CMAC
Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

MEDSHIELD
medical scheme

MEMBER DECLARATION

I, _____ (potential member's full name) the undersigned, ID number _____ am aware 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 to as 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 amounts which they may have paid to me, or any person on my or my dependant's behalf, under such contracts.

SECTION 1 MEDICAL HISTORY (tick yes or no)

Failure to disclose pre-existing conditions could limit exclude certain benefits or result in termination of your membership.
Have you or any of your dependants sought any advice, been diagnosed with, or treated for, any of the following conditions in the past 12 months? If Yes to any of the questions please provide full details, should you require additional space please add an additional page to the application form.

1. Any chronic illnesses? e.g. Cardio and vascular conditions, Obstructive lung disease, Diabetes, insulin or non insulin dependent diabetes mellitus, Thyroid or other glandular or blood disorders, etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

2. Skin, muscle or bone disease? e.g. Any skin rash, acne, eczema or psoriasis, multiple sclerosis, osteo or rheumatoid arthritis,osteoporosis, injury, back / neck or joint problems or replacement, fibromyalgia, prosthetic limbs, lumbago sciatica, spasms, etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

3. Digestive system, stomach, liver, gall bladder or pancreas? e.g. Stomach or duodenal ulcer, GORD/heartburn, hiatus hernia, Crohn's disease, ulcerative colitis, irritable bowel syndrome, rectal bleeding, hepatitis, cirrhosis, liver failure, etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

4. Psychiatric conditions? e.g. Schizophrenia, bipolar mood disorder, substance abuse, eating disorder, depression, panic attacks and / or Anxiety, ADHD or post traumatic stress disorder, etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

5. Complaints of the nervous system or brain? e.g. Epilepsy, stroke, blackouts, migraine, headaches, paralysis, Parkinson's or Alzheimers.

Y | N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

6. Complaints/disorder of the Ear, nose, throat or eye? e.g. Defective vision, cataracts, glaucoma, eye disorders, blindness, retinitis, disorders of the cornea or wear spectacles or contact lenses, hearing loss, ear discharge, otitis media, allergies or recurrent tonsillitis, etc.

Y | N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

7. Urinary tract, genital system or gynaecological disorders? e.g. UTI , kidney stones, kidney failure, prostatitis, sexually transmitted disease, HRT, ovarian cysts, fibroids, menstrual disorders or any abnormality of pregnancy or confinement, etc.

Y | N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

8. Are you or any of your dependants pregnant or suspect that you are pregnant?

Y | N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

9. Malignant or Benign neoplasms? e.g. cancers, malignant or non-malignant tumours/growths of any kind including removal of malignant or benign moles, etc.

Y | N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

10. Dentistry? e.g. Specialised dentistry/maxillo-facial treatment (currently undergoing or anticipating any specialised/ orthodontic or maxillofacial treatment), etc.

Y | N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

11. Any other medical condition not listed in question 1 - 10?

Y | N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		

DETAILS OF CONDITION/S OR TREATMENT/S

If you answer yes to any of the above questions please provide details in the table below:

Question No.	Beneficiary Name	Condition and Duration	Date of Last Treatment	Name of Attending Doctor

SURGERY AND HOSPITAL ADMISSIONS

Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past, and/or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future.

Beneficiary Name	Surgical procedure/Hospital admission	Date	Reason	Doctor

CHRONIC MEDICATION

Please supply details of any prescribed medication that you or any of your dependants are currently taking or expect to take in the future.

Question No.	Beneficiary Name	Condition and duration of condition	Date	Name of attending doctor	Date of treatment

SIGNATURE OF CONSULTANT _____ DATE D D M M Y Y Y Y

SIGNATURE OF MEMBER _____ DATE D D M M Y Y Y Y

Completed form must be faxed to 010 597 4710 or submitted via e-mail to membership@medshield.co.za .