



# My Medihelp application form 2020



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

**Thank you for choosing to join Medihelp medical scheme.**

**How to complete this form:**

- Please complete in print, using black ink, and email, fax or post all pages of the form to Medihelp.
- Please complete all sections in full and sign the application form.
- Note the following at section 5: If you apply for membership of the Necesses benefit option, complete item 5.2.
- Never sign a blank application form.

**1. Date from when membership is required**

2	0	y	y	m	m	d	d
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**2. Details of applicant (person who requests membership)**

ID/passport number 

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 Title 

Mr	Mrs	Ms	Other (specify)
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A copy of your passport must be attached if you use your passport number.

Surname \_\_\_\_\_ Initials \_\_\_\_\_  
 First names \_\_\_\_\_ Gender 

Male	Female
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 Known as \_\_\_\_\_

Marital status 

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

y	y	y	y	m	m	d	d
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 Date of marriage 

y	y	y	y	m	m	d	d
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 Income tax number 

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 Language 

Afrikaans	English
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**3. Contact details of applicant**

Residential address \_\_\_\_\_ Tel No. (W) Code \_\_\_\_\_ No. \_\_\_\_\_  
 \_\_\_\_\_ Tel No. (H) Code \_\_\_\_\_ No. \_\_\_\_\_  
 \_\_\_\_\_ Code 

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 Fax No. Code \_\_\_\_\_ No. \_\_\_\_\_  
 Postal address \_\_\_\_\_ Cell number \_\_\_\_\_  
 \_\_\_\_\_ Email address \_\_\_\_\_  
 \_\_\_\_\_ Code 

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May Medihelp use your/your dependant's(s') personal details to determine the quality of our service? 

Yes	No
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To improve the quality of our communication to you, please indicate if the following is applicable to you:

Visually impaired 

Yes	No
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 Hearing impaired 

Yes	No
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**4. Details of employer/institution responsible for paying your contributions**

NB: Complete only if contributions are paid in full or partially by your employer or any other institution.

Name of employer/institution \_\_\_\_\_ Campus/site \_\_\_\_\_  
 Branch code/Employer group No. \_\_\_\_\_  
 Payroll number \_\_\_\_\_  
 Appointment date 

y	y	y	y	m	m	d	d
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 Appointment 

Permanent	Temporary
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 Pay area \_\_\_\_\_

Office stamp of employer

**5. Choice of benefit option (choose only one benefit option by marking with an "X" at 5.1)**

**5.1 Benefit options**

**Note:**

- If you choose any of the savings options, please refer to section 5.3; and
- If you choose any of the network options (including Necessé), please refer to section 5.4.

Prime 1   Hospital plan	<input type="checkbox"/>	Prime 1 Network   Hospital plan	<input type="checkbox"/>	Prime 2   Savings	<input type="checkbox"/>	Prime 2 Network   Savings	<input type="checkbox"/>
Prime 3   Comprehensive	<input type="checkbox"/>	Prime 3 Network   Comprehensive	<input type="checkbox"/>	Elite   Comprehensive	<input type="checkbox"/>	Plus   Comprehensive	<input type="checkbox"/>
Necessé   Network	<input type="checkbox"/>	Unify   Savings	<input type="checkbox"/>				

**5.2 Gross monthly income – Necessé only**

Gross monthly income of applicant	<input type="text"/>	Occupation of applicant	_____
Gross monthly income of spouse/partner	<input type="text"/>	Occupation of spouse/partner	_____

For the purpose of the Necessé option, "monthly income" means the gross monthly income before any deductions.

**Proof of income must only be provided if the monthly income of both the applicant and the registered spouse/partner is less than the highest income category, since Medihelp will use the highest of the incomes declared to determine the contribution category.**

**Acceptable proof of income**

**Important:**

- If you cannot provide acceptable proof of income, your contribution will be calculated according to the highest income category.
- Medihelp may require additional proof other than the above.
- Only official bank statements on which the account holder's initials and surname are indicated, are acceptable. Please indicate clearly on the bank statements which payment(s) refer to your income.

<p><b>Income from investments:</b> This income must be declared by all individuals, if applicable, and includes interest, dividends and rental income.</p> <ul style="list-style-type: none"> <li>• Letter from an auditor/accountant/income tax adviser</li> <li>• Latest tax assessment – ITA34</li> <li>• IT3(a) and the past three months' bank statements*</li> <li>• Rental income – rental agreement and past three months' bank statements*</li> </ul>	<p><b>Income from full-time employment:</b> Gross monthly income includes all forms of remuneration, such as basic salary, overtime, commission, bonuses, allowances, fringe benefits and one-off payments.</p> <ul style="list-style-type: none"> <li>• Past three months' official payslips</li> <li>• Latest tax assessment – ITA34</li> <li>• IRP5 of the previous tax year</li> <li>• Past three months' commission and bank statements* indicating commission deposits</li> <li>• An official appointment letter by an employer, not older than three months, which indicates the member's gross monthly income</li> </ul>
<p><b>Pensioners: (Pension, annuity)</b></p> <ul style="list-style-type: none"> <li>• Latest tax assessment – ITA34</li> <li>• Past three months' pension payment advices. If you have fewer than three months' proof, please also supply the past three months' bank statements*</li> </ul>	<p><b>Self-employed: (Income from vocation/profession, total income from business, irregular income)</b></p> <ul style="list-style-type: none"> <li>• Latest tax assessment – ITA34</li> <li>• Letter from an auditor/accountant/income tax adviser</li> <li>• Past three months' commission and bank statements*</li> </ul>
<p><b>Unemployed:</b> Individuals who receive no income from a vocation/profession/business, who are unemployed or receive an allowance</p> <ul style="list-style-type: none"> <li>• UIF payments</li> <li>• Past three months' bank statements*</li> </ul>	<p><b>Employer groups:</b></p> <ul style="list-style-type: none"> <li>• Any proof of income applicable to individuals as indicated above</li> </ul>
<p><b>Full-time students:</b></p> <ul style="list-style-type: none"> <li>• A notice or letter of confirmation on an official letterhead from the institution where you are registered as a full-time student</li> <li>• New students who register for the first time: A letter of acceptance for the specific study year</li> </ul> <p><b>Full-time students who are 26 years or older or have dependants:</b></p> <ul style="list-style-type: none"> <li>• Proof of studies as well as the past three months' bank statements*</li> </ul>	<p><b>Income from trusts:</b></p> <ul style="list-style-type: none"> <li>• Latest tax assessment – ITA34</li> <li>• The past three months' bank statements indicating trust payments*</li> </ul>

\*Only the past three months' official bank statements indicating the account holder's initials and surname will be accepted. Please indicate clearly on the bank statements which payments refer to your income. Medihelp may require additional proof other than the above.

**5.3 Utilisation of savings account funds (Prime 2, Prime 2 Network and Unify)**

Please indicate your preference. If you do not select an option, Medihelp will pay all qualifying medical expenses from your savings account.

- Pay all qualifying medical expenses from my savings account.
- Pay only selective qualifying medical expenses from my savings account, excluding certain in-hospital expenses (e.g. tariff reductions, co-payments, amounts exceeding available benefits).

**5.4 Declaration by applicants who apply for enrolment on a network option (including Necessé)**

I confirm that I am aware of the following:

1. I will be liable for co-payments if I do not use Medihelp's hospital network, designated service providers (DSPs) and formulary medicine.
2. I must register my prescribed minimum benefit (PMB) condition with Medihelp and my PMB chronic medicine must be pre-authorized by Medihelp. Medihelp uses a DSP for PMB chronic medicine and a formulary applies. I will be responsible for a co-payment\* on my PMB chronic medicine should I fail to obtain this medicine from the DSP or deviate from the formulary for my benefit option.
3. My treating specialists should form part of Medihelp's DSP specialist network in order to prevent co-payments on PMB treatments.
4. I must use Medihelp's hospital network for all planned hospital admissions. If there is no network hospital available near my place of residence, I will need to travel to the nearest network hospital to obtain medical services. If I use a non-network hospital instead, I will be liable for a co-payment\*.

\* Please refer to your benefit option's guide/brochure for all applicable co-payments.

Signature of applicant	<input type="text"/>	Date	<input type="text"/>
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## 7. Banking details

### 7.1 Individual who pays own contributions (choose only one option by marking an "X")

I hereby authorise Medihelp to recover the applicable contributions payable by me to Medihelp by debit order from my bank account, monthly on the date indicated below. I further authorise Medihelp to increase or decrease the contribution, should it be necessary, and recover the amended amount, or any contributions in arrears, from my bank account.

Please deduct my monthly contributions by debit order from my bank account on the following date:

<input type="checkbox"/>	On the first workday of the month in which I requested enrolment and thereafter on the first workday of every subsequent month.
<input type="checkbox"/>	On the 25th day of the month prior to my enrolment and thereafter on the 25th day of the subsequent months of my membership.
<input type="checkbox"/>	On the last workday of the month prior to my enrolment and thereafter on the last workday of the subsequent months of my membership.

**Note:**

- Your contributions are payable in advance, and if your membership cannot be finalised in time for the deduction date chosen above, Medihelp will make two separate debit order deductions in your first month of membership, namely on the first available workday following the activation of your membership AND on the actual date you have chosen in the same month. Medihelp will thereafter collect your contributions monthly on the date you have chosen above.
- If the debit order deduction date falls on a weekend or a public holiday, your contributions will be deducted on the first workday after the selected deduction date.
- If no debit order deduction date is selected, Medihelp will make the deduction on the first workday of the month.

### 7.2 Individual whose employer/institution pays contributions

My employer/institution as my authorised agent hereby authorises Medihelp to recover the applicable contributions payable by my employer/institution as my authorised agent to Medihelp by debit order from my employer/institution as my authorised agent's bank account monthly on the last workday of each month as from the date of enrolment. I authorise Medihelp to increase or decrease the contributions, should it be necessary, and recover the amended amount, or any contributions in arrears, from my employer/institution as my authorised agent's bank account.

### 7.3 Banking details for debit order deductions and credit refunds (must be completed by all applicants)

<p><input type="checkbox"/> 1. Use this account for all transactions</p> <p><input type="checkbox"/> 2. Use this account only for the recovery of contributions  <b>NB: If you select this option, please complete your banking details for credit refunds in the table on the right.</b></p> <p>Bank _____</p> <p>Branch _____</p> <p>Branch code <input style="width: 100px;" type="text"/></p> <p>Type of account <input type="checkbox"/> Savings <input type="checkbox"/> Cheque</p> <p>Name of account holder _____</p> <p>Account number _____</p>	<p><input type="checkbox"/> Use this account for credit refunds only  <b>NB: If you selected option 2 on the left, please complete your banking details below.</b></p> <p>Bank _____</p> <p>Branch _____</p> <p>Branch code <input style="width: 100px;" type="text"/></p> <p>Type of account <input type="checkbox"/> Savings <input type="checkbox"/> Cheque</p> <p>Name of account holder _____</p> <p>Account number _____</p>
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If only one bank account number is provided, this account will be used both for the recovery of contributions and for refunding credit amounts. In the case of a trust, a copy of the trust deed must be submitted and the responsible trustee must sign.

<p>Signature of account holder/authorised signatory for recovery of contributions</p> <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 10px;"></div>	<p>Signature of account holder for credit refunds</p> <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 10px;"></div>
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**8. Previous/current membership of medical scheme(s)**

8.1 Has this application been necessitated by a change in employment which resulted in the cancellation of your 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
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8.2 Please provide details of ALL the medical schemes where you and your dependant(s) are currently or have previously been enrolled:

- NB:
- The date joined and date ended are important to place you and your dependants in the correct enrolment category.
  - Indicate "current" if your/your dependant's(s') membership of the particular scheme is still active.
  - Ensure that the dates of your/your dependant's(s') membership at the different schemes do not overlap.
  - Information regarding previous and current membership must be indicated separately for you and your dependant(s).
  - The Medical Schemes Act makes provision for a late-joiner penalty (LJP) to be imposed on an applicant aged 35 years or older at the time of joining a scheme who has not enjoyed previous coverage with a medical aid. The penalty, which is added to the member's monthly contribution, is calculated as a percentage of the member's contribution based on the total number of years without creditable coverage since the age of 35 years, as shown below:

**LJP intervals and penalty percentages**

1 – 4 years	5%	of the contribution of the beneficiary (excluding savings contribution)
5 –14 years	25%	
15 – 24 years	50%	
25 years +	75%	

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

\* This information is compulsory. If not completed, your application for membership cannot be finalised.

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

Yes	No
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If "Yes", please provide the following details:

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

8.4 Did your or 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
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If "Yes", please provide the following details:

Name of applicant/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.

**9. Medical history**

- Please ensure that you have completed **section 8** of this application form in full.
- Only complete **section 9.1** if you **and** your dependant(s) mentioned in this application form have been members of a medical scheme registered in South Africa for a continuous period of more than 24 months and the lapse between medical schemes is less than 90 days.
- Complete **section 9.2** in full if you or your dependant(s) mentioned in this application form have not been members of a medical scheme registered in South Africa for a continuous period of more than 24 months or the lapse between medical schemes exceeds 90 days.

**NB:** Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a possible non-disclosure of information investigation before the hospital admission or chronic medication will be authorised. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.

**9.1 Applicants who are moving from another medical scheme to Medihelp**

1. Have you or your dependant(s) been admitted to hospital within the last 12 months prior to submitting this application?
2. Are you or your dependant(s) currently taking regular, ongoing medicine and/or receiving treatment for a medical condition or symptom?
3. Are you or your dependant(s) planning or expecting to be hospitalised (including for a pregnancy) or to receive medical or surgical treatment and/or undergo examinations during the next 12 months?

Yes	No
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Yes	No
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Yes	No
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**9.2 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 you and/or 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).

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

**9.2 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 you and/or 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).**

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)? Mark with an “X”

Yes	No
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Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

5. Is any female beneficiary indicated in this application currently pregnant or is pregnancy suspected? Mark with an “X”

Yes	No
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Name(s) of patient(s)	Specify any known complications, if applicable	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the 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)? Mark with an “X”

Yes	No
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Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the 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)? Mark with an “X”

Yes	No
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Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the 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)? Mark with an “X”

Yes	No
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Name(s) of patient(s)	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months



**9.2 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 you and/or 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).**

9. Are you or any dependant(s) mentioned on this application HIV positive or diagnosed with Aids?\*

Mark with an “X”

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

\*If you or any of your dependant(s) prefer not to disclose your and/or your dependant(s)’s 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 type of treatment, therapy and the name of the medicine used during the past 12 months

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

Yes	No
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Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 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
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Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the 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 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](http://www.medihelp.co.za) by logging on to the secured website for members.

## 10. Conditions of membership, declaration by applicant 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 membership, 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 your banking details, unless you instruct Medihelp otherwise.

### Your responsibilities as a member 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](http://www.medihelp.co.za) on the secured website for members, and to not submit any fraudulent claims or commit any fraudulent acts.
8. I declare that the information provided in this application for membership 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 my health status or that of my dependants after my application for membership has been submitted but prior to my membership commencement date. I confirm that the residential address stated on page 1 is the address that I choose for the purpose of serving any legal documentation. I undertake to notify Medihelp in writing should there be any future changes in my personal details 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.**
9. 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.
10. I confirm that neither my dependant(s) nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.
11. I take note that the monthly contribution fees will be due on the date selected by me at Section 7 of this application form or on the first workday after this date, and thereafter on the same day of every subsequent calendar month. Should my employer/institution, as my authorised agent, undertake to pay my contributions 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 contributions: 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.
12. I confirm that I am responsible to give advance notice of termination of membership, and that neither my dependant(s) nor I will be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

### Medihelp's rights as a medical scheme:

13. I am aware that a three-month general waiting period and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on my membership and that of my registered dependant(s) in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise my membership without issuing a document containing the conditions of my membership in the event that no waiting period and/or late-joiner penalty is imposed.
14. 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.
15. 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.
16. 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.
17. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
18. I am further aware that my benefits may be suspended should I not pay my contributions or debt in full, that my membership may be terminated should any amount still be outstanding 30 days after the date of suspension, and that my account will be handed over for collection.
19. I am aware that Medihelp may increase its contributions annually at the beginning of the year.

### Protection of information:

20. I hereby give permission, and declare that I have obtained the consent of all my dependant(s), that –
  - 20.1 Medihelp may enquire about my health status or that 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;
  - 20.2 my dependant(s) may enquire about my personal and medical information and that of any of my dependant(s) at Medihelp's disposal;
  - 20.3 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;



**Additional information (if necessary)**

Membership number 

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 Title 

Mr	Mrs	Ms	Other (specify)
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Initials \_\_\_\_\_ Surname \_\_\_\_\_

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