Affidavit regarding previous medical scheme(s) cover

P.O. Box 1101, Florida Glen, 1708 Call 0860 002 108
Fax (011) 758 7171 Email membermaint@bonitas.co.za

Section 1: Membership details

Title:		Surname:	
First names:			
Identity number:			
Physical address:			
		Code:	
Postal address:			
		Code:	

I hereby state under oath that the information provided below regarding previous medical scheme(s) membership is true and correct and that reasonable efforts have been made to obtain documentary evidence of such periods, but that I have been unsuccessful in my efforts.

Section 2: Details of previous medical scheme(s)

Name of medical scheme(s)	Names & surnames of all beneficiaries covered on this scheme	Inception date			Termination date		

Kindly ensure the blocks indicating the inception date and termination date are fully completed (e.g. 01012013). Also note that this affidavit is only applicable to medical schemes that are no longer registered with the Council for Medical Schemes ("CMS") as an active medical scheme(s).

Section 3: Acknowledgement and declaration

1. I declare that the information contained in this application form, is correct.
2. I declare that any false information in this application form or the non-disclosure of any material information will result in my membership being declared null and void.
3. I allow Bonitas to take all reasonable steps to verify information provided by me in this application form and agree to submit proof of identification to Bonitas on demand.
4. I consent to my telephone conversations with the Bonitas call centre being recorded and forming part of Bonitas' records. I also agree that such records will remain the sole property of Bonitas.
5. I declare that the information provided in this document is true and accurate and if accepted will form the basis of my agreement with Bonitas.
6. I acknowledge that I have read and understood the content of this application form. I confirm that the content of this application form and the implications thereof have been read and explained to me if necessary.
7. I hereby authorise the Scheme to share my and my dependants' personal and healthcare information with the Scheme healthcare management facility, the Scheme's administrator or the relevant government authorities for administrative and statistical purposes, provided such information shall be treated as confidential at all times. I agree that my and my dependants' personal healthcare data may be shared with third parties for the purpose of our membership trend analysis (e.g. employer). I have read and understood these statements and my permission and the permission of my dependants are given voluntarily. My signature below confirms that I give permission.

Signature of principal member: _____

Date: _____

Commissioner of oaths: _____

Date: _____

Commisioner of oaths stamp

The deponent having acknowledged that he/she knows and understands the contents of this affidavit.