Informed Healthcare Solutions (IHS)

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FAX COVER SHEET

To:	Graham Pike of IHS	**From:**	
Fax:	0866 200 320	**Company:**	
Tel:	021 712 8866	**Tel:**	
Pages:		**Date:**	
Re:	Medshield Application		

Comments:

Instructions:

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 0866 200 320 or scan and email it to forms@medicalaidcomparisons.co.za
4. Sit back while we do all the complicated stuff.

Save time and hassle with your medical aid application and make sure it gets the best possible chance of success

MEDSHIELD
ALWAYS THERE FOR YOU.

Medshield Member Application

Please complete in black ink. Print clearly using capital letters. Only one character per block.
Leave one block between words. Mark with an X where necessary. You must complete all sections of this application form.

Please note: I.D/passport numbers are to be provided for the principal member as well as all beneficiaries.
Should this be outstanding, your application cannot be processed. Please include copies of all I.D. documents and/or birth certificates, and a copy of your bank statement or cancelled cheque.

Benefit Option: .....

Membership number	| | | | | | | | | | | | |
Date membership to commence	Y Y Y Y M M D D
Total Premium	| | | | | | | |

Applicant's Signature ..... Date Y Y Y Y M M D D

Section A Personal Details

Title | Initials | Surname

First name/s

ID / passport number | Date of birth (Y Y Y Y M M D D)

Postal Address

Postal code

Street Address

Postal code

E-mail address

Telephone number (W) C O D E | (H) C O D E

Cell | (Fax) C O D E

Tax number | Basic monthly income R

Please complete for marketing purposes | Persal number (if applicable)

Race | Gender Male Female | Marital status Single Married Divorced Widowed

Section B Dependants You Wish to Register

Complete a separate (MEM02) to register the following dependants: mother, father, grandparent, grandchild, adopted child, brother, sister child over 25 or any other relative. Acceptance of dependants will be in accordance with the Rules of the Scheme.
Please complete a separate MEM03 form in case of a common law spouse / partner.

Spouse / Partner

Title | Initials | Surname

First name/s

ID / passport number | Gender Male Female | Date of birth (Y Y Y Y M M D D)

Maiden surname

Contact details (W) C O D E | (H) C O D E

Cell

E-mail address

Tax number

Race | Date of benefit (office use) (Y Y Y Y M M D D)

Dependants If student dependant over the age of 21, please provide a copy of student registration details

1 Surname

First name/s

ID / passport number | Gender Male Female

Relationship to principal member | Date of birth (Y Y Y Y M M D D)

Race

2 Surname

First name/s

ID / passport number | Gender Male Female

Relationship to principal member | Date of birth (Y Y Y Y M M D D)

Race

3 Surname

First name/s

ID / passport number | Gender Male Female

Relationship to principal member | Date of birth (Y Y Y Y M M D D)

Race

4 Surname

First name/s

ID / passport number

Gender Male Female

Relationship to principal member

Date of birth Y Y Y Y M M D D

Race

Section C Previous Medical History

Where applicable, please provide details and proof of membership of previous medical scheme cover for a period of 24 months or longer, with less than a 90 day break between schemes, prior to joining Medshield Medical Scheme
**Membership certificates must be attached to this application. Copies of membership cards will not be accepted.

Name of scheme	Membership number	Date joined	Date terminated
		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

Section D Medical History

Have you or any of your dependants sought any advice, been diagnosed with, or treated for, any of the following conditions in the past 12 months?
Please provide details on the following page if you have answered yes to any of these questions:

1. Cardio and vascular conditions e.g. high blood pressure, high cholesterol or lipids, ischaemic heart disease, heart failure, angina, stroke (CVA) or peripheral vascular disease? Yes No
2. Obstructive lung disease (asthma, emphysema, bronchitis, shortness of breath or C.O.A.D.)? Yes No
3. Endocrine, metabolic and nutritional disorders, e.g. diabetes (insulin or non-insulin dependent diabetes mellitus)? Yes No
4. Hypo- or hyperthyroidism? Yes No
5. Joint, bone and muscle disorders, e.g. osteo, rheumatoid arthritis, osteoporosis or gout? Yes No
6. Musculoskeletal disorders, e.g. back or neck injuries, lumbago sciatica, spasms etc? Yes No
7. Gastro-oesophageal reflux disease (Gord / heartburn) or stomach or duodenal ulcers? (Please circle) Yes No
8. Blood clotting disorders, e.g. haemophylia? Yes No
9. Gynaecological disorders, e.g. hormone replacement therapy, endometriosis or ovarian cysts? Yes No
10. Psychiatric conditions, e.g. Schizophrenia, bipolar mood disorder, substance abuse, eating disorders, depression and/or anxiety? Yes No
11. Any nervous or mental complaint, e.g. epilepsy, blackouts, paralysis or headaches? Yes No
12. Eye disorders, e.g. glaucoma, cataracts, poor vision, blindness etc? Yes No
13. Parkinson's Disease, Multiple Sclerosis or Altzheimer's Disease? (Please circle) Yes No
14. Urinary or genital system disorders, e.g. hyperplasia of prostate (BPH) or prostatism, kidney stones, urinary incontinence or obstruction, kidney failure etc? Yes No
15. Bowel disorders, e.g. Crohn's Disease or ulcerative colitis? Yes No
16. Are you, or any of your dependants pregnant? Yes No
17. Have you had, or are you planning to have, any surgical procedure over the next past 12 months? Yes No
18. Are you currently using any prescribed medication? If so, please provide details. Yes No
19. Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical aid claim within the next 12 months? Yes No
20. Skin conditions / disorders, e.g. acne, eczema, psoriasis etc? Yes No
21. Ear, nose or throat disorders, e.g. ear discharge, recurrent tonsillitis? Yes No
22. Infectious diseases, e.g. Tuberculosis, shingles, measles, etc? Yes No
23. Malignant neoplasms (cancers, growths or malignant tumours)? Yes No
24. Benign neoplasms (non-malignant tumours / growths)? Yes No
25. Specialised dentistry / maxillo-facial treatment? Yes No
26. Have you had, or are you expecting to have, plastic or reconstructive surgery? Yes No

Please provide details if you have answered yes to any of the above questions:

Question No	Patient's Name	Condition and duration of condition	Name of attending doctor	Date of treatment
				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
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				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

You and each of your dependants must apply separately for chronic medicine benefits

Immune deficiency status (confidential disclosure)

If you or any of your dependants have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact 0860 100 646 for more information or join Aid for AIDS, a comprehensive care and counselling programme for people living with HIV/AIDS.

I, the undersigned consultant, hereby declare that as a broker I have explained the AFA programme and the benefits it provides, as well as the importance of joining this programme should the principal member or any dependants have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies.

Signature of consultant ..... Date Y Y Y Y M M D D

Section E — Bank Details of Principal Member claim refund payments / debit order instruction

I hereby authorise the scheme administrators to deduct monthly contributions and/or pay refunds to the following bank account.
**Should the bank details provided not be that of the principal member of the scheme, please complete a MEM04 "Statement of Official Declaration."

☐ Use this account for contribution collections and claims refunds

☐ Use this account for contribution collections only

Bank name .....

Branch name .....

Bank branch code .....

Type of account Current | Transmission | Savings

Name of account holder .....

Bank account number

Signature of account holder .....

☐ Use this account for all refunds

Bank name .....

Branch name .....

Bank branch code .....

Type of account Current | Transmission | Savings

Name of account holder .....

Bank account number

Date

Signature of account holder .....

Section F — Stop Order Authorisation to be completed by government sector employees

Department

Province

Place of employment

Contribution

Member's portion	R
Government's subsidy	R
Total contribution	R

I, the undersigned, hereby grant permission to the relevant provincial administration or government department to deduct my portion of the full monthly contribution, as well as any arrears and pay this amount to Medshield Medical Scheme. I understand that the future contributions may change due to contribution increases or changes to my membership record. This authorisation will remain valid until I provide a written cancellation. I also understand that subscriptions are payable monthly in advance. I further grant permission for any refund amounts due to me to be paid into my bank account using the banking details provided in Section E of this form.

Applicant's Signature ..... Date Y Y Y Y M M D D

Section G — Employer Information (only for existing Paypoints)

Name of employer

Department code

Division number (if applicable)

Paypoint (if applicable)

Organisation code (if applicable)

Employment date Y Y Y Y M M D D

Number of dependants	Adult	Child	Non-subsidised
Plan contribution			
Total			

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the Scheme Rules and option chosen. All sections of the application form have been completed.

Employer's e-mail address

Employer representative's name

Employer representative's designation

Company Stamp

Signature of employee representative ..... Date Y Y Y Y M M D D

Important Conditions of Membership

1 Disclaimer
Brochures are summaries and do not supersede the registered Rules of the Scheme. All benefits are paid in accordance with the registered Rules of the Scheme.

2 Are all benefits available once I am a member?
Benefits are based on a 12-month period (January to December). Depending on which month you join the Scheme, your benefits will be pro-rated accordingly, i.e. should you join in April, you have 9 months' benefits available. If a benefit for the year is R1200 you will have 9/12 x R1200 = R900. Waiting periods are applied to some conditions i.e. pregnancy.

3 How do I pay contributions?
Your contributions are deducted from your salary by your employer or directly from your bank account.

4 Do I have to wait before I can claim for benefits?
Yes, on pre-existing conditions, e.g. a condition prior to joining the Scheme. You will receive written notification if waiting periods are imposed.

5 Will contributions increase after I become a member?
Yes. All medical schemes increase contributions from time to time when the cost of medical, dental, hospital or other health services increase or when benefits are improved.

6 What happens when I exceed my annual benefit limits?
You will be liable for the payment of any excess amount directly to the service provider.

7 Can I resign from the scheme at any time?
The Scheme requires three months notice in writing of your intention to cancel your membership.

8 Late Joiner Penalty
Late Joiner Penalty may be applied to an applicant or dependant(s) joining a medical aid after the age of 35, who had no creditable cover with one or more medical scheme prior to 1 April 2001 without a break in membership exceeding 3 consecutive months.

9 Non-disclosure of medical condition
Failing to disclose your medical history, and that of your dependants, accurately on this application form entitles Medshield to terminate your membership and that of any dependants in terms of the Medical Schemes Act.

Member Declaration

1. I, the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree to abide by its Rules and Regulations in accordance with the provisions of the Medical Schemes Act (Act 131 of 1998) as amended.
2. I certify that all the information given is true and correct and agree that any false statements in this application will immediately render my membership null and void.
3. I hereby authorise my employer to deduct, from my emoluments, any amount I may lawfully owe to the Scheme and to remit such amounts to the Scheme.
4. Furthermore, I understand that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership until such money is recouped.
5. I hereby authorise and request any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my / the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its and its trustee, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of, or arising out of, the disclosure of any test results or medical information.
6. I acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void and that all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me, or any person on my or my dependant's behalf, under such contracts.
7. The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi which will be deemed to be in my postal address unless otherwise notified Any notice given to me by prepaid registered post at my domicilium citandi et excutandi shall be deemed to have been received by me on the 7th day after the date posting.
8. I also accept any penalties that may be imposed as proposed by the Medical Schemes Act (Act 131 of 1998) as amended.
9. I hereby authorise the Scheme, or any of its nominated representatives, to confirm my bank details.

Should your state of health change significantly from the date of signing this application to the date of acceptance, please notify the Scheme in writing. Please ensure that the following documentation accompanies your application: a photocopy of your ID / passport; a signed copy of your salary advice (not older than three months; proof of membership of another medical aid scheme(s) for a period two years prior to this application. Copies of membership cards will not be accepted. A copy of the Scheme Rules is available on request.

Signature of applicant ..... Date Y Y Y Y M M D D

Consultant Declaration

Healthcare consultant **GRAHAM PIKE (INFORMED HEALTHCARE SOLUTIONS PTY LTD)**

Healthcare consultant's number **70322** Agent number

I ..... hereby understand that it is an offence to submit fraudulent business.

I ..... have explained the following to the prospective member:

Non-disclosure ☐ Waiting periods ☐ Pro-rating of benefits ☐

Signature of consultant ..... Date Y Y Y Y M M D D

Documents	YES	NO
Principal Member ID		
Spouse/Partner ID		
Children Birth Certificates		
Additional Dependants IDs		
MEM02 if registering any special dependants (parents, adult, or overage child, foster child)		
MEM03 in case of common law spouse / partner		
Proof of Banking Details (Bank Statement / Cancelled Cheque)		
Affidavits (different surnames / overage dependants)		
Student Certificate (where applicable)		
Proof of Previous Medical Scheme (Certificate of membership with end date)		
Deposit slip attached (where applicable)		
MEM04 if account holder is not the principal member		
Copy of any additional broker fees charged (e.g. upfront admin fee)		

Contact Medshield
086 000 2120
Monday - Friday:
08:30 - 16:30

Medshield Medical Scheme
PO Box 68618, Bryanston, 2021
www.medshield.co.za
member@medshield.co.za

Medshield Distribution Offices:

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KwaZulu-Natal	Durban	(031) 581 7480
Western Cape	Cape Town	(021) 418 3139
Eastern Cape	Port Elizabeth/ East London	(041) 373 1717
	Mthatha	(047) 532 2873/2877
North West Province	Mafikeng	(018) 381 7642/43