Medical Aid online.co.za
compare choose save join

Jenus

Instructions

Complete and sign the application form and fax cover sheet and fax it to 086 248 4524.
Alternatively scan and email to us at info@medicalaidonline.co.za
We will contact you shortly thereafter to discuss the status of your application.

Thank you for choosing Medical Aid Online.

FAX COVER SHEET

To:	Medical Aid Online	**From:**	.....
Fax no:	086 248 4524	**Tel no:**	.....
		Date:	.....
Comments:		**Pages:**	.....

.....

.....

.....

.....

No 6 Robin Drive, Fourways P O Box 70687 . Bryanston . 2021
Fax 086 248 4524 www.jenus.co.za . Reg no. 2004/018981/07
An authorised financial services provider. FSP36088

Directors: AJ Smart | AA Graham

LIBERTY MEDICAL SCHEME

We care. **For you**

Private Bag X3
Century City, 7446
Contact Centre 0860 002 163
New Business fax 021 657 7651
www.libmed.co.za

Application for Membership 2013

Important:

- Please write clearly using capital and block letters.
- It is compulsory for fields marked with * to be completed.
- Arrear contributions may be collected in respect of applications activated after the 20th of the month.
- Please submit completed forms to: newbusiness@libertyhealth.co.za or fax: 021 657 7651.
- Registration date will be the 1st of the following month following the application date, (backdating will NOT be permitted).
- Existing members who wish to register additional dependant(s), please complete the Dependant Registration form, available on www.libmed.co.za.
- Each page other than the signature page is to be initialled by the applicant.
- In instances where a broker completes a form on behalf of the member and material information is not disclosed as the member directed, the member and not the broker will be liable since members are legally required to read, understand and be made aware of the information disclosed in the application forms before they sign such applications.
- The member remains at all times liable for payment of contributions to the Scheme, irrespective whether he/she receives financial assistance from the employer towards a subsidy. An employer subsidy remains a matter between the member and his/her employer.
- Refer to page 12 - Choice of Benefit Option Details - 2013.
- **Please note**: Where the applicant is a minor, the parent/guardian must sign and initial the form.

DOCUMENTS REQUIRED FOR REGISTRATION

Document(s) Required	Applicant	Lawful Spouse	Partner	Child* under the age of 21	Child* 21 years and older ****	Biological Parent of applicant ****	Biological Sibling of applicant ****
Copy of ID/(Passport only if not SA citizen)/Birth Certificate/hospital confirmation reflecting the baby's name	√	√	√	√	√	√	√
Copy of Marriage Certificate		√					
Copy of the latest payslip/salary advice	√				√	√	√
Copy of Membership Certificate(s)/Affidavit detailing previous medical scheme cover** (also see Section 6)	√	√	√	√	√	√	√
LMS Declaration*** confirming financial dependency of adult dependants****					√	√	√
Proof of studies (current proof of full-time registration at a RSA recognised educational institution)****					√		√
Copy of the Doctor's disability report (if applicable) indicating permanent disability					√		√
Proof of legal adoption (if applicable)				√	√		

Refer to page 12 - Choice of Benefit Option Details - 2013

* Child means an applicant's natural child, child by virtue of a surrogate motherhood agreement as provided for in the Children's Act (Act 38 of 2005), a stepchild or legally adopted child and who is not a beneficiary of any other medical scheme.

** Copy of Membership Certificate(s)/Affidavit detailing previous cover (registration date, benefit date, resignation date, any/all waiting periods and late joiner penalties). Membership cards or copies thereof will not be accepted. If not attached, a Late Joiner Penalty may apply.

*** LMS Declaration templates are available on www.libmed.co.za.

**** Subject to Annual Review.

Financial Dependency: Total Income that is equal to or less than the tax threshold per annum for person's below the age of 65 years.

FOR ADMINISTRATIVE USE ONLY

Membership number

Group number L B T

Interchangeability Y N

Initials of Applicant/Guardian/Parent

LIBERTY

SECTION 1 – DETAILS OF APPLICANT

Please leave a space between names

Last name*

Maiden name (if applicable)*

Title* First name(s)*

Initials* Date of birth* Y Y Y Y M M D D

Gender* M F Status* UNMARRIED MARRIED DIVORCED WIDOWED PARTNER

SA ID number/
Passport (only if not SA citizen)*

Contact Details

Telephone (Home)* (Work)*

Fax Cell*

Email*

Home address* (chosen as domicilium citandi et executandi)

Postal code

Postal address* Same as Home Y N

If No

Postal code

Smoker* Y N Weight * kg Height* cm

Alternate Contact Details/Details of Guardian or Parent in the case of minor applicants (<18)

Person's Name*

Relationship to applicant*

Telephone (Home)* (Work)*

Fax Cell*

Email*

SECTION 2 – DEPENDANTS TO BE REGISTERED

- It is compulsory to complete this section if you have any dependants you would like to register.
- Registration of a dependant is strictly subject to the rules of the Scheme **(refer to Documents required for registration)**.

Dependant 1 - Spouse/Partner (Please delete what is not applicable)

Title* Initial(s)* Last name*

First name(s)* (as per identity document)

Gender* M F Date of birth* Y Y Y Y M M D D

SA ID number/
Passport* (only if not SA citizen) Smoker* Y N Weight* kg Height* cm

Dependant 2

Title* Initials* Last name*

First name(s)* (as per identity document)

Marital status Gender* M F Date of birth* Y Y Y Y M M D D

Relationship to applicant*
(For example child. Where your child is not your biological child, please state relationship.
For example stepchild, adopted child.)

SA ID number/
Passport* (only if not SA citizen) Smoker* Y N Weight* kg Height* cm

Is your dependant: financially dependent on you? Y N permanently disabled? Y N a full-time student? Y N

Does your dependant earn an income? Y N How much does your dependant earn each month? R

Initials of Applicant/Guardian/Parent

Dependant 3

Title* | Initials* | Last name*

First name(s)* (as per identity document)

Marital status | Gender* M F | Date of birth* Y Y Y Y M M D D

Relationship to applicant* (For example child. Where your child is not your biological child, please state relationship. For example stepchild, adopted child.)

SA ID number/ Passport* (only if not SA citizen) | Smoker* Y N | Weight* kg | Height* cm

Is your dependant: financially dependent on you? Y N | permanently disabled? Y N | a full-time student? Y N

Does your dependant earn an income? Y N | How much does your dependant earn each month? R

Dependant 4

Title* | Initials* | Last name*

First name(s)* (as per identity document)

Marital status | Gender* M F | Date of birth* Y Y Y Y M M D D

Relationship to applicant* (For example child. Where your child is not your biological child, please state relationship. For example stepchild, adopted child.)

SA ID number/ Passport* (only if not SA citizen) | Smoker* Y N | Weight* kg | Height* cm

Is your dependant: financially dependent on you? Y N | permanently disabled? Y N | a full-time student? Y N

Does your dependant earn an income? Y N | How much does your dependant earn each month? R

Dependant 5

Title* | Initials* | Last name*

First name(s)* (as per identity document)

Marital status | Gender* M F | Date of birth* Y Y Y Y M M D D

Relationship to applicant* (For example child. Where your child is not your biological child, please state relationship. For example stepchild, adopted child.)

SA ID number/ Passport* (only if not SA citizen) | Smoker* Y N | Weight* kg | Height* cm

Is your dependant: financially dependent on you? Y N | permanently disabled? Y N | a full-time student? Y N

Does your dependant earn an income? Y N | How much does your dependant earn each month? R

Dependant 6

Title* | Initials* | Last name*

First name(s)* (as per identity document)

Marital status | Gender* M F | Date of birth* Y Y Y Y M M D D

Relationship to applicant* (For example child. Where your child is not your biological child, please state relationship. For example stepchild, adopted child.)

SA ID number/ Passport* (only if not SA citizen) | Smoker* Y N | Weight* kg | Height* cm

Is your dependant: financially dependent on you? Y N | permanently disabled? Y N | a full-time student? Y N

Does your dependant earn an income? Y N | How much does your dependant earn each month? R

Dependant 7

Title* | Initials* | Last name*

First name(s)* (as per identity document)

Marital status | Gender* M F | Date of birth* Y Y Y Y M M D D

Relationship to applicant* (For example child. Where your child is not your biological child, please state relationship. For example stepchild, adopted child.)

SA ID number/ Passport* (only if not SA citizen) | Smoker* Y N | Weight* kg | Height* cm

Is your dependant: financially dependent on you? Y N | permanently disabled? Y N | a full-time student? Y N

Does your dependant earn an income? Y N | How much does your dependant earn each month? R

(Please complete a blank page if you have more dependants to register.)

Initials of Applicant/Guardian/Parent

SECTION 3 – EMPLOYMENT DETAILS

Are you applying as:

☐ Individual	Applicants who will pay their own contribution via debit order.
☐ Employee of an employer group	Applicants who form part of a participating employer group where the employer is responsible for the full payment of their contributions.
☐ Government employee (Persal Member)	Applicants who form part of a government institution and whose contributions will be made via Persal.

If you are applying as an individual, the following need not be completed and you can proceed to Section 5.

If you are an employee of an Employer group or government employee, please have your employer complete the section below, if this application form is not submitted together with an Employer Group Registration form.

Name of Employer

Telephone number Fax

Email

Date of employment Y Y Y Y M M D D Employee/Persal number

EMPLOYER DECLARATION

1. We confirm that the applicant detailed in Section 1 is an employee of our organisation.
2. The Scheme may bill us for the amount due for this applicant in the same way as it does for our other employees with the Scheme.

Authorised Signatory

Designation

Y Y Y Y M M D D
Date

COMPANY STAMP

Initials of Applicant/Guardian/Parent

SECTION 4 – BANKING DETAILS

A. ☐ **Use this account for ALL transactions: debit order contributions/collections as well as to deposit claim refunds**

B. ☐ **Use this account ONLY for debit order contribution collections**

Full name of Account holder

Name of bank

Branch name | Branch code

Account type: CHEQUE | TRANSMISSION | SAVINGS

Account number

Note:

- Please be aware that the default effective/lodgement date for all debit orders will be on the first business day of the month
- Credit card details are not acceptable
- For third party banking details (if someone else pays your contribution), we require the following supporting documents:
  - Certified copy of ID of Account holder
  - A verified (stamped by the Bank) copy of bank statement (not older than 3 months).

Signature of Account holder _____ Date Y Y Y Y M M D D

C. ☐ **Use this account for savings/claim refunds (if different from the above account)**

Full name of Account holder

Name of bank

Branch name | Branch code

Account type: CHEQUE | TRANSMISSION | SAVINGS

Account number

Signature of Account holder _____ Date Y Y Y Y M M D D

DECLARATION FOR ACCOUNT HOLDER BANKING DETAILS

As signatory above, I declare as follows:

1. I instruct the Scheme to electronically collect contributions and/or to deposit claims and savings funds, via the ACB electronic system, using the information provided above.
2. I also irrevocably authorise the Scheme to reverse any erroneous transactions and/or rectify any electronic transfer of funds.
3. I authorise the Scheme to debit my bank account for contributions.
4. I authorise the Scheme to contact my bank, should it need to verify any of my bank account details.
5. I authorise the Scheme to collect, process and share the above banking details with any contracted Third Party Provider in order to allow the Scheme to fulfill its functions, duties and obligations.

Initials of Applicant/Guardian/Parent

SECTION 5 – UNDERWRITING INFORMATION

Waiting periods

Depending on the circumstances, the Scheme may apply either or both of the following two waiting periods in respect of you or a nominated dependant:

- a 3-month general waiting period (i.e. a period in which a beneficiary is not entitled to claim any benefit); and
- a 12-month condition-specific waiting period (i.e. a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made).
- depending on the circumstances, these waiting periods will not apply in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

Late Joiner Penalties

If any beneficiary is 35 years of age or older and does not have sufficient years of creditable medical scheme cover as a beneficiary on a South African medical scheme, the Scheme may impose a late joiner penalty which means that the normal contribution payable in respect of such beneficiary may be increased by a certain percentage.

SECTION 5.1 – PREVIOUS MEDICAL INFORMATION

Please answer the following questions in relation to you and your nominated dependants:

1. Has anyone been admitted to hospital, undergone any procedure or received medical/dental treatment other than routine medical/dental examinations/treatments in the last 12 months before this application? Y N

   * If the answer to the above is yes, please provide the details i.r.o. the person(s) in Section 5.3 below.

2. Has anyone regularly taken, or is anyone reasonably expecting to need medicine on an on-going basis, or been diagnosed with a chronic condition? Y N

   * If the answer to the above is yes, please provide the details i.r.o. the person(s) in Section 5.3 below.

3 Is anyone planning to or reasonably expecting to be hospitalised (including for pregnancy), or to undergo a procedure in the next 12 months? Y N

   * If the answer to the above is yes, please provide the details i.r.o. the person(s) in Section 5.3 below.

4. Do you or any of your nominated dependants suffer from a physical/mental impairment or any other disability? Y N

   * If the answer to the above is yes, please provide the details i.r.o. the person(s) in Section 5.3 below.

Should you have answered "YES" to any of the above questions, your application will be sent for Underwriting Review and the terms set out in Section 5 above could be applied.

If you have answered "NO" to questions 1, 2, 3, & 4, then you do not have to complete Section 5.3.

SECTION 5.2 – PREVIOUS MEDICAL SCHEME COVER DETAIL

Please provide details of previous cover by a South African medical scheme i.r.o. applicant and dependants:

1. During the 24 months preceding this application in respect of every person to be covered and who is under the age of 35;
2. During the 24 months preceding this application in respect of every person to be covered and who is 35 years and older and who did not at any stage after 1 April 2001 have a break in coverage exceeding 3 consecutive months;
3. Who had a break in coverage exceeding 3 consecutive months at any stage after 1 April 2001, as from the age of 21 and who is 35 years and older.

Please attach relevant proof of membership. This may be a Sworn Affidavit detailing previous membership history (registration date, benefit date, resignation date, any/all waiting periods and exclusions. Membership cards or copies thereof will not be accepted.)
If not attached, or insufficient proof provided, waiting periods and/or the Late Joiner Penalty may apply.

Person covered	Scheme name	Membership number	Cover started	Cover ended	Reason for leaving
			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	
			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	
			Y Y Y Y M M D D	Y Y Y Y M M D D	

Initials of Applicant/Guardian/Parent

SECTION 5.3 – HEALTH QUESTIONNAIRE

All sections below must be completed – failure to do so will delay processing (Refer to Section 5.1).

NOTE: If you answer "YES" to any of the questions in this section, and if the space provided to complete your answer is not sufficient to disclose the necessary information, please provide additional information on separate pages.

Name and last name of current family doctor

Telephone

How long has he/she been your doctor? year(s)

Postal address

Postal code

Have you or any of your nominated dependants received medical advice, care or treatment for any of the following in the last 12 months?

1. Heart & Circulation e.g. Chest pain/Angina; Heart attack; Heart failure; Heart valve defects; Rheumatic fever; High blood pressure (Hypertension); High cholesterol; Heart murmurs; Circulatory problems/disorders; Varicose veins; Deep Vein Thrombosis (DVT) or any other heart or circulatory problems — Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

2. Breathing & Respiratory e.g. Asthma; Difficulty with breathing; Bronchospasm; Tuberculosis (TB); Coughing up blood; Emphysema; Pneumonia; Cystic Fibrosis; Chronic bronchitis; Shortness of breath or any other breathing problems — Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

3. Bladder & Kidneys e.g. Blood in urine; Kidney failure; Polycystic Kidneys; Kidney or bladder infections; Kidney removal (Nephrectomy); Kidney stones; Abnormal Kidney or urine tests or any other bladder or kidney problems — Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

4. Reproductive Organs e.g. Endometriosis; Infertility; Ovarian Cysts; Hysterectomy; Abnormal Pap Smears; Laser treatment; Cervix and Breast Biopsies; Fibro-adenosis of the Breast; Laparoscopies; receiving Hormone Replacement Therapy (HRT); Prostate infections or surgery; Prostate enlargement or any other reproductive problems — Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

5. Digestive System e.g. Duodenal Ulcers; Gastric Ulcers; Hiatus Hernia; Colon problems; Crohn's Disease; Ulcerative Colitis; Gall Bladder problems; Liver problems or any other digestive system problems — Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

6. Ear, Nose & Throat e.g. Deafness; Ear infections; Sinus problems; Nasal surgery; Throat surgery; Orthodontics; Dental surgery; Speech impairments; Harelip; Cleft Palate or any other nose or throat problems — Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

Initials of Applicant/Guardian/Parent

7. Eyes	e.g. Blindness (partial or full); Eye surgery; Lens implants; Cataracts; Glaucoma; Retinitis Pigmentosa; Retinal Detachment; Impaired vision or any other eye or eyesight problems	Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

8. Endocrine	e.g. Diabetes ("high blood sugar"); Underactive Thyroid; Overactive Thyroid; Thyroid surgery; Cushing's Syndrome; Addison's Disease; Pituitary Gland problems or any other glandular problems	Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

9. Back & Muscles	e.g. Neck or back problems or operations; Recurrent back pain; Osteoporosis; Ankylosing Spondylitis; Rheumatoid Arthritis; Osteo-Arthritis; Paget's Disease or any other bone or skeletal disorders	Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

10. Neurological	e.g. Epilepsy; Stroke (CVA); Migraine; Brain injuries; Spinal Cord injuries; Paralysis; Cerebral Palsy; Multiple Sclerosis; Mental retardation; Narcolepsy; Motor Neurone Disease; Parkinson's Disease; Alzheimer's Disease or any other neurological problems	Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

11. Psychological	e.g. Depression; Anxiety; Psycosis; Suicide attempts; Bipolar Disorders; Manic Depression; "Stress"; Schizophrenia; Tourette's Syndrome; Anorexia Nervosa; Received advice, counselling or treatment for Alchohol or Drug abuse; Attention Deficit Disorder; Bulimia or any other psychological problems	Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

12. Tumours & Growths	e.g. Benign or Malignant growths or lumps or tumours including: Melanoma; Lymph Gland Cancer; Leukaemia and Breast Cancer or any other tumours, growths and cancers	Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

13. Blood	Blood or bleeding disorders e.g. Haemophilia; Christmas factor deficiency; Platelet or any other blood clotting disorders	Y N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

Initials of Applicant/Guardian/Parent

14. Skin	e.g. Eczema; Acne; Dermatomyositis; Pemphigus; Psoriasis; Scleroderma or any other skin disorders	Y	N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

15. Sexually Transmitted Diseases	e.g. Advice, treatment or counselling for any of the following: HIV/AIDS; Syphilis; Gonorrhoea; Herpes; Genital Ulcers; Pelvic Infectious Disease (PID); Genital Warts; Hepatitis B or any other sexually transmitted disease or disorder	Y	N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

16. Pregnancy	Are you or any of your dependants currently pregnant? **If the answer to this question is "Yes", when is the expected date of delivery?** Y Y Y Y M M D D Name of patient	Y	N

17. Other medical conditions	Do you or any of your nominated dependants have any medical condition not mentioned in the above questions 1 to 16?	Y	N

Patient	Condition/diagnosis	Medication	Currently receiving treatment	Date of last treatment/ hospitalisation	Healthcare provider
				Y Y Y Y M M D D	Name:
				Y Y Y Y M M D D	Tel:

SECTION 6 – DECLARATION BY APPLICANT

1. I, the undersigned, hereby apply for myself and my nominated dependants to join the Liberty Medical Scheme (the Scheme).
2. I understand that this application, together with any supporting documents, together with the rules of the Scheme, form the basis of my contract with the Scheme.
3. **Acceptance of risk**
   It is further agreed and understood that, notwithstanding any statement made to the contrary by any person, membership will not commence and no liability whatsoever will attach to the Scheme as a result of this application, unless and until express written notice of acceptance (also referred to as Welcome letter) has been given by the Scheme and the first contribution has been paid to and received by the Scheme.
4. **Declaration in respect of partner (if applicable)**
   I confirm that my partner and I are in a committed relationship akin to a marriage based on mutual dependency and a shared household.
5. **Scheme Rules and Benefits**
   a. I agree that I and my dependants will be bound by the Scheme rules and will abide by them.
   b. The Scheme shall not be bound in any way by any representations or undertakings made or given by any person save as contained in the registered rules of the Scheme.
   c. I understand that certain benefits may be pro-rated if my membership commences after 1 January of a year.
6. **Waiting periods and late joiner penalties**
   a. I understand that the Scheme may impose waiting periods and/or late joiner penalties in respect of myself and/or any of my nominated dependants.
   b. I accept any such waiting periods and/or late joiner penalties that may be imposed in terms of the rules of the Scheme.
7. **Banking Detail**
   a. I agree to advise the Scheme in writing of any changes to my banking details.
   b. I understand that failure to do so will result in me being liable for any subsequent banking charges or other costs/losses incurred due to the use of the incorrect banking detail.
8. **Contributions and amounts owed to the Scheme**
   a. I hereby acknowledge that any credit extended by the Scheme to myself in terms of the rules of the Scheme will become payable in full by the end of the benefit year in which it arose and that interest may be charged on all amounts due and owing to the Scheme.
   b. I acknowledge that it remains my responsibility to ensure that the monthly contribution and any other amounts due by me are paid to the Scheme.
   c. I accept that the Scheme has the right to amend monthly contributions and benefits from time to time.
   d. I understand that if contributions or other amounts due are not paid, that the Scheme will suspend my membership resulting in the non-payment of benefits irrespective of when services were obtained and that if such amounts remain outstanding, that my membership will be terminated.
   e. I agree that any amounts owing by me may be off-set against any benefits or payments that may be due to me by the Scheme.
   f. I also accept that I will be responsible for any costs associated with the recovery of any arrear contributions or other debts.
9. **Disclosure of information**
   a. I confirm that I have the necessary authorisations to disclose the information the Scheme may require and provide the necessary authorisations in respect of my nominated dependant/s.
   b. I confirm that the information provided in this application and in any other documents submitted in support of this application is true, correct and complete and that I have not withheld, concealed or misstated any information.
   c. I furthermore confirm that I understand that my membership will become null and void should the above statement be found to be incorrect and that in such an event all monies paid in respect of my membership shall be forfeited and that the Scheme shall furthermore be entitled to recover any amounts paid for services rendered from the provider and/or myself.

Initials of Applicant/Guardian/Parent

d. I undertake to promptly advise the Scheme of any change in status of health of myself or any of my nominated dependants that occurs prior to the date of registration with the Scheme and acknowledge that the additional information may be subject to underwriting. I acknowledge that not doing so may lead to the Scheme reconsidering the basis of my membership application.

e. I understand that should there be any additional information required by the Scheme that is not received within 14 days, that the Scheme has the authority to suspend my application for membership.

f. I indemnify Liberty Medical Scheme and its trustees, agents and administrator against any claim, of whatever nature, which may be made against them as a result of or arising out of the disclosure of any medical information in fulfilling this agreement.

g. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information about my own, or my nominated dependants' health status to the Scheme or any entity contracted by the Scheme in order to fulfil its functions, duties and obligations in terms of this agreement and I agree that this authorisation shall remain in force after my/their death/s.

h. I irrevocably authorise the Scheme to collect, process and share my personal information and that of any nominated dependant/s with any entity contracted by the Scheme in order to fulfil its functions, duties and obligations in terms of this agreement. I agree that this authorisation shall remain in force after my/their death/s and understand that this may partially limit my/their right to privacy.

10. **Resignation**

a. I hereby acknowledge that any credit extended by the Scheme to myself in terms of the rules of the Scheme will become payable in full upon resignation of my membership of the Scheme and that interest may be charged on all amounts due and owing to the Scheme.

b. I further acknowledge that on resignation of membership, any amounts owing to the Scheme will be deducted from any amounts due to me by my Employer.

c. For this purpose I hereby permit the Scheme to advise my employer of any amounts due to the Scheme where applicable.

d. I confirm that I understand that it is illegal to belong to or be a dependant on more than one registered medical scheme at a time and that all my dependants and I will cease our current medical scheme cover with my/our current scheme prior to joining the Scheme.

e. I understand that according to the rules, I may resign my membership of the Scheme on giving one calendar month written notice and that all rights to benefits cease after the last day of my membership.

11. **Personal contact**

a. I consent to the use of any of the contact details given in this application to send me information pertaining to my membership (confidential or other).

b. I undertake to inform the Scheme of any change of address and contact details. The Scheme shall not be held liable as a result of me neglecting to inform the Scheme of any changes to the aforementioned.

c. I consent to my telephone conversations with the Scheme being recorded and forming part of the Scheme's records.

d. I also agree that such records shall remain the sole property of the Scheme.

12. **Marketing**

In order to keep you updated on activities at Liberty Medical Scheme (LMS), we would like to communicate, where necessary, via emails, sms's or post.

a. Do you wish to receive LMS marketing communications? Y N

b. If yes, how would you like to receive them? Email Y N SMS Y N Post Y N

c. I consent to LMS marketing products, services and special offers being sent to me from time to time. Y N

d. I consent that any Third Party contracted to LMS may contact me from time to time regarding their products, services and special offers. Y N

13. **Financial Adviser**

a. I hereby appoint the financial adviser, who has submitted this application on my behalf, to be my nominated financial adviser.

b. I authorise the Scheme to share all membership information pertaining to myself and my registered dependants with my nominated financial adviser.

- Please advise if all membership information should:
  (Please tick applicable box)
  - **Include** Claims Information ☐
  - **Exclude** Claims Information ☐

Signed at _____ on this _____ day of _____ 20 _____

Signature of Applicant
(Guardian/Parent) _____

SECTION 7 – TO BE COMPLETED BY FINANCIAL ADVISER

First name and last name: Alexia Graham

Financial Adviser's Commission code: 200337

Are you accredited with the Council for Medical Schemes? Y X

If "YES" please provide Accreditation number _____ Date accredited Y Y Y Y M M D D

Branch name _____ Cell _____

Office Telephone _____ Other number 0862484524

Email address: info@medicalaidonline.co.za

Secondary email address (e.g. Broker Consultant) _____

Additional instructions by Financial Adviser to Liberty Medical Scheme administration

Signature of Financial Adviser A.Graham Date Y Y Y Y M M D D

Initials of Applicant/Guardian/Parent

RECORD OF ADVICE (Applicable to Liberty Agents and Franchise Financial Advisers only)

Analysis date Y Y Y Y M M D D

Produced for

ID number

Option that matches your needs based purely on our life stages segmentation

Day-to-day cover required

Non-PMB Chronic Cover required

Threshold Cover required

Option that matches your needs based on our life stages segmentation and considering the above specific health and financial needs.

Recommended LMS Option

Actual LMS Option chosen

Reason for choosing other option _____

RECORD OF ADVICE – I DECLARE THAT:

1. I am appointed by the applicant to provide advice about this application.
2. I have a valid contract with Liberty Medical Scheme.
3. I am responsible for providing the applicant with:
   - my name, physical address, postal address and telephone number
   - impartial advice that is in his or her best interest
4. I am accountable for any advice given to the applicant about completion of this application form and joining the Scheme.

Signature of Financial Adviser

Y Y Y Y M M D D
Date

Initials of Applicant/Guardian/Parent

LIBERTY MEDICAL SCHEME

We care. **For you**

Private Bag X3
Century City, 7446
Contact Centre 0860 002 163
New Business fax 021 657 7651
www.libmed.co.za

Choice of Benefit Option Details - 2013

CHOICE OF BENEFIT OPTION DETAILS 2013

Important: Please submit completed form to: newbusiness@libertyhealth.co.za or fax: 021 657 7651.

SECTION 1 – DETAILS OF APPLICANT

Please leave a space between names

First name

Last name

SA ID number/Passport
(only if not SA Citizen)

SECTION 2 – CHOICE OF BENEFIT OPTION DETAILS

Please tick the appropriate box.

	Principal Member	Adult Dependant	Child Dependant
Private Option			
☐ Prestige	R4 487	R3 951	R1 064
Complete Options			
☐ Platinum Complete	R3 476	R2 583	R1 001
☐ Titan	R1 889	R1 511	R511
☐ Titan Select* *Selected providers	R1 637	R1 310	R443
Saver Options			
☐ Platinum Saver	R2 036	R1 830	R660
☐ Gold Saver	R1 534	R1 258	R564
☐ Gold Saver Select* *Selected providers	R1 329	R1 090	R489
Hospital Options			
☐ Platinum Focus	R1 666	R1 499	R538
☐ Gold Focus	R1 164	R981	R442
☐ Gold Focus Select* *Selected providers	R1 048	R883	R398
Network Managed Option			
☐ Bona Plus	R1 215	R930	R356

DISCLAIMER

The monthly contributions will be made up of Risk, Savings and Late Joiner Penalties (LJP) where applicable.

Signed at _____ on this _____ day of _____ 20 _____

Signature of Applicant
(Guardian/Parent) _____

2760_ENGAPP_0912

LIBERTY