Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1009

SIZWE MEDICAL FUND
Caring for the health of the nation

APPLICATION FOR MEMBERSHIP

PLEASE USE BLACK INK TO COMPLETE ALL SECTIONS AND RETURN AS SOON AS POSSIBLE TO ENSURE SPEEDY REGISTRATION.

MEDICAL FUND OPTION

☐ Gomomo Care

FOR INTERNAL USE ONLY

Medical aid number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Employer code: ☐☐☐☐☐☐☐☐

SECTION 1 PERSONAL DETAILS OF PRINCIPAL MEMBER

Title: _____ Surname: _____

First names: _____ Initials: _____

ID number: _____

Postal address: _____ Code: _____

Physical address: _____ Code: _____

Email address: _____ Occupation: _____

Telephone (H): ( )_____ (W): ( )_____ (C): _____

SECTION 2 EMPLOYER DETAILS

Date joining the Fund: D D / M M / Y Y Y Y Date of benefit: D D / M M / Y Y Y Y

Income category: _____ Payroll number: _____

Member's share of contribution: _____ Employer's share of contribution: _____

Employer or account number: _____

NB: Proof of income/salary slip to be submitted with this form.

We confirm that the applicant is employed and commenced employment on (date): D D / M M / Y Y Y Y

and that contributions are being deducted in accordance with the applicant's income and the eligible dependants, in terms of the appropriate contribution table. Any further changes to the employee's status will be advised to the Fund within seven days.

Company/division: _____ Name: _____

Designation: _____ Email contact: _____

Date: D D / M M / Y Y Y Y Telephone: _____ Fax: _____

_____

SIGNATURE OF EMPLOYER

OFFICIAL STAMP OF EMPLOYER

FOR OFFICE USE ONLY

Total monthly contribution: _____

SECTION 3 PRINCIPAL MEMBER AND DEPENDENT DETAILS (SHADED AREAS FOR OFFICE USE ONLY)

Marital codes
M = Married S = Single
D = Divorced W = Widowed

Gender codes
M = Male
F = Female

Relationship codes
S = Spouse C = Child
P = Parent LP = Life partner

Important: New applications will not be considered unless the correct documentation is supplied. Non-compliance will result in either a delay in processing or rejection of your application. (Please complete with names as stated on your identity document or birth certificate.)

NB: Shaded areas for office use only	Surname	First name	Date of birth	Gender	Marital status	Relationship	ID number
Principal member 00			DD/MM/YY			N/A	
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 01			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 02			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 03			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 04			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							

Note: Child Dependants who are aged between 21 and 25 years, who are either full-time students or financially dependent on their parents, must provide proof thereof.(Full-time students, please submit a confirmation letter from your registered institution; financially dependent child dependants please submit an affidavit).

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SECTION 4 PREVIOUS MEDICAL SCHEME

Please give full details of your membership of any previous medical scheme(s) and termination dates (list the most recent first and provide proof by attaching your certificate/s of membership).

Main member

Name of scheme: _____

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership from: D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

Are you still a member? ☐ Yes ☐ No End date if you have already resigned: D D / M M / Y Y Y Y

Reason for leaving: _____

If all dependants were on the same medical scheme(s) as completed above, please tick to confirm: ☐

Dependant 1

Name of scheme: _____

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership from: D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

Are you still a member? ☐ Yes ☐ No End date if you have already resigned: D D / M M / Y Y Y Y

Reason for leaving: _____

Dependant 2

Name of scheme: _____

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership from: D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

Are you still a member? ☐ Yes ☐ No End date if you have already resigned: D D / M M / Y Y Y Y

Reason for leaving: _____

Dependant 3

Name of scheme: _____

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership from: D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

Are you still a member? ☐ Yes ☐ No End date if you have already resigned: D D / M M / Y Y Y Y

Reason for leaving: _____

NOTE: If you have more than three dependants, please photocopy this page

Did you contribute to a savings account? ☐ Yes ☐ No

If yes, please indicate what percentage you paid towards savings: _____ %

Waiting period imposed? ☐ Yes ☐ No

If yes, please indicate what waiting periods were imposed: _____

Late joiner penalties imposed? ☐ Yes ☐ No

If yes, please indicate what penalties were imposed: _____

SECTION 5 MOVING FROM ANOTHER MEDICAL SCHEME

Please ensure that you have completed the information in Section 4 before completing the below:
For any person named on this application form:

1. Have they been admitted to hospital in the 12 months before this application? ☐ Yes ☐ No
2. Are they currently taking regular, ongoing medicine for a medical condition? ☐ Yes ☐ No
3. Are they planning to, or expecting to, be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment in the next 12 months? ☐ Yes ☐ No

If you answered YES to any of the above questions, we may apply a three-month general waiting period and/or a 12-month condition-specific waiting period to your application. During the waiting period we will only cover claims relating to Prescribed Minimum Benefits.

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SECTION 6 FOR INTERNAL USE ONLY

			Number of years subject to penalty	Penalty imposed (please tick)	
Current age		years			
Less: creditable coverage		years	1-4 years	5%	
= Number of years not covered		years	5-14 years	25%	
Less: qualifying age		years	15-24 years	50%	
Years subject to penalty		years	25+ years	75%	

Vetted by (name): _____

Signature (supervisor): _____ Date: D D / M M / Y Y Y Y

Processed by (name): _____

Signature: _____ Date: D D / M M / Y Y Y Y

SECTION 7 MEDICAL HISTORY OF PRINCIPAL MEMBER AND DEPENDANTS TO BE REGISTERED

To match the correct dependant code with the codes below, please refer to Section 3.
IMPORTANT: Please submit proof and date of treatment of pre-existing health conditions of principal member and all dependants. This means a sickness or condition for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months preceding application. Please ask your treating doctor to help you to provide the relevant ICD-10 code for your condition.

Please provide full details for any of the conditions below in the space provided and attach relevant medical reports to this form):

	Mark one		Dependant number (Mark with X where applicable)					ICD- 10 code	Date of last treatment
1. Any disorder of the heart (e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	Y	N	00	01	02	03	04		
2. High blood pressure or disease of the blood vessels or circulatory disorder (e.g. cramp during exercise, stroke, high cholesterol, hardening of arteries)?	Y	N	00	01	02	03	04		
3. Any respiratory or lung disease (e.g. asthma, bronchitis, persistent cough, tuberculosis?	Y	N	00	01	02	03	04		
4. Any disorder of the digestive system, gall bladder, pancreas or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, anal bleeding, haemorrhoids or jaundice)?	Y	N	00	01	02	03	04		
5. Disease or disorder of the kidneys, bladder or reproductive organs (e.g. albumin in urine, kidney stones, prostatitis, venereal diseases, infertility or impotence)?	Y	N	00	01	02	03	04		
6. Any nervous or mental complaint (e.g. epilepsy, blackouts, anxiety or depression)?	Y	N	00	01	02	03	04		
7. Any type of nerve ailment (e.g. loss of sensation, numbness or paralysis)?	Y	N	00	01	02	03	04		
8. Ear, eye, nose or throat disorder (e.g. discharge, defective vision)?	Y	N	00	01	02	03	04		
9. Disorder or disease of skin, muscles, bones, joints, limbs, spine (e.g. psoriasis, arthritis, gout, slipped disc or other back trouble)?	Y	N	00	01	02	03	04		
10. Diabetes, hormonal imbalance, glandular or metabolic diseases, thyroid or blood disorders?	Y	N	00	01	02	03	04		
11. Cancer, growth, tumour of any kind?	Y	N	00	01	02	03	04		
12. Any other illness, disorder, operation, disability or accident (e.g. fractured nose, breathing disorders, mammary hypertrophy [enlarged breasts with associated side-effects], AIDS, congenital abnormalities, etc)?	Y	N	00	01	02	03	04		

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	Mark one		Dependant number (Mark with X where applicable)					ICD- 10 code	Date of last treatment
13. Are you pregnant? State expected date of confinement.	Y	N	00	01	02	03	04		
14. Are you or your dependants currently undergoing or expecting to undergo any medical, dental or surgical treatment?	Y	N	00	01	02	03	04		
15. Have you or your dependants received any medical, dental or surgical treatment?	Y	N	00	01	02	03	04		
16. Have any exclusions been imposed on yourself or your dependants by any medical scheme on which you have been registered? If YES, please state details below.	Y	N	00	01	02	03	04		

17. Please give any other relevant information: _____

_____

_____

DISCLAIMER: I will inform the Fund Fund of any changes in my health status or the health of my dependant/s within 30 days of the change occuring from the date of application and within 90 days of the activation date.

Question no.	Name of patient	Nature and duration of complaint and full details of treatment being, or expected to be, received. NB: Please specify all medication	Name and telephone number of attending doctor or hospital

SECTION 8 GENERAL

I hereby apply to be admitted as a member of Sizwe Medical Fund, hereafter referred to as "the Fund" and agree to familiarise myself with, and abide by, its rules and regulations as amended from time to time. I am familiar with the benefits and conditions of my chosen option and hereby authorise my employer to deduct from my salary my monthly contribution as I may lawfully owe to the Fund and to remit such amounts to the Fund. Furthermore, I understand that I will be held liable for any legal costs incurred in the recovery of any amounts owing to the Fund. I hereby authorise any doctor or other person, who may be in possession of, or hereafter acquire information concerning my health or the health of any of my dependants, to disclose this information at their reasonable discretion. I understand that the Fund may request a medical report at its own cost when I join the Fund and that all health and personal information given to the Fund be handled confidentially by them for purposes outlined in Section 10. In the event the Fund wishes to use my, or my dependants', confidential information for purposes other than those outlined in Section 10, the Fund will require consent from me or my dependant/s within 30 days of the change occurring from the date of application and within 90 days of the activation date. I understand that the Fund may impose a general and/or condition-specific waiting period according to the Medical Schemes Act (131 of 1998) when I and/or my dependants join. I understand that according to the Medical Schemes Act, I may only belong to one medical scheme at a time. I consent to all conversations between the Fund or its contracted parties and myself being recorded. I understand that application for admission to the Fund is not subject to the services of a broker, but should I appoint the below broker to manage my application, I am entitled to cancel the broker's services at any time. I hereby declare that the information in this application is true and correct and agree that any false declaration could render my application null and void. I hereby declare that the accuracy and completeness of all answers, statements and other information provided by or on behalf of me, is my responsibility.

Applicant's signature: _____ Date: D D / M M / Y Y Y Y

IMPORTANT: Failure to disclose all relevant and/or correct information may adversely affect the benefits available to you and your dependants.

SECTION 9 APPOINTED BROKER DETAILS (WHERE APPLICABLE)

I authorise _____ (broker's name) to act and sign all necessary documentation on my behalf and that his/her commission will be paid on receipt of my first contribution to the Fund.

To be completed by broker:

Brokerage: _____ Financial Services Provider number _____

Intermediary code: _____ Email _____

Tel: ( ) _____ Cell: _____ Date: D D / M M / Y Y Y Y

Physical address: _____

_____ Postal code:_____

Postal address: _____

_____ Postal code: _____

CMS accreditation number: _____

I hereby declare that I am accredited with the Council of Medical Schemes, am a licensed Financial Services Provider and have a valid contract with Sizwe Medical Fund. I hereby declare that the information on this application form is correct and that there is no material misrepresentation of any fact. In the event of material misrepresentation or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation. The applicant is familiar with the information requested in the application form and all the relevant information was provided to the applicant. The advice given to the member was impartial and in the best interests of the applicant.

Applicant's signature: _____ Broker's signature: _____

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Commission payable: _____

SECTION 10 THE FUND RESERVES THE RIGHT TO CANCEL

The fund reserves the right to cancel or suspend membership and impose restrictions on a member or dependants, on the grounds of:

A) FAILURE TO TIMEOUSLY PAY THE MONTHLY CONTRIBUTIONS AS SPECIFIED IN THE RULES

B) FAILURE TO REPAY ANY DEBT TO THE FUND

C) SUBMISSION OF FRAUDULENT CLAIMS

D) THE NON-DISCLOSURE OF MATERIAL INFORMATION

SECTION 11 FUND DECLARATION

Sizwe Medical Fund declares that the member's personal details and medical information, obtained from healthcare providers with the consent of the member, shall be kept confidential and will not be used for purposes of related company business nor sold for commercial purposes. All staff within the Fund and contracted third parties are bound by internal confidentiality agreements. Information given to the Fund will be used for the following purposes: processing the member's application, re-imbursement of claims, determining member entitlements to benefits, managed care and risk management practices. In the event of a breach in confidentiality, the Fund assumes responsibility and the breach will be managed according to the Fund's internal protocols.

SECTION 12 INCOME DECLARATION AND BANKING DETAILS FOR REFUND PURPOSES AND DEBIT ORDER AUTHORITY

A) Banking details

Bank: _____ Branch: _____ Branch code: _____

Type of account: _____ Account number: _____

EFT payment (payment of claims refunds directly into your bank account): Please include an original cancelled cheque (for a cheque account) or a recent original bank statement (for a savings or transmission account). Copies of cheques or bank statements cannot be accepted.

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B) Income declaration (compulsory for all members)

Your Gomomo Care contributions depend on the higher income of you or your spouse/ partner. Income for this purpose includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (including self-employment and informal employment); pension and annuity proceeds; interest earned on active and passive investments, including rental income from leasing properties; and distributions received from a trust.

IMPORTANT: Declaring income that is lower than your actual income is fraud. This will lead to the immediate termination of your membership.

By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources.

	Main Member	Spouse/partner
Total earnings over the last 12 months	R	R
Total monthly earnings	R	R

I declare that this income declaration is true and accurate.

Signature of main applicant: _____

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C) Contribution payments

I hereby authorise that the monthly contribution, as raised by the Sizwe Medical Fund, may be withdrawn from the above-mentioned account on the 1st of each month for the current month's membership contributions. This payment will represent the full monthly contribution payable to the Fund. I further understand that if payment is not made to the Fund on the 1st of each month, then my membership can be terminated with immediate effect and all benefits derived from the Fund will cease. I hereby declare that the information in this application is true and correct and agree that any false declaration could render my application null and void.

Date of first payment: D D / M M / Y Y Y Y

SECTION 13 ESSENTIAL DOCUMENTS (COMPULSORY)

Please provide the following documentation with your application:

	Are the relevant documents attached?			
Copy of ID for yourself and your dependants:	YES		NO	
Fully completed doctor choice form (at the end of this application):	YES		NO	
Birth certificates of children (where ID is not available):	YES		NO	
Clinic cards for newborn babies (within 30 days of birth to avoid waiting periods):	YES		NO	
Documentary proof in the case of adopted/foster children:	YES		NO	
Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting periods):	YES		NO	
Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable):	YES		NO	
Membership certificates with termination dates from previous medical aids, for member and dependants (where applicable):	YES		NO	
Proof of study for dependant/s, from age of 21 years, or affidavit for financially dependent dependant/s or doctor's letter for mentally or physically disabled children:	YES		NO	
Proof of taxable income (ie, pay slip, SARS IT34 form, etc):	YES		NO	
Either an original cancelled cheque (for a cheque account) or an original bank statement (for a transmission or savings account) so that claims can be paid directly into your bank account:	YES		NO	
ID photos for main member and dependants	YES		NO	

PLEASE ENSURE THIS SECTION IS COMPLETED IN FULL AND ALL NECESSARY DOCUMENTS ARE ATTACHED WITH YOUR APPLICATION. FAILURE TO SUBMIT THE RELEVANT DOCUMENTS WILL DELAY THE PROCESSING OF YOUR MEMBERSHIP APPLICATION.

DOCTOR SELECTION FORM

PLEASE ENSURE THAT THE MEMBER AND DEPENDANT DETAILS ON THIS FORM ARE THE SAME AS ON YOUR/THEIR ID DOCUMENT OR BIRTH CERTIFICATE.

	Principal member	Dependant 1 (spouse)	Dependant 2	Dependant 3	Dependant 4
Member details					
Surname					
First names					
ID number					
Date of birth					
Gender (male/female)					
Address					
Doctor details					
Name of doctor of choice					
Doctor's address					
Doctor's telephone number					
Dentist details					
Name of dentist of choice					
Dentist's address					
Dentist's telephone number					
Optometrist details					
Name of optometrist of choice					
Optometrist's address					
Optometrist's telephone number					
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Practice number					
Membership number					

If you have more than four dependants, please complete a second form.

Signature: _____ Date: D D / M M / Y Y Y Y

Company name:_____

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Contact us on: **0860 tel arc / 0860 835 272,** P.O. Box 1874, Parklands, 2121, www.aon.co.za
FSB number: 20555; CMS number: ORG895

Acknowledgement of appointment

I hereby authorise Aon Hewitt to be my duly appointed Broker with immediate effect.

My ID ☐☐☐☐☐☐☐☐☐☐☐☐☐ and membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

I have also been informed of the commission due to Aon Hewitt, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum of R75.00 excl. Vat per month. I have further been issued with a Statutory Notice and Section 13 certificate.

Signed at (town or city) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on yy/mm/dd ☐☐☐☐☐☐

Signature ______________________

Permission to make certain information available to Aon Hewitt

I give consent for the disclosure of information about me.

Membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Medical Scheme ______________________ Aon Hewitt Broker Code ______________________

Title ☐☐☐☐ Initials ☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

ID or passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐

To clarify this, the following information will be made available:

Personal examples	**Benefit examples**	**Financial examples**	**Medical examples**
Membership number Date of birth ID number Postal and e-mail Address Contact details Physical address Telephone numbers	Plan type Medical Savings Account amounts available Medical Savings Account choice Scheme Rate or Cost Current Medical Savings Account spent Limits Waiting period: details Wellness benefits Self-payment Gap Above Threshold Benefit	Tax certificate and tax reports Banking details Total contribution and breakdown	Chronic indicator Chronic condition PMB Chronic condition details Confirmation of claims paid (excluding amount and paid from where) Claims transaction history Hospital procedures Procedures codes Procedures done in doctor's rooms paid from Hospital Benefit

I hereby also authorise Aon Hewitt and/or Aon to provide me with any products that they consider appropriate to me.

Yes ☐ No ☐

Signed at (town or city) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on yy/mm/dd ☐☐☐☐☐☐

Signature ______________________