

I/We hereby grant permission for Selfmed Medical Scheme to arrange with the abovementioned Bank or any other Bank to which I/we might change the account, to deduct the contribution (current and/or arrears) due in terms of the Rules of the Selfmed Medical Scheme (including any amendments that may be made during the term of membership) from the abovementioned banking account each month.

Please note that the effective/lodgement date for all debit orders will only be on the first day of the month.

If personal banking account:

Signature:
Account holder

Date

Name : Account holder

ⓓ Addition of dependant

In order to add a dependant to your membership (if application is not made within 30 days of date of acquisition), please complete sections D1 and D2. Please provide copies of all ID documents.

ⓓ 1) Addition of dependants (In the case of newborns, within 30 days of date of birth and in the case of marriage, within 30 days of the wedding date. Please attach a copy of the birth certificate / marriage certificate.)

	Full name(s)	Surname	Gender (M/F)	Date of birth	Identity number	Relationship to Principal member
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

ⓓ 2) Previous Medical Scheme history (Please attach copies of all previous medical scheme certificates. Copies of membership cards will not be accepted.)

Are you changing Medical Schemes as a result of a change of employment? (If YES, please provide letter of resignation from company) YES NO

Please provide details of all medical schemes that you (or any of your dependants) previously belonged to: If you do not provide full details of your previous membership, waiting periods and late joiner penalties may be imposed. The Scheme reserves the right to request documented proof of membership if required.

	Scheme Name	Member No.	Registration Date	Cancellation Date	Reason for cancellation of membership
Applicant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name of bank or building society

Branch

Branch code

Type of account Savings account Cheque account Transmission account

Account number

Gross monthly income

Signature:
Account holder

(H) Declaration by member

I, the undersigned, hereby declare that:

The scheme, or its agents may from time to time do the following in respect of me (and any of my dependants):

- Request and receive any medical and medically related information that is relevant to consider this application and any claim-related benefits for me (and any of my dependants for whom this application is accepted). Such information may be obtained from any healthcare provider or healthcare facility.
- Communicate any medical and medically related information from any healthcare provider or healthcare facility to the scheme's contracted healthcare management company. The purpose of this exchange is to ensure that the most cost-effective and high quality medical care benefits are obtained for all members of the scheme.

I further acknowledge that, the scheme or its agents may from time to time, and without notice to me, do the following in respect of me (and any of my dependants):

- conduct investigations into any claim submitted by me or on behalf of my dependants;
- conduct medical investigations of any kind and at any time, into my or my dependants medical history and/or current medical condition, including but not limited to, obtaining copies of my or my dependants medical records, information regarding my or their medical history and results of any medical tests and examinations;
- instruct me or my dependants to undergo any medical testing and examinations as are deemed by the scheme or its agents to be a necessary part of such investigations;
- access any/all results of such tests and examinations carried out at the instance of the scheme or its agents, without my consent; and
- request that I furnish to them copies of all my or my dependants medical records and any information regarding my or their medical history as well as any results of medical tests and examinations, immediately upon request thereof.

By my signature below I expressly authorise the scheme to do all things necessary to carry out the abovementioned investigations.

I further give my permission for:

- The required information to be requested, communicated and received at any time. This may even be after my death (or that of any of my dependants).
- the Scheme to perform a credit search with any Credit Bureau and any information so obtained may be disclosed to any other third party.

I warrant that the information in this application, whether it is in my own handwriting or not, is complete and correct. This also applies to information in other documents provided by me, any of my dependants, or healthcare provider or healthcare facility. If any information is not complete or correct the Scheme may cancel my membership in full. The scheme may also cancel my membership in full if the incomplete or incorrect information is about any of the dependants. Otherwise the Scheme may cancel the registration of the dependant regarding whom the information was incomplete or incorrect. In either case, I shall forfeit the full contributions already paid to the Scheme, or the contributions for the dependant who has been removed from my membership. If my membership is cancelled in full, I shall also pay back to the Scheme all benefits paid out to me and any of my dependants. If a dependant is removed from my membership, I shall pay back all benefits paid for such a dependant.

I understand that the relationship between me (and any of my dependants) and the Scheme is controlled by the rules of the Scheme. I undertake to familiarise myself (and any of my dependants) with the rules of the Scheme, as well as the changes that are made to the rules from time to time.

Signature:
Principal member

Date signed