MEDSHIELD medical scheme

GROUP TAKE-ON APPLICATION

Please complete all the relevant sections of this form in BLOCK LETTERS.

Email: newapplication@medshield.co.za

Broker code

Membership number: (for office use only):

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Date membership to commence: Y Y Y Y M M D D

DOCUMENT CHECK LIST

In order to avoid rejection of your application please provide the following documents:	PLEASE TICK
ID document copy/s for all beneficiaries (e.g. ID / Birth certificate)	
Student certifcate (child dependant age 21-28 that is studying or turning 21 in the next 3 months)	
Proof of previous medical scheme (certifcate of membership refecting an end date)	
Mem02 - Member Record Amendment (for Special Dependants: e.g. parents, foster child, niece, nephew, brother,sister, grandchild)	
Persal payslip (for persal members only)	
Stamped bank statement, stamped confirmation letter from the bank, copy of cancelled cheque, signed letter of authority for 3rd parties	
MEM013 - Family Practitioner Nomination form (only applicable to the MediValue and MediPhila options)	

I, ______________________________ hereby understand that it is an offense to submit fraudulent business and I have explained Non-disclosure, General and condition specific waiting periods, Late Joiner Penalty, PMB and Pro-rating of benefits.

I further declare that I have attached all documents as per the document check list above to this application form and that the application form is submitted to the Scheme within 14 days of the member declaration sign date.

Section A TO BE COMPLETED BY PRINCIPAL MEMBER : (Copy of ID required)

The MediValue and MediPhila benefit options require a completed MEM013 (a) or (c) Family Practitioner Nomination form to be submitted with this form.

Option selection:

First Name:

Surname:

ID/Passport Number:

Date of Birth: Y Y Y Y M M D D

Postal Address:

Postal Code:

Residential Address:

Postal Code:

E-mail Address:

Telephone No:

Gender: M F

Cell No:

Title:

Section B DEPENDANT DETAILS (attach copies of ID or Birth Certificate)

Please complete a MEM02 form for Special Dependants (e.g. Parents, Foster child, Niece, Nephew, Sibling, Grandchild).
Acceptance of dependants will in accordance with the Rules of the Scheme. Affidavits required for Special Dependants.

Name of Beneficiary	Surname (If different to Principal Member)	ID Number	Gender (M/F)	Relationship to Principal Member	Adult over 21 (Yes/No)
1					
2					
3					
4					
5					

Section C PREVIOUS MEDICAL AID HISTORY

Where applicable, please provide details of membership of all previous medical schemes cover.

Name of Scheme	Membership Number	Date Joined	Date Terminated

Section D EMPLOYER INFORMATION

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date: Y Y Y Y M M D D

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section F have been completed:

Employer's Email Address:

Employer Representative's Name:

Employer Representative's Designation:

Employer Representative Signature: ____________________ Date: Y Y Y Y M M D D

Section E BANK DETAILS OF PRINCIPAL MEMBER

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account.
A stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank in the name of the Principal Member is required.
Should contributions be paid by a 3rd party, a stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank together with a signed letter of authorisation from the account holder must accompany this form. For Organisations a signed letter of authorisation needs to be on a company letterhead.

Use this account for: claims refunds only ☐ contributions only ☐ contributions and claim refunds ☐

Name of Account Holder:

Bank Name:

Branch Name:

Bank Branch Code:

Bank Account Number:

Type of Account: Current | Transmission | Savings

Signature of Account Holder: ____________________

Section F IMMUNE DEFICIENCY STATUS (confidential disclosure)

If you or any of your dependants have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Programme on 086 050 6080 for more information on how to join the Programme.

Consent for Disclosure of Information to 3rd Party

Please complete the below should you require a nominated person to contact/make changes to your Medshield Medical Scheme membership on your behalf (i.e. a family member, attorney, etc.) - Please note that this is not complusory and merely for your convenience, should you so choose.

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Relationship to Member:

Email address:

Cellphone number:

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Relationship to Member:

Email address:

Cellphone number:

MEDSHIELD MEDICAL SCHEME

P.O. Box 4346, Randburg, 2125
www.medshield.co.za
newapplication@medshield.co.za or fax to 010 597 4710

Contact Centre:	086 000 2120
	Mon - Fri 8:30 - 17:00

BANK DETAILS

Account Holder:	Medshield Medical Scheme
Bank:	Nedbank
Branch:	Rivonia, 196905
Account number:	1969125969

Section F MEMBER DECLARATION

1. I, the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree to abide by its Rules and Regulations in accordance with the provisions of the Medical Schemes Act (Act 131 of 1998) as amended. I have been informed that the Scheme rules will be made available on request and that I am responsible to read and be bound by them.

2. I certify that all the information given is true and correct and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void and that all contributions paid by me shall be forfeited to the Scheme In such events, the Scheme shall be entitled to reclaim any which they may have paid to me, or any person on my or my dependant's behalf, under such contracts.

3. I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

4. As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

5. Notwithstanding point 3 and 4, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

6. As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

7. I hereby authorise the Scheme, or any of its nominated representatives, to confirm my bank details.

8. Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

9. I hereby authorise and request any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my / the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my / their death, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of any nature, which may be made against them as a result of, or arising out of, the disclosure of any test results or medical information.

10. The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi which will be deemed to be my postal address unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi shall be deemed to have been received by me on the 7th day after the date of posting.

11. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

    - a 3 (three) month general waiting period in respect of all benefits;
    - a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
    - a late joiner contribution penalty.

12. Should my state of health change significantly from the date of signing this application to the date of acceptance, I will notify the Scheme in writing.

13. I hereby confirm that I am not an active beneficiary on another medical scheme.

14. I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: ______________________________

Principal Member Signature: ______________________________

NB: Medshield Medical Scheme requires that your application form is submitted to the Scheme within 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

Date: | Y | Y | Y | Y | M | M | D | D |