Registration of my dependant(s)

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Postal address: PO Box 26004, ARCADIA, 0007
www.medihelp.co.za

For use by corporate clients
Payroll number

Employer's office stamp

How to complete this form:

1. Please complete in print using black ink and email, fax or post all pages of the form to Medihelp.
2. Please complete all sections in full and sign the application form.
3. Never sign a blank application form.

1. Details of member

Member number | Initials _____ | Title | Mr | Mrs | Ms | Other (specify)

First names _____

Surname _____

Cell No. _____ Tel No. (W) Code _____ No. _____

_____ Tel No. (H) Code _____ No. _____

Email address _____

Marital status

Married in community of property	Married out of community of property	Single	Divorced	Widow	Widower	Other (specify)

Date of marriage y y y y m m d d

2. Date on which my dependant(s) should be registered

2 0 y y m m d d

3. Details of dependant(s) I wish to register

The following dependants of a member may be registered:

- Spouse/partner.
- Father/mother/brothers/sisters/grandchildren of the member and whose financial care is entrusted to the member (**PLEASE NOTE:** these dependant(s) of the spouse/partner cannot be registered as dependant(s) of the member, and grandchildren of the member pay the same subscription as that of an adult dependant, unless legally adopted).
- Dependent own children (of the member and spouse/partner).
- Dependent stepchildren (of the member and spouse/partner).
- Adopted children/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement (of the member and spouse/partner). Official proof of the Court/clerk of the Court/appointed social worker must be provided in terms of the set criteria determined by Medihelp – foster children and children in temporary safe care may be registered as dependant(s) only up to the age of 21 years in terms of legislation.
- In the case of dependant(s) who are not South African citizens, a copy of their passport must be submitted with the completed application form.

Dependant

Surname _____

First names in full _____

Known as _____

ID/passport number | Gender | Male | Female

Date of birth y y y y m m d d | Cell No.

Email address _____

Relationship to member _____

3. Details of dependant(s) I wish to register (continued)

Dependant

Surname ______

First names in full ______

Known as ______

ID/passport number | | | | | | | | | | | | | | Gender Male Female

Date of birth y y y y m m d d Cell No.

Email address ______

Relationship to member ______

Dependant

Surname ______

First names in full ______

Known as ______

ID/passport number | | | | | | | | | | | | | | Gender Male Female

Date of birth y y y y m m d d Cell No.

Email address ______

Relationship to member ______

Dependant

Surname ______

First names in full ______

Known as ______

ID/passport number | | | | | | | | | | | | | | Gender Male Female

Date of birth y y y y m m d d Cell No.

Email address ______

Relationship to member ______

Dependant

Surname ______

First names in full ______

Known as ______

ID/passport number | | | | | | | | | | | | | | Gender Male Female

Date of birth y y y y m m d d Cell No.

Email address ______

Relationship to member ______

Dependant

Surname ______

First names in full ______

Known as ______

ID/passport number | | | | | | | | | | | | | | Gender Male Female

Date of birth y y y y m m d d Cell No.

Email address ______

Relationship to member ______

4. My dependant's(s') previous/current membership of medical scheme(s)

4.1 Has this application been necessitated by a change in employment which resulted in the cancellation of your dependant's(s') membership of a previous medical scheme? (Not applicable to employees who have retired and are entitled to remain at their previous/current medical scheme.)

Yes	No

Who was the member of the previous scheme? Name and surname

4.2 Please provide details of ALL the medical schemes where your dependant(s) are currently or have previously been enrolled:

NB:
- The date joined and date ended are important to place your dependant(s) in the correct enrolment category.
- Indicate "current" if your dependant's(s') membership of the particular scheme is still active.
- Ensure that the dates of your dependant's(s') membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated **separately** for each of your dependants.

Name of medical scheme*	Name and surname*	Membership number	Date joined*	Date ended*

* This information is compulsory. If not completed, your application to register your dependant(s) cannot be finalised.

4.3 Did your dependant's(s') previous medical scheme apply any late-joiner penalty?

Yes	No

If "Yes", please provide the following details:

Name of dependant(s)	Late-joiner penalty			
	5%	25%	50%	75%
	5%	25%	50%	75%
	5%	25%	50%	75%

4.4 Did your dependant's(s') previous medical scheme apply any condition-specific waiting period and was it still active at the time of termination of membership? (The treatment of a specific condition was excluded from benefits for a certain period.)

Yes	No

If "Yes", please provide the following details:

Name of dependant(s)	Condition-specific waiting period (CSW)	End date of CSW
		y y y y m m d d
		y y y y m m d d
		y y y y m m d d

If the space provided is insufficient, please provide additional information on a separate page.

5. Medical questionnaire

- All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

1. Muscle and skeletal/bone system, brain, nerve and skin conditions (e.g. back and neck problems, including injuries, osteoarthritis, rheumatoid arthritis, gout, multiple sclerosis, hip and knee problems, osteoporosis, dermatitis, stroke, epilepsy, paralysis, tremors)?

Mark with an "X"

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

2. Gastrointestinal system (e.g. gastro-oesophageal reflux, heartburn, ulcer, Crohn disease, ulcerative colitis, diverticulitis, spastic colon, liver conditions, hernias, piles)?

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

3. Urinary tract system and/or genital disorders (e.g. kidney stones, renal failure, dialysis, prostate disorders, endometriosis, ovarian cysts, menstrual disorders, pelvic inflammatory conditions, miscarriages)?

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

4. Chronic illness (e.g. elevated cholesterol, chest pain, heart diseases, pacemaker, diabetes, high blood pressure, asthma, bronchitis, obstructive lung disease, emphysema, systemic lupus erythematosus, thyroid, porphyria)?

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

6. Medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependant(s) mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

5. Is any female beneficiary indicated in this application currently pregnant or is pregnancy suspected?

Mark with an "X"

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

6. Blood conditions/disorders and/or any type of cancer (e.g. haemophilia, leukaemia, lymphoma, tissue-specific cancers)?

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

7. Psychiatric conditions and/or any substance dependency (e.g. depression, bipolar disorder, stress, panic attacks, schizophrenia, alcohol and/or drug abuse)?

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

8. Any disorder of the ears, nose, throat, eyes and/or teeth (e.g. glaucoma, cataracts, glasses or contact lenses, deafness, retinal conditions, orthodontics, crowns and bridges, maxillofacial and oral surgery)?

Yes	No

Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

5. Medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether your dependant(s) mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

9. Is any dependant mentioned on this application HIV positive or diagnosed with Aids?*

Take note that if no selection is made, Medihelp will regard your answer as "No".

Mark with an "X"

Yes	No

*If any of your dependants prefer not to disclose thier HIV status on this application form, it will remain your responsibility to inform the Scheme and to enrol on the Medihelp HIV/Aids programme within 21 days from your enrolment date by phoning LifeSense on 0860 50 60 80. If you fail to adhere to this condition, it will be considered as non-disclosure of information, which may result in the termination of your membership. On receipt of this request, Medihelp will determine whether underwriting conditions will be applied, and if this is the case, you will receive an amended Proof of membership document.

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

10. Are your dependant(s) planning to have any examination, treatment and/or procedure done in the next 12 months?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate any examination, treatment and/or therapy that is planned within the next 12 months

11. Has any person indicated in this application been examined (medical tests, X-rays, scans), diagnosed and/or treated (with/without procedures) for any condition or disorder **not** mentioned in the medical questionnaire (including medicine/vitamins bought without prescription)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

Please note that this medical questionnaire does not constitute an application to register or authorise chronic medicine/PMB services/planned procedures/treatment for benefits. Should you need to obtain authorisation for chronic medicine, please phone Medihelp on 086 0100 678 once your dependant's(s') membership of Medihelp has been finalised, to obtain an application form for chronic medicine benefits. Alternatively, you can download an application form from the Medihelp website at www.medihelp.co.za by logging on to the secured website for members.

6. Conditions of membership, declaration by member/dependant and consent for Medihelp to process personal information

Medihelp confirms that –

1. your and your registered dependant's(s') personal and medical information will be treated confidentially and will not be sold to a third party or used for commercial or related purposes;
2. security measures have been implemented to protect your data and that Medihelp staff and contracted parties have access to your data to process and pay claims, among other things, and that they have signed a confidentiality agreement in terms of which they undertake not to disclose your personal information to any unauthorised parties;
3. your personal information will only be used for purposes such as processing your application for the registration of your dependant(s), paying your medical claims, determining whether you are entitled to benefits, managing risks, and for any communication purposes;
4. the Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy; and
5 should you make use of a Medihelp-contracted brokerage's services, then relevant membership information will be made available to the appointed brokerage in order to render a service to you, and any authorised person at the brokerage may instruct Medihelp to change any of your personal information, except for banking details, unless you instruct Medihelp otherwise.

Your responsibilities as a member/dependant of Medihelp:

6. I will ensure that I know all the provisions of Medihelp's Rules and will read all the correspondence from Medihelp, such as newsletters and statements, and I will study my benefit guide and familiarise myself with the coverage offered by the benefit option that I have chosen.
7. I undertake to abide by the Rules, as amended from time to time and available at www.medihelp.co.za on the secured website for members, and to not submit any fraudulent claims or commit any fraudulent acts. I understand that on approval of my application for the registration of my dependant(s), the Rules of Medihelp will be binding on my registered dependant(s), as the Rules are binding on me.
8. By signing this application I confirm that I have the right to apply for the registration of my dependant(s) and to act for those that I apply for, in any matter relating to this application.
9. I declare that the information provided in this application for the registration of my dependant(s) is accurate and complete. I understand that any false declaration or omission of information may result in the termination of my membership and that of my registered dependant(s) or any other measures which Medihelp, in its sole discretion, may decide to take, subject to appeal procedures. **I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependant(s), even if this application was completed by my financial adviser or any other third party on my behalf. I undertake to notify Medihelp in writing should there be any changes in the health status of my dependant(s) after my application for the registration of my dependant(s) has been submitted but prior to their membership commencement date. I undertake to notify Medihelp in writing should there be any future changes in my personal and/or banking details and I understand that any non-adherence hereto may result in my membership being terminated in accordance with provisions of the Medical Schemes Act and Medihelp's registered Rules.**
10. I understand that this application form is valid for a period of 30 days from the date of signature. The period may be further extended, subject to Medihelp's discretion, up to a maximum of 60 days, whereafter the application form will be cancelled and I will be required to submit a new application form.
11. I confirm that my dependant(s) will not be registered as beneficiaries of another registered medical scheme on the date on which I request their registration at Medihelp.
12. I take note that the monthly subscription fees will be due as per arrangement with Medihelp and thereafter on the same day of every subsequent calendar month. Should my employer/institution, as my authorised agent, undertake to pay my subscriptions to Medihelp, I give permission to my employer/institution to deduct the amount payable to Medihelp from my salary and pay such amount over to Medihelp. I furthermore give permission that Medihelp may provide the following information to my employer/institution in order to pay subscriptions: my identity number, my tax certificate information, as well as my dependant's(s') dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account should I terminate my membership of Medihelp.
13. I confirm that I am responsible to give advance notice of termination of membership, and that my dependant(s) will not be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

Medihelp's rights as a medical scheme:

14. I am aware that a three-month general and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on the membership of my registered dependant(s) in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise their membership without issuing a document containing the conditions of their membership in the event that no waiting period and/or late-joiner penalty is imposed.
15. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid in respect of particular services, for example by enforcing co-payments and exclusions.
16. Medihelp's Rules may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and designated service providers.
17. Medihelp may also restrict interchanges between benefit options to the beginning of a year, and require a notice period as set out in the Rules.
18. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
19. I am further aware that my membership may be suspended should I not pay my contributions or debt in full for a period of one month, and that my membership may be terminated should I be in arrears for a period of two months, and that my account will be handed over for collection.
20. I am aware that Medihelp may increase its subscriptions annually at the beginning of the year.

Protection of information:

21. I hereby give permission, and declare that I have obtained the consent of my dependant(s), that –

21.1 Medihelp may enquire about the health status of my dependant(s) at any medical doctor or any person who is in possession of such information, and give permission for the doctor or person concerned to make such information available to Medihelp and its contracted third parties for the administration of my health plan;

21.2 my dependant(s) may enquire about my personal and medical information and that of any of my dependant(s) at Medihelp's disposal;

21.3 an adviser in the service of a Medihelp-contracted brokerage, should I make such an appointment and use their services, may have access to my personal and medical information and that of any of my registered dependant(s) at Medihelp's disposal, and that such adviser or an authorised person at the brokerage may instruct Medihelp to change any of my personal information for the purpose of proper administration and underwriting, except for my banking details;

21.4 Medihelp may disclose my and my dependant's(s') medical and personal information to medical service providers for the purpose of delivering medical services to me and my dependant(s) and to pay for such services; and

6. Conditions of membership, declaration by member/dependant and consent for Medihelp to process personal information (continued)

21.5 Medihelp may share my information for statistical analysis and academic research purposes.

22. I understand that the information contemplated in paragraph 21 will only be used for the purposes as set out in Medihelp's confidentiality statement (on this application form) and that any deviation will be regarded as a breach of confidence. Should Medihelp wish to use the information for any other purpose, Medihelp must first obtain my approval.

23. I agree that all my telephone conversations and/or that of my dependant(s) with Medihelp and/or its contracted third parties may be recorded for quality control purposes and to help detect and prevent fraud.

24. I agree that Medihelp may, for the purpose of considering my application for the registration of my dependant(s) or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependant(s) from medical practitioners, financial advisers, industry regulatory bodies or employers.

25. I further consent, and declare that I have obtained the consent of my dependant(s), that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependant's(s') consumer credit record, including and not limited to information about my/my dependant's(s') credit history, financial history, personal information (excluding medical information) and judgment or default history.

Signature of member _____ Date 2 0 y y m m d d

Should you be applying on behalf of another person as guardian or curator, please complete the following:

In your capacity as Member ☐ Guardian ☐ Curator ☐

ID/passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Title Mr Mrs Ms Other (specify)

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator, must accompany this application.

First name _____ Surname _____

Tel No. Code _____ No. _____ Fax No. Code _____ No. _____

Cell number _____

7. Undertaking and declaration by adviser

NB: If this section is not completed in full by the adviser, no commission will be paid.

I declare that –

1. the member has appointed me as his/her adviser and is entitled to cancel my services at any time;
2. I have signed a valid contract with my Medihelp-contracted brokerage; and
3. the member has signed the application in person.

I take note that the adviser/brokerage indemnifies Medihelp against any non-adherence to the legal requirements as quoted above.

Name of brokerage _____

Brokerage code A ☐☐☐☐ Adviser code ☐☐☐☐

Name and surname of adviser _____

Tel No. Code _____ No. _____ Fax No. Code _____ No. _____

Email address _____

Signature of adviser _____ Date 2 0 y y m m d d

For office use only

Lead reference number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ M H ☐☐☐☐☐

In case of a dispute, the registered Rules of Medihelp will apply.