Application for membership 2008

self med medical scheme

Simplicity
Sincerity
Security

- Use only black ink.
- Use block capital letters to fill in the spaces.
- Use only one character per block.
- Leave one block empty between words.
- Where necessary, mark square clearly with a ✓.

Enquiries:
Tel: 0860 787 372 (SUPERB)
Fax: 0860 288 363 (ATTEND)
Selfmed Medical Scheme
PO Box 5543
Tygervalley 7536

Reg. No: 1446 FSP No: 15494

For office use only:
Member number:

Ⓐ Details of the applicant

Surname
Full names
Initials
Title

Please submit a copy of the first page of your identity document.

Identity number
Date of birth D D M M Y Y Y Y

Nickname
Gender M F
Marital status
Language E A

Physical address
Postal code
Postal address
Postal code

Telephone number (h)
Telephone number (w)
Cellphone number
Fax number

E-mail address
Preferred method of communication Telephone E-mail sms Ordinary mail

Ⓑ Details of the intermediary

Are you accredited with the Council of Medical Schemes? YES NO

Intermediary code
Accreditation number
Financial Advisory and Intermediary Services Act (FAIS) number
E-mail address

If your details have changed, or if you have not submitted business within the past six months, please complete the following:

Company

Name and initials

Surname Language A E

Cellphone number Fax number

I understand that commission will be paid to me in accordance with legislation.

Signature: Intermediary

Date signed D D M M Y Y Y Y

c Option choice

Selfmed 80%	Tick here (X)		Principal Member	Adult Dependant	Minor Dependant
From 1/1/08		All income	R2 765	R2 396	R477

MEDXXI	Tick here (X)		Principal Member	Adult Dependant	Minor Dependant
From 1/1/08		All income	R699	R600	R386

MEDXXI – Chronic	Tick here (X)		Principal Member	Adult Dependant	Minor Dependant
From 1/1/08		All income	R1 799	R1 418	R545

MEDXXI Comprehensive	Tick here (X)		Principal Member	Adult Dependant	Minor Dependant
From 1/1/08		All income	R1 113	R834	R443

Selfsure	Tick here (X)		Principal Member	Adult Dependant	Minor Dependant
From 1/1/08		All income	R1 086	R1 029	R304

Preferred inception date: 0 1 M M Y Y Y Y

NB: Your benefit start date may vary from your inception date.

Declaration for acceptance of waiting periods

I am aware that a 3-month general and/or a 12-month condition specific waiting period (nine months on existing pregnancy) may be imposed on my membership with effect from date of registration if:

- I have not been on a previous scheme for more than 3-months prior to my application for membership.
- I was on a previous scheme for more than 3-months prior to my application for membership (12-month condition specific waiting period only).
- I was on a previous scheme for 2 years or more and apply for membership within 3 months (3-month general waiting period only).

Name Date D D M M Y Y Y Y Signature

Declaration for acceptance of late joiner penalty

I am aware that a penalty may be added to my monthly contributions and/or that of my dependants with effect from date of registration if I, and/or any of my dependants are aged 35 years or older at the time of application, and was/were not registered as a member or dependant on a registered medical scheme on 1 April 2001, and/or has/have been without medical cover for a period exceeding three consecutive months since 1 April 2001.

Name Date D D M M Y Y Y Y Signature

Ⓓ Details of dependants

Please submit copies of all ID documents and tertiary institution registration certificates. A copy of a student card will not be accepted. Affidavits are required in respect of a common law spouse or partner.

- **Dependant 1**

Surname

Name and initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant

- **Dependant 2**

Surname

Name and initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant

- **Dependant 3**

Surname

Name and initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant

- **Dependant 4**

Surname

Name and initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant

- **Dependant 5**

Surname

Name and initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant

Ⓔ Bank details for benefit refunds *(what Selfmed must pay you)*

Bank name

Branch name

Branch number

Account type ☐ Current ☐ Savings ☐ Transmission

Account number

NB: Please verify all details and attach supporting documentation, e.g. cancelled cheque, copy of bank statement.
I hereby request and authorise you to credit any Medical Scheme benefits which may accrue to me to the account mentioned above.

Signature

Date D D M M Y Y Y Y

Ⓕ Payment details

• Contribution details (what you must pay Selfmed)

Mode of payment — Debit order ☐ — Contribution schedule ☐

Is the applicant the contribution payer? — YES ☐ — NO ☐

Please supply the following details:

Type of contribution payer? — Individual ☐ — Company ☐

Full name of contribution payer

Identity number of contribution payer *(only individuals)* — Date of birth *(only individuals)* D D M M Y Y Y Y

Name of bank

Branch

Branch code — Date of first deduction 0 1 M M Y Y Y Y

Type of account — ☐ Savings account — ☐ Cheque account — ☐ Transmission account

Account number

I (a) authorise Selfmed to draw against my above-mentioned bank and (b) authorise my bank / employer to pay Selfmed the amount of my monthly contribution (current and arrears) as applicable from time to time.
Please note that the effective/lodgement date for all debit orders will only be on the first day of the month.

Authorisation for deduction granted:

Signature (contribution payer) — Date signed D D M M Y Y Y Y

OR: If joint or company bank account (at least two persons who have signing powers must sign this debit order):

Stamp:
Company *(if applicable)* — Date stamped D D M M Y Y Y Y

1st signature — 2nd signature

Authorised capacity — Authorised capacity

Date D D M M Y Y Y Y — Date D D M M Y Y Y Y

NOTE: Please check all details and attach supporting documentation e.g. cancelled cheque, copy of bank statement etc.
If you transfer your account at any time, or if your banking details change, please advise Selfmed immediately.

Ⓖ Previous Medical Scheme history *(Please attach copies of all previous medical scheme certificates. Copies of membership cards will not be accepted.)*

Are you changing Medical Schemes as a result of a change of employment? *(If YES, please provide letter of resignation from company)* YES ☐ NO ☐

Please provide details of all medical schemes that you (or any of your dependants) previously belonged to: If you do not provide full details of your previous membership, waiting periods and late joiner penalties may be imposed. The Scheme reserves the right to request documented proof of membership if required.

	Scheme Name	Member No.	Registration Date	Cancellation Date	Reason for cancellation of membership
Applicant					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					
Dependant 5					

(H) Health statement

Medical details of the applicant (and any dependants – excluding a child registered within 30 days of date of birth)

Information must be supplied in respect of all the questions below. Please indicate your answers with an "X" in the appropriate block and provide full details below. All questions in this section must be completed or application will be considered incomplete.

General Practitioner's Name

General Practitioner's Contact Number

During the past 12 months, have you (or any of your dependants) been diagnosed with or received treatment/advice for any condition/impairment or illness relating to one of the following categories listed? Indicate specific condition by underscoring the specific condition. As this is not an all inclusive list, if your particular condition does not appear in the list of examples, it is imperative that you insert the condition in the relevant block.

• Section A				
A.1	Heart, blood vessels, or circulatory system	e.g. Cardiac murmurs, high blood pressure, chest pain, tightness of chest, palpitations, coronary thrombosis, valve defects, shortness of breath, stroke, high cholesterol, cramps during light exercise or walking, varicose veins, cardiac irregularities, swelling of the legs, or leg ulscers.	Yes	No
A.2	Respiratory system or lungs	e.g. Asthma, tuberculosis (TB), chronic bronchitis, pneumonia, persistent cough, coughing up blood,emphysema/COOPD or bronchospasm.	Yes	No
A.3	Digestive system or liver	e.g. Ulcers of the stomach or duodenum, chronic indigestion, jaundice, liver disease, Hepatitis B, bleeding from the rectum, any related hernia, ulcerative colitis, Crohn's Disease, "gall stones", heartburn, persistent abdominal pain, loss of weight (not due to diet), persistent diarrhea, or persisten constipation.	Yes	No
A.4	Kidneys, bladder or sexual organs	e.g. Kidney stones, infections, blood or protein in the urine, or difficulty in passing urine.	Yes	No
A.5	Nervous system and	e.g. Depression, anorexia, anxiety or stress-related disorders, nervous tension, frequent headaches, psychological disturbances, migraine, fits, fainting, blackouts, multiple sclerosis, epilepsy, paralysis, brain impairment, Alzheimers multiple sclerosis or dizziness.	Yes	No
A.6	Eye, ear, nose or throat	e.g. Defective sight, glaucoma, retinitis pigmentosa, hearing impairment, recurrent ear infections, balance disturbance, vocal problems, hoarseness, impaired speech, allergies, cataracts, chronic sinusitus, and/or strabismus.	Yes	No
A.7	Skeleton, vertebral column, joints, muscles, or skin	e.g. Back pain, displacement of the vertebrae or discs, any other back or neck trouble or operations, arthritis or arthritic pain, chronic gout, rheumatism, eruptions or diseases of the skin such as porphyria, psoriasis, dermatitis, acne – valgaris or nodular cystic, any physical disability, any chiropractic treatment, eczema or sciatica.	Yes	No
A.8	Reproductive system	e.g. Ovarian cysts, hysterectomy, venereal diseases, any condition of the cervix, breast lumps, symptomatic excessive enlargement of breast, prostatitis, testicular tumours, endometriosis, bladder, urological condition or fertility treatment.	Yes	No
A.9	Dental system	e.g. Poor closure of the jaws, implants, orthodontic, periodontic or maxillo-facial surgery.	Yes	No
A.10	Tropical or infectious diseases	e.g. Malaria, bilharzia, brucellosis, typhoid fever, etc.	Yes	No
• **Section B: Use table on next page to supply detail.**				
B.1	Are you (or any of your dependants) currently pregnant? If so, please specify the expected date of delivery_____ and specify how many months_____.		Yes	No
B.2	Have you or any of your dependants had cancer, growths, or any other kind of tumours, lumps (benign or malignant) incl. Hodgkins disease?		Yes	No
B.3	Have you or any of your dependants had diabetes, sugar in the urine, leukaemia, haemophilia, bleeding disorders, anaemia, spleen, thyroid gland or other glandular or blood diseases and/or any related endocrine disorder?		Yes	No
B.4	Have you or any of your dependants had dialysis for renal failure?		Yes	No
B.5	Has any application by you (or any of your dependants) for life, medical, disability or dread disease insurance ever been declined, postponed, withdrawn, or accepted with special terms, or at a special premium? Or have you ever submitted a disability, accident or trauma benefit claim (as a result of dread disease) to any insurer or fund?		Yes	No
B.6	Have you (or any of your dependants) ever undergone any specialised tests or examinations such as the following: ECG, X-rays, ultrasound, CT, MRI scans or any other pathological tests (such as cholesterol tests)? If so, please provide full details of the results.		Yes	No
B.7	Are you (or any of your dependants) currently taking any prescribed medication?		Yes	No
B.8	Are you (or any of your dependants) receiving any treatment for a medical or other problem?		Yes	No
B.9	Have you (or any of your dependants) taken any drugs such as Mandrax, cocaine or dagga during the past 12 months?		Yes	No
B.10	Has any member of your (or your spouse's) immediate family, e.g. parents, brothers, sisters, suffered from diabetes, heart disease, high blood pressure, raised cholesterol, mental disease, porphyria, or any other hereditary disease? If "YES", please state which relative, his/her age and type of disease.		Yes	No
B.11	Do you or any of your dependants plan to seek medical advice or treatment during the next 6 months?		Yes	No
B.12	**The above questions are not all inclusive. Should you (or one of your dependants) have any condition that is not covered by these questions, you must provide us with such information. Are you aware of any such condition?**		Yes	No

If the answer to any of the questions in sections A and B was "YES", please give full details below of treatment received:

Question number	Name of applicant (or dependant)	Nature of illness, ailment, abnormality or treatment prescribed/received	Frequency and duration of illness, ailments or treatments with dates of occurences	Dates of last symptoms of each ailment and details of medication and dosage prescribed

Medication table

If the answer to any of the questions in sections A and B was "YES", please give full details below:

Question number	Name of applicant (or dependant)	Nature of illness, ailment, abnormality or treatment prescribed/suggested	Name of medication

I have read the declaration below and am fully aware of the consequences of withholding information or providing any false or incomplete information.

D D M M Y Y Y Y
Date

Signature of applicant

(I) Declaration by applicant

I, the undersigned, apply for the membership as set out in this application for myself (and the registration of my dependants).
I acknowledge that I (and my dependants) will not be considered as members of Selfmed until I receive written confirmation of membership.
The scheme, or its agents may from time to time do the following in respect of me (and any of my dependants):

- Request and receive any medical and medically related information that is relevant to consider this application and any claim-related benefits for me (and any of my dependants for whom this application is accepted). Such information may be obtained from any healthcare provider or healthcare facility.
- Communicate any medical and medically related information from any healthcare provider or healthcare facility to the scheme's contracted healthcare management company. The purpose of this exchange is to ensure that the most cost-effective and high quality medical care benefits are obtained for all members of the scheme.

I further acknowledge and accept that, once I receive written confirmation of membership of the scheme, the scheme or its agents may from time to time, and without notice to me, do the following in respect of me (and any of my dependants):

- conduct investigations into any claim submitted by me or on behalf of my dependants;
- conduct medical investigations of any kind and at any time, into my or my dependants' medical history and/or current medical condition, including but not limited to, obtaining copies of my or my dependants' medical records, information regarding my or their medical history and results of any medical tests and examinations;
- instruct me or my dependants to undergo any medical testing and examinations as are deemed by the scheme or its agents to be a necessary part of such investigations;
- access any/all results of such tests and examinations carried out at the instance of the scheme or its agents, without my consent; and
- request that I furnish to them copies of all my or my dependants' medical records and any information regarding my or their medical history as well as any results of medical tests and examinations, immediately upon request thereof.

By my signature below I expressly authorise the scheme to do all things necessary to carry out the abovementioned investigations.
I further give my permission for:

- The required information to be requested, communicated and received at any time. This may even be after my death (or that of any of my dependants).
- the Scheme to perform a credit search with any Credit Bureau and any information so obtained may be disclosed to any other third party.

I warrant that the information in this application, whether it is in my own handwriting or not, is complete and correct. This also applies to information in other documents provided by me, any of my dependants, or healthcare provider or healthcare facility. If any information is not complete or correct the Scheme may cancel my membership in full. The scheme may also cancel my membership in full if the incomplete or incorrect information is about any of the dependants. Otherwise the Scheme may cancel the registration of the dependant regarding whom the information was incomplete or incorrect. In either case, I shall forfeit the full contributions already paid to the Scheme, or the contributions for the dependant who has been removed from my membership. If my membership is cancelled in full, I shall also pay back to the Scheme all benefits paid out to me and any of my dependants. If a dependant is removed from my membership, I shall pay back all benefits paid for such a dependant.
I undertake to advise Selfmed of any change in my state of health (or that of any of my dependants) which occurs prior to my inception date.
If any of the medical details that I have supplied in this application change before my membership starts, the Scheme may reconsider my application. The Scheme, at its own discretion and even after my membership has started, may reconsider the full application, or only that of a certain dependant. If this is the case, the terms as explained in this declaration will apply.
I understand that the relationship between me (and any of my dependants) and the Scheme is controlled by the rules of the Scheme. I undertake to familiarise myself (and any of my dependants) with the rules of the Scheme, as well as the changes that are made to the rules from time to time.
I undertake to give the Scheme one (1) calendar months' notice should I decide to cancel my membership.
I also confirm that I have appointed the intermediary as set out in this application as my healthcare consultant. This healthcare consultant or any other healthcare consultant appointed by me may also request the Scheme to provide any information about my membership and claims history or that of any of my dependants.

Signature:

Date signed D D M M Y Y Y Y