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CMAC
Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

hosmed medical scheme
care for life
Established IN 1988

SALGA FREEDOM OF ASSOCIATION MEMBERSHIP APPLICATION FORM

DOCUMENTS REQUIRED

	Yes	No
• Main member's copy of ID	☐	☐
• Dependant's copy of ID	☐	☐
• Birth certificate of child (where ID is not available)	☐	☐
• Documentary proof if dependant is adopted/foster child/student/disability status/adult dependant	☐	☐
• Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable)	☐	☐
• Membership certificate from previous medical aid (where applicable)	☐	☐

Broker Stamp

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss		Initials		First name	
Surname				Identity no.	
Tel. no. (h)		(w)		(Cell)	
Email					
Residential address					
				Postal code	
Postal address					
				Postal code	

Race (please tick) African ☐ Coloured ☐ Indian/Asian ☐ White ☐

Preferred method of communication (please tick) Email ☐ SMS ☐ Post ☐

SECTION B: HOSMED MEMBERSHIP DETAILS

Option: Plus ☐ Value ☐ Value Core ☐ Access* ☐ Essential ☐

**Please note that the Access Option has a 20% Medical Savings Account*

Employer name				Payroll no.	
Join date		Total contribution	R	Gross monthly salary	R

SECTION C: PARTICULARS OF DEPENDANTS

	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Name and Surname of dependant					
ID number (compulsory)					
Relationship to member (spouse, partner, daughter etc.)					
Sex (M/F)					
Race (African, Coloured, Indian/Asian, White)					
Address, if different from member					
Cell no.					

Note: Full 13 digit ID numbers are required in full in order to have the dependant considered for processing

SECTION D: MEDICAL CONDITIONS

Kindly supply the Scheme with any current medical and chronic conditions.

Please remember to register your chronic medication at our ChroniLine. Also register on our Chronic Disease Management Programme to qualify for additional benefits.

SECTION E: EMPLOYER DETAILS

Company			
Region		Date of employment	

Name _____ Employer signature _____ Designation _____ Date _____

SECTION F: BANKING DETAILS FOR DEDUCTION OF MONTHLY CONTRIBUTIONS (BY DEBIT ORDER)

Account holder						
Account number		Account type (please mark appropriate)	Current		Transmission	Savings
Name of bank						
Branch						
Branch code						
Debit order run date						

I authorise Hosmed to draw from my bank account (wherever it may be), the contribution and members portion of claims due in terms of the Rules of Hosmed, without prejudice to the rights of Hosmed. I further authorise Hosmed to increase the amounts due, in terms of the rules, and authorise my bank to effect payment of such increased amounts upon receipt of a written notice from Hosmed stating the increased amount and the date from which it is payable. This authorisation is to remain in effect until I cancel it by giving written notice to Hosmed. I agree that I am not entitled to recover any amount drawn from my account by means of this debit order and that should my bank repay such amount to me, I will refund it immediately to Hosmed. I undertake to notify Hosmed immediately of any change in respect of my details. I acknowledge that Hosmed may not cede or assign any of their right to any third party without my prior consent and that I may not delegate any of my obligations in terms of the contract to any third party without prior written consent of the authorised party. Hosmed is hereby authorised to debit by bank account with my portion of accounts paid on my behalf by Hosmed.

Name _____ Signature _____ Date _____

SECTION G: BANK DETAILS (FOR CLAIMS REFUND)

Account holder						
Account number		Account type (please mark appropriate)	Current		Transmission	Savings
Name of bank		Branch code				

SECTION H: UNDERTAKING BY MAIN MEMBER

I acknowledge that:

(a) I am aware that, once I have decided to move to another medical aid scheme – for which provision is made by my employer – I will not be allowed to move to another scheme during the next 12 months.

(b) The onus rests with me to ensure that my application is submitted to my Support Services Division.

(c) The onus rests with me to provide cancellation to my current Medical Aid before the deduction for Hosmed Medical Scheme can be implemented

(d) I must register my chronic medication with Hosmed.

(e) I agree to access www.hosmed.co.za to access full conditions and undertakings of the Scheme as a member of Hosmed Medical Scheme.

(f) Where applicable: Member Savings Account allocations will be pro-rated depending on when joining the option.

(g) The Scheme has the sole right to collect negative balances owed to the Scheme by the member even when member has terminated from the Scheme.

Signature of member _____ Employer Name _____ Employer Signature _____ Effective date of first deduction _____ Date _____

Membership Number			Employer stamp
Department			
Depot			
Tel			
Municipality name		Broker	

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