure that the dates of your dependants' membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated separately for each of your dependants.
- The Medical Schemes Act makes provision for a late-joiner penalty (LJP) to be imposed on an applicant who is 35 years or older at the time of joining a scheme and has not enjoyed previous coverage with a medical aid. The penalty, which is added to the member's monthly contribution, is calculated as a percentage of the member's contribution based on the total number of years without creditable coverage since the age of 35 years, as shown below:

LJP intervals and penalty percentages

1 – 4 years	5%	of the contribution of the beneficiary (excluding savings account contribution)
5 –14 years	25%	
15 – 24 years	50%	
25 years +	75%	

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

* This information is compulsory. If not completed, your application for membership cannot be finalised.

4.3 Did your dependants' previous medical scheme apply a late-joiner penalty?

Yes	No

If "Yes", provide the following details:

Name of applicant/dependant	Late-joiner penalty			
	5%	25%	50%	75%
	5%	25%	50%	75%
	5%	25%	50%	75%

4.4 Did your dependants' previous medical scheme apply any condition-specific waiting periods and were these 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", provide the following details:

Name of applicant/dependant	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

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

5. Medical history

- Please ensure that you have completed **Section 4** of this application form in full.
- To ensure quick and easy enrolment, please complete **Section 5.1.**
- If you answered "Yes" to any of the questions in Section 5.1, please complete the full medical questionnaire in **Section 5.2.**

NB: Medihelp will review all requests for hospital admission or chronic medicine authorisation made by dependants during their first year of membership before we authorise benefits. If we find that you did not complete your application form in full, had withheld information or provided inaccurate details, we may terminate your dependants' membership.

Doctors consulted in the past 12 months

If your dependants have consulted a doctor in the past 12 months, please provide us with the details:

Name and surname ________________

Telephone number (W) | | | | | | | | | | | How long has he or she been your doctor (in years)? | | |

Name and surname ________________

Telephone number (W) | | | | | | | | | | | How long has he or she been your doctor (in years)? | | |

Name and surname ________________

Telephone number (W) | | | | | | | | | | | How long has he or she been your doctor (in years)? | | |

5.1 Short medical questionnaire

	Question	Mark with an "X"	
1.	Have any of your dependants been admitted to hospital and/or diagnosed with an illness within the last 12 months prior to submitting this application? If "Yes", please complete **Section 5.2**.	Yes	No
2.	Are any of your dependants currently taking or should be taking regular and/or ongoing medicine, including homeopathic, natural or over-the-counter medication, and/or receiving treatment for a medical condition or symptom? (Please take note of question 18 in Section 5.2). If "Yes", please complete **Section 5.2.**	Yes	No
3.	Are any of your dependants currently pregnant, suspect pregnancy or undergoing testing for pregnancy, and/or currently in hospital and/or aware of or planning to have any test, examination, treatment and/or procedure done, and/or obtaining medical advice that could result in a claim in the next 12 months? If "Yes", please complete **Section 5.2.**	Yes	No

5.2 Full medical questionnaire

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 get authorisation for chronic medicine, please call Medihelp on 086 0100 678 once your membership of Medihelp has been finalised, to get 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, the Member Zone.

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

1. Cancer, non-cancerous growths and related test results

Cancer or tumours of any organ or skin, cancerous tumours, non-cancerous tumours, (also list if removed and enter removal date under last follow-up). **Examples:** blood-related cancers, lymphoma, leukaemia, skin lesions, warts or moles, breast disease, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal Pap smear result, abnormal prostate-specific antigen result, any other abnormal cancer screening or diagnostic test result.

Yes | No

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

5.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

2. Blood conditions

Examples: blood clots or bleeding problems, high or low iron, anaemia, deep vein thrombosis, lung clots, ITP and platelet deficiencies, any other bleeding or blood-related disorders.

Mark with an "X"

Yes	No

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

3. Metabolic and endocrine conditions

Examples: diabetes, thyroid disease, Addison disease, Cushing syndrome, obesity, growth problems, metabolic syndrome, parathyroid disease, Paget disease, osteoporosis, osteopenia, growth deficiency, any other metabolic or endocrine condition.

Yes	No

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

4. Mental health

Examples: depression, bipolar disorder, anxiety disorder, panic attacks, post-traumatic stress disorder, obsessive compulsive disorder, schizophrenia, personality disorders, insomnia, sleeping disorders (such as narcolepsy), eating disorders, Alzheimer disease, dementia, autism, attention deficit hyperactivity disorder, drug or alcohol dependency or abuse, rehabilitation for drug or alcohol dependency or abuse, suicide attempt, counselling, any other psychological condition.

Yes	No

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

5. Brain and nerve conditions

Examples: migraine, chronic headaches, stroke, weakness or paralysis, bleeding on the brain, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, Parkinson disease, Guillain-Barré syndrome, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal shunt, intellectual disability, any other brain or nerve condition or if you had a previous MRI or CT scan.

Yes	No

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

5.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

6. Eye and eyelid conditions

Examples: vision problems, cataracts, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, cornea transplant, eye surgery, including blepharoplasty, glasses, partial or full blindness, any other eye or eyelid condition.

Mark with an "X"

Yes	No

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

7. Ear, nose and throat conditions

Examples: hearing problems or deafness, middle ear infection (otitis media), external ear infection (otitis externa), any chronic ear infection or ear discharge, perforated eardrum, hearing aid, cochlear implant, tonsillitis or enlarged tonsils, adenoid problems, dizziness, vertigo, tinnitus, blocked nose, sinus problems or allergies, nasal surgery, dental or orthodontic treatment, dental surgery, any other ear, nose or throat condition, jaw problems, impacted teeth, or any other anticipating or current orthodontic-, dental or maxillofacial treatment.

Yes	No

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

8. Heart and circulation conditions

Examples: high blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease or heart murmurs, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins, any other condition affecting the heart or blood vessels (including catheter based vascular procedures like angiograms, angioplasty, and grafts).

Yes	No

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

9. Breathing and respiratory conditions

Examples: asthma, bronchitis, chronic cough, chronic obstructive pulmonary disease, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia, any other breathing or respiratory condition.

Yes	No

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

5.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

10. Abdominal and digestive conditions

Examples: reflux, heartburn, hiatus hernia, hepatitis, irritable bowel syndrome or chronic bloatedness, previous gastroscopy or colonoscopy, cirrhosis, piles, fistulae or rectal bleeding, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder conditions, gall stones, oesophageal disease, stomach or duodenal ulcers, any hernia, digestive problems or malabsorption, Crohn disease, ulcerative colitis, diverticulitis, any other abdominal or digestive condition.

Mark with an "X"

Yes	No

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

11. Skin conditions

Examples: chronic wounds, eczema, psoriasis, acne, sunspots, skin cancer, melanoma, any other condition affecting the skin.

Yes	No

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

12. Spinal, bone, muscle, and related autoimmune conditions

Examples: lower back, neck or spinal area pain, rheumatoid arthritis, osteoarthritis, knee, hip, or shoulder problems or any other joint pain, joint replacements, ankylosing spondylitis, lupus, gout, clubfoot, bunions, Sjögren syndrome, scleroderma, polymyositis, polyarteritis nodosa, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, any other autoimmune conditions, any other condition affecting the back, bones, or muscles.

Yes	No

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

13. Gynaecological and obstetric conditions

Examples: abnormal Pap smear result, menstruation problems or abnormal bleeding, endometriosis, polycystic ovarian syndrome, infertility, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, conditions or complications related to pregnancy, emergency Caesarean section, any other gynaecological or obstetric condition.

Yes	No

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

5.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

14. Pregnancy

Mark with an "X"

Are any of your dependants pregnant, suspect pregnancy or undergoing testing for pregnancy?

Yes	No

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

15. Kidney and urinary conditions

Examples: kidney or renal failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, any other kidney or bladder problems, sexually transmitted diseases.

Yes	No

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

16. Male urinary and genital conditions

Examples: prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, and urine retention, any other male urinary or genital condition.

Yes	No

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

17. Chronic or regular medication

Are any of your dependants currently taking regular, ongoing medicine, and/or receiving treatment for a medical condition or symptom even for a condition not mentioned in the medical questionnaire, including homeopathic, natural or over-the-counter medication?

Yes	No

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

5.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

18. HIV/Aids

Mark with an "X"

Are any of your dependants mentioned on this application HIV positive or have they been diagnosed with Aids?*

Yes	No

Please note that if you do not make a selection, Medihelp will regard your answer as "No".

*If any of your dependants prefer not to disclose their HIV status on this application form, you will remain responsible to inform the Scheme and to register on the Medihelp HIV/Aids programme within 21 days from their enrolment date by phoning LifeSense on 0860 50 60 80.

It is important to disclose this information to prevent the possible termination of your dependants' membership. When we receive your application to register on the HIV/Aids programme, we will determine whether underwriting conditions must be applied and, if this is the case, issue an amended proof of membership document to you.

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

19. Possible services

Are any of your dependants aware of or planning to have any test, examination, treatment and/or procedure done, or get medical advice that could result in a claim in the next 12 months?

Yes	No

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

20. Any other conditions not mentioned

Has any person indicated in this application form been examined (for example, medical tests, X-rays, scans), diagnosed and/or treated (with/without procedures) for any condition or disorder not mentioned in the medical questionnaire (including any injuries sustained at home, work or in a vehicle-related accident)?

Yes	No

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

6. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information

Medihelp confirms that:

1. Your and your registered dependants' 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 employees 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.

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

Medihelp confirms that: (continued)

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 or marketing initiatives undertaken by Medihelp.
4. The Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy.
5. Should you use a Medihelp-contracted brokerage's services then relevant membership information will be made available to the appointed brokerage 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. I will also study my benefit guide and familiarise myself with the coverage offered by the benefit plan 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 dependants, the Rules of Medihelp will be binding on my registered dependants, as the Rules are binding on me.
8. By signing this application form, I confirm that I have the right to apply for the registration of my dependants 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 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 dependants 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 dependants, even if financial adviser or any other third party completed this application 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 the 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 60 days, whereafter the application form will be cancelled and I will be required to submit a new application form.
11. I confirm that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.
12. I take note that the monthly contribution fees will be due on the date of my enrolment and thereafter on the same day of every subsequent calendar month. Should my employer/institution, as my authorised agent, undertake to pay my contributions 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 contributions: my identity number, my tax certificate information, as well as my dependants' dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account, if applicable, should I terminate my membership of Medihelp.
13. I confirm that I am responsible to give advance notice of termination of membership, and that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

Medihelp's rights as a medical scheme

14. 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 dependants 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.
15. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid for 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 using designated service providers.
17. Medihelp may also restrict interchanges between plans 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 benefits may be suspended should I not pay my contributions or debt in full, that my membership may be terminated should any amount still be outstanding 30 days after the date of suspension, and that my account will be handed over for collection.
20. I am aware that Medihelp may increase its contributions annually at the beginning of the year.

Protection of information

21. I hereby give permission and declare that I have obtained the consent of all my dependants, that:

21.1 Medihelp may enquire about my health status or that of my dependants 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;

21.2 My dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;

21.3 Any adviser whom I appoint and whose appointment Medihelp accepts may have access to my personal and medical information and that of any of my registered dependants 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;

21.4 Medihelp may disclose my and my dependants' 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

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

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

Protection of information (continued)

22. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act (POPIA), No. 4 of 2013.
23. I agree that all my telephone conversations and/or that of my dependants with Medihelp and/or its contracted third parties may be recorded for quality control purposes and to help detect and prevent fraud.
24. 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 dependants from medical practitioners, financial advisers, industry regulatory bodies or employers/institutions.
25. I further consent and declare that I have obtained the consent of my dependants, that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependants' consumer credit record, including and not limited to information about my/my dependants' credit history, financial history, personal information (excluding medical information) and judgment or default history.
26. If you believe that Medihelp has used your personal information contrary to its Privacy Policy, you have the right, under the Protection of Personal Information Act, to lodge a complaint with the Information Regulator. However, we encourage you to first follow our internal complaints process to resolve the matter. If, thereafter, you believe that we have not resolved the matter adequately, you can contact the Information Regulator at: The Information Regulator (South Africa), JD House, 27 Siemens Street, Braamfontein 2017, Telephone number: **010 023 5207**, Email: PAIAComplaints@inforegulator.org.za or POPIAComplaints@inforegulator.org.za.
27. If you believe that Medihelp has not handled your enquiry satisfactorily, please first follow our internal complaints process to resolve the matter. If thereafter, you believe that we have not resolved the matter adequately, you can contact the Council for Medical Schemes (CMS), as Medihelp is a registered medical scheme and regulated by the CMS. The CMS' contact details are as follows: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, Customer Care Centre: **0861 123 267**, Email: complaints@medicalschemes.co.za, Website: www.medicalschemes.co.za.

Signature of member

Date 2 0 y y m m d d

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

In your capacity as: Guardian ☐ Curator ☐ Power of attorney (legal appointment) ☐

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/power of attorney, must accompany this application. If you are signing as the applicant's parent, a copy of your passport/ID document and the applicant's birth certificate must accompany this application.

First name

Surname

Telephone number (W)

Cell phone number

7. 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 or 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

Telephone number

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.

Enquiries: 086 0100 678, **Email:** newbusiness@medihelp.co.za
189 Clark Street, Brooklyn, Pretoria, 0181, **www.medihelp.co.za**

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

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Medical Aid in Action