

## Application to Register a Dependant

### Instructions

1. A copy of each Dependant's ID / Passport / Birth Certificate / Proof of Birth from hospital or clinic must be attached.
2. Any deviating or illegible information will result in further enquiries which could delay your application for Dependant membership.
3. Membership is subject to the conditions, exclusions or limitations of benefits in accordance with the Medical Schemes Act 131 of 1998 and/or Scheme Rules.
4. Terms and conditions issued in respect of this application are valid for 30 days from the signature date.

### Additional documentation required for this application:

Application for recognition of:	Document required:
a) Newly born child	Birth certificate or proof of birth from hospital or clinic
b) Legally adopted child	Birth certificate and adoption order
c) Spouse/Partner	Marriage certificate
d) Full-time student	Proof of full-time registration at a recognised national educational institution
e) Medical unfitness	Doctor's report

### Section 1: Details of Principal Member

Member Number

Title  Initials  First name

Surname

ID number

Race African/Black (A)  Coloured (C)  White (W)  Indian/Asian (I)  Unknown (U)

Telephone number

### Section 2: Details of Dependant(s)

First name	Surname, if different from Principal Member	ID No./Passport No.	Race	Gender (M/F)	Relationship to Principal Member
1.			A C W I U		
2.			A C W I U		
3.			A C W I U		
4.			A C W I U		

Inception date of Dependant(s) Date  0 1 -  M M -  2 0 Y Y

### Section 3: Financial Advisor / Broker

Name

Broker Code  Accreditation Number

Telephone number (code - number)

Email Address

I \_\_\_\_\_ (Principal Member), declare that, I am aware of the appointment of the abovementioned Financial Adviser/Broker and that;

1. I give my broker access to my and my dependant(s) membership information with the Scheme in order to be of service to me;
2. This appointment was made voluntarily by me and can be cancelled at any time;
3. This appointment will entitle me to receive certain services from my Financial Advisor/Broker and that this was explained to my satisfaction.

Account Holder Signature  Date  D D -  M M -  2 0 Y Y

Financial Advisor Signature  Date  D D -  M M -  2 0 Y Y

## Section 4: Previous Medical Scheme Information

Please attach certificate(s) of previous medical scheme(s), if applicable.

Should additional space be required, copy this section and attach it to this application.

Please list previous medical scheme details below for each additional Dependant.

Name of Dependant	Name of scheme	Member number	Date joined	Date terminated or current

Have any of your Dependants ever had a waiting period, pre-existing condition, exclusion or a late joiner penalty?

Yes

No

### Section 4.1: Medical Details Questionnaire

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

All questions must be answered with either 'Yes' or 'No'. If the answer to any question is 'Yes', please provide full details. If more space is required, please include additional pages.

4.1.1 Have your dependant/s suffered from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, headaches, Systemic Lupus Erythematosus (SLE) depression, anxiety, epilepsy, and/ or thyroid disorders)? If yes, provide details.

Yes

No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.2 Have your dependant/s suffered from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/or a spastic colon)? If yes, provide details.

Yes

No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.3 Have your dependant/s suffered from muscle, bone, joints, skin or nerve illnesses or disorders (e.g. back and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, motor neuron disease, osteoporosis, dermatitis)? If yes, provide details.

Yes

No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.4 Have your dependant/s suffered from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts, irregular menstrual cycle / abnormal (irrespective of severity) menstrual bleeding)? If yes, provide details.

Yes

No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.5 Have your dependant/s suffered from eye, ear, nose, mouth (teeth or gums) or throat disorders (e.g. glaucoma, cataracts, sinusitis, visual disorders, deafness, rhinitis, orthodontics)? If yes, provide details.

Yes

No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.6 Have your dependant/s suffered from any blood disorders, cancer (either benign or malignant)? If yes, provide details.

Yes

No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

## Section 4.1: Medical Details Questionnaire - Continued

4.1.7 Are any of your dependant/s pregnant?

If yes, provide details.

Yes   No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.8 Were your dependant/s hospitalised or had surgery in the past (including but not limited to pacemaker, VP shunt, joint replacements)? If yes, provide details.

Yes   No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.9 Are your dependant/s planning any hospitalisation or surgery within the next 12 months?

If yes, provide details.

Yes   No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.10 Is there any other condition or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim (including planned procedures, paraplegia, quadriplegia and birth defects)? If yes, provide details.

Yes   No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

4.1.11 Have your dependant/s experienced any symptoms, how insignificant it might seem, that have not yet been treated or diagnosed?

If yes, provide details.

Yes   No


## Section 4.2: GP Nomination - Essence Option Only

Members on the Essence Option are required to nominate a General Practitioner (GP) in respect of the treatment of chronic conditions. Please note that a GP nomination is required for each beneficiary.

First name of Beneficiary	Surname, if different from Principal Member	GP Name	Practice Name	Practice number
1.				
2.				
3.				
4.				
5.				
6.				

## Section 4.3: HIV/Aids

**Failure to disclose a pre-existing condition as stipulated, could limit and/or exclude certain benefits or result in termination of membership.**

If you and/or any of your Dependants are living with HIV/Aids and would prefer not to disclose your and/or their HIV-status on this form due to confidentiality, you may wait until you have received your membership number; please then dial **0860 50 60 80** in order to notify the Scheme that you and/or any of your Dependants are living with HIV/Aids. This information must be disclosed to KeyHealth within 7 days of your official entry onto KeyHealth.

## Section 5: Employer Consent and Support

As the Employer of the above Principal Member, we support this application to register the Dependant(s) indicated under Section 2 and undertake to deduct and pay over to the Scheme the altered member's portion and employer's portion of contributions, where applicable.

**SIGNATURE AND STAMP OF EMPLOYER**

**DESIGNATION**

Date   -   -

## Section 6: Declaration by Principal Member

### PLEASE NOTE

- 6.1. Acceptance of this application is at the discretion of the Scheme and shall be subjected to such conditions as the Scheme may determine in its rules from time to time.
- 6.2. The Scheme reserves the right to call for such additional information on the income, where applicable, and health of the applicant and/or Dependants.
- 6.3. With specific reference to and acknowledgement of the detail contained in the Medical Details section, failure to disclose pertinent information or to supply false information could lead to the termination of membership or such other measures as the Scheme may determine in its sole discretion, and the applicant's attention is specifically drawn to Article 66 of the Medical Scheme Act, Act No. 131 of 1998.

#### 6.4.1. I declare that

- 6.4.1.1. the contents of this application, and any other documents which may be required in support thereof, are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and should there be any change in state of health or illness suffered by myself or any of my registered dependants from the date of signing this application form and the date of inception on the Scheme, notification of such change will be provided to the Scheme in writing with full details of such condition/ailment;
- 6.4.1.2. none of the applicants are registered with another medical scheme.

#### 6.4.2. further accept that

- 6.4.2.1. my statements and answers in this application form shall form the basis of the proposed membership;
- 6.4.2.2. if I omit any pertinent information or make any false statement in my application, the Scheme may decline the application, or if membership has already been granted, terminate my or my dependants' membership, or impose such appropriate sanctions as it may determine in its sole discretion;
- 6.4.2.3. I will be responsible for all monthly contributions for the applicants and for any other amounts legally due to the Scheme, which may be incurred by them, and that such amounts may be recovered from me retrospectively;
- 6.4.2.4. I will be responsible for informing the Scheme of any changes to any of my dependants and their income, where applicable, within 30 days and for obtaining confirmation of those changes, in writing, from the Scheme.
- 6.4.2.5. All conversations between myself and the Scheme or its contracted parties may be recorded.
- 6.4.2.6. The terms and conditions issued in respect of this application are valid for 30 days from the signature date.

#### 6.4.3. authorise

- 6.4.3.1. the Scheme to obtain and disclose any medical information it may require in order to consider and process this application for membership, and, during my period of membership, to obtain as it may require, disclose and utilise any information concerning my own and my dependants medical history;
- 6.4.3.2. where applicable, my employer to pay to the Scheme any portion of the monthly contribution due by me, by deduction from my salary, and any amount in arrears by way of double deduction from my salary, until fully recovered;
- 6.4.3.3. the Scheme to register me and my dependants' membership.

#### 6.4.4. state that

- 6.4.4.1. I am familiar with the conditions and benefits of the option selected, notwithstanding representation by any other party;
- 6.4.4.2. I undertake to abide by the latest Rules of the Scheme as amended from time to time.
- 6.4.4.3. I am of sound mind, memory and understanding.
- 6.4.4.4. I understand that the Scheme may impose general and/or conditions specific waiting periods, as provided for in the Medical Schemes Act 131 of 1998;
- 6.4.4.5. I fully understand the implications of moving from one scheme to another;
- 6.4.4.6. Admission to the Scheme is not subject to the services of a broker being employed;
- 6.4.4.7. I understand the role of my broker (if applicable).

**This authorisation will remain valid until cancelled in terms of the Rules of the Scheme.**

Signature of  
Principal Member

Print Name and Surname  
of Principal Member

Date

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