

## Continuation Form

Membership Number

### Existing KeyHealth members to complete this form to continue membership due to the following:

- Principal member and spouse swop
- Dependant becoming principal member

**Please note:**

- To qualify as continuation of membership no break in your KeyHealth membership is allowed.

### Section 1: Principal Member Details

Title  Initials  First name

Surname

ID number  Gender:  Male  Female

Passport number  Marital status

Residential address

Postal address (if different)

Courier address (if different from residential address)

Telephone - home (code - number)  Cellphone number

Telephone - work (code - number)  Fax - work (code - number)

E-mail address

Language preference  English  Afrikaans

### Section 2: Dependants

Please complete the table below to confirm the details of your spouse/partner and/or dependants who will remain on your membership. If you are adding a spouse/partner and/or dependants who were not previously covered on your membership, please complete and submit an Application to register a dependant form with this form.

#### Spouse or Partner

Title  Initials  First name

Surname

Previous surname

ID number  Gender:  Male  Female

Passport number  Country of origin

Country of residence

Relationship to Principal Member

#### Dependants

First name	Surname, if different from Principal Member	ID No./Passport No.	Date of Birth						Gender (M/F)	Relationship to Principal Member
			Y	Y	M	M	D	D		
1.										
2.										
3.										
4.										

\*An Applicant may be requested by the Scheme to confirm relationship to Principal Member.

## Section 3: Contribution Collection and Claims Reimbursements

Please indicate the choice of monthly debit order deduction date:

<input type="checkbox"/> Use this account for <b>contribution collections and claims reimbursements</b> <input type="checkbox"/> Use this account for <b>contribution collections only</b> <hr/> Name of account holder _____ <hr/> Name of financial institution _____ Bank Branch code <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> Type of Account <input type="text" value="Cheque"/> <input type="text" value="Transmission"/> <input type="text" value="Savings"/> Bank account number <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> *Please note that no credit card banking details will be accepted <div style="border: 1px solid #ccc; padding: 5px; margin-top: 5px;">                     Account Holder Signature <input style="width: 100%;" type="text"/>                      Date <input type="text" value="D"/> <input type="text" value="D"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/> </div>	<input type="checkbox"/> Use this account for <b>claims reimbursements only</b> <hr/> Name of account holder _____ <hr/> Name of financial institution _____ Bank Branch code <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> Type of Account <input type="text" value="Cheque"/> <input type="text" value="Transmission"/> <input type="text" value="Savings"/> Bank account number <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> *Please note that no credit card banking details will be accepted <div style="border: 1px solid #ccc; padding: 5px; margin-top: 5px;">                     Account Holder Signature <input style="width: 100%;" type="text"/>                      Date <input type="text" value="D"/> <input type="text" value="D"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/> </div>
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**If a company account is to be debited:**

- I warrant that the Principal Member, referred to in this application, is an employee of the organisation.
- KeyHealth may bill the employer for the amount due for this member in the same manner as for other members that the organisation employs.

Name   
 Position in company

Authorised signatory <input style="width: 90%;" type="text"/>	Date <input type="text" value="D"/> <input type="text" value="D"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
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## Section 4: 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 <input style="width: 90%;" type="text"/>	Date <input type="text" value="D"/> <input type="text" value="D"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Financial Advisor Signature <input style="width: 90%;" type="text"/>	Date <input type="text" value="D"/> <input type="text" value="D"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

## Section 5: Declarations

### Section 5.1: Medical Scheme Declaration

#### KeyHealth Medical Scheme confirms that:

- 5.1.1 A member's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential;
- 5.1.2 Member information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes;
- 5.1.3 The Medical Scheme has data security measures in place including anti-virus security, prevention of unauthorized access to members detail, eliminating unauthorized e-mails, web-mails and access controls for signing on to the computer system;
- 5.1.4 The Medical Scheme has granted access, to certain persons within the organisation and its contracted third parties, to a beneficiarie's personal and health information. This is for the facilitation of normal business processes;
- 5.1.5 All KeyHealth employees and its contracted third parties is bound by internal confidentiality agreements;
- 5.1.6 The Medical Scheme and its contracted third parties will use the medical health/diagnosis/procedure information for the following purposes: processing the application for membership; re-imburement of claims, determining member entitlement to benefits, and risk management practices. Risk management practices include: hospital risk management, disease risk management and medicine risk management;
- 5.1.7 The Medical Scheme has ensured that confidentiality agreements have been entered into with all contracted third parties who have access to beneficiary information for the purposes of data transfer and management, Scheme administration and managed care arrangements;
- 5.1.8 In the event of a breach in confidentiality, the Medical Scheme assumes responsibility and the breach will be managed according to the Scheme's internal protocols.

### Section 5.2: Financial Declaration

- 5.2.1 I hereby instruct and authorise the Scheme to draw against my bank indicated in this application form (or any other bank or branch to which I may transfer my account) the amount necessary for payment of my monthly contribution due in respect of the abovementioned membership on the selected deduction date as indicated in Section 4 each and every month and continuing until termination of our agreement or until cancelled by me in writing. All such withdrawals from my bank account by the Scheme shall be treated as though they had been signed by me personally.
- 5.2.2 I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher.
- 5.2.3 I agree to pay any bank charges relating to this debit order instruction.
- 5.2.4 This authority may be cancelled by me giving you thirty days notice in writing, but I understand that I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my bank (whichever it is or will be).

### Section 5.3: Declaration by Principal Member

#### PLEASE NOTE

- 5.3.1. 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.
- 5.3.2. The Scheme reserves the right to call for such additional information on the income, where applicable, and health of the applicant and/or Dependants.
- 5.3.3. 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.

#### 5.3.4.1. I declare that

- 5.3.4.1.1. 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;
- 5.3.4.1.2. none of the applicants are registered with another medical scheme.

#### 5.3.4.2. further accept that

- 5.3.4.2.1. my statements and answers in this application form shall form the basis of the proposed membership;
- 5.3.4.2.2. 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;
- 5.3.4.2.3. 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;
- 5.3.4.2.4. 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.
- 5.3.4.2.5. All conversations between myself and the Scheme or its contracted parties may be recorded.
- 5.3.4.2.6. The terms and conditions issued in respect of this application are valid for 30 days from the signature date.

#### 5.3.4.3. authorise

- 5.3.4.3.1. 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;
- 5.3.4.3.2. 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;
- 5.3.4.3.3. the Scheme to register me and my dependants' membership.

## Section 5.3: Declaration by Principal Member - Continued

### 5.3.4.4. state that

- 5.3.4.4.1. I undertake to familiarise myself with the latest Rules of the Scheme as amended from time to time;
- 5.3.4.4.2. I am familiar with the conditions and benefits of the option selected, notwithstanding representation by any other party;
- 5.3.4.4.3. I am aware that the Scheme may impose general and/or conditions specific waiting periods, as provided for in the Medical Schemes Act 131 of 1998;
- 5.3.4.4.4. I fully understand the implications of moving from one scheme to another;
- 5.3.4.4.5. Admission to the Scheme is not subject to the services of a broker being employed;
- 5.3.4.4.6. 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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Be Smart. **Keep it Simple.**