

C Details of Dependants

Please submit copies of all ID documents and tertiary institution registration certificates. A copy of a student card will not be accepted. Affidavits are required in respect of a common law spouse or partner.

Dependant 1

Surname

Name and Initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant _____

Dependant 2

Surname

Name and Initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant _____

Dependant 3

Surname

Name and Initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant _____

Dependant 4

Surname

Name and Initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant _____

Dependant 5

Surname

Name and Initials Gender M F

Identity number Date of birth D D M M Y Y Y Y

Relationship to applicant _____

D 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 Number	Registration Date	Cancellation Date	Reason for cancellation of membership
Applicant					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					
Dependant 5					

If the answer to any of the questions in sections A and B was "YES", please give full details below of treatment received:

Question Number	Name of applicant (or dependant)	Nature of illness, ailment, abnormality or treatment prescribed/received	Frequency and duration of illness, ailments or treatments with dates of occurrences	Dates of last symptoms of each ailment and details of medication and dosage prescribed

Medical Table

If the answer to any of the questions in sections A and B was "YES", please give full details below of treatment received:

Question Number	Name of applicant (or dependant)	Nature of illness, ailment, abnormality or treatment prescribed/received	Name of medication

I am fully aware of the consequences of withholding information or providing any false or incomplete information.

Date

Signature of applicant _____

F Option Choice

Please indicate, by means of an X in the appropriate block below, your choice of option:

	MedXXI	Selfsure	Med Elite	Selfmed 80%
	<i>from 1/1/2011</i>			
Principal Member	R970	R1 494	R2 174	R3 941
Adult Dependand	R950	R1 469	R1 932	R3 414
Minor Dependand	R454	R505	R658	R680
Mark here (X)				

Preferred inception date

NB: Your benefit start date may vary from your inception date.

Declaration for acceptance of waiting periods

I am aware that a 3-month general and/or a 12-month condition specific waiting period (nine months on existing pregnancy) may be imposed on my membership with effect from date of registration if:

- I have not been on a previous scheme for more than 3-months prior to my application for membership.
- I was on a previous scheme for more than 3-months prior to my application for membership (12-month condition specific waiting period only).
- I was on a previous scheme for 2 years or more and apply for membership within 3 months (3-month general waiting period only)

Name

Date

Signature

Declaration for acceptance of late joiner penalty

I am aware that a penalty may be added to my monthly contributions and/or that of my dependants with effect from date of registration if I, and/or any of my dependants are aged 35 years or older at the time of application, and was/were not registered as a member or dependant on a registered medical scheme on 1 April 2001, and/or has/have been without medical cover for a period exceeding three consecutive months since 1 April 2001.

Name

Date

Signature

G Payment Details

Contribution details (what you must pay Selfmed)

Mode of payment

Debit order Contribution schedule

Is the applicant the contribution payer?

Yes No

Please supply the following details

Type of contribution payer

Individual Company

Full name of contribution payer

Identity number of contribution payer (only individuals) Date of birth (only individuals)

Name of bank

Branch

Branch code Date of first deduction

Type of account Savings account Cheque account Transmission account

Account number

I (a) authorise Selfmed to draw against my above-mentioned bank and (b) authorise my bank / employer to pay Selfmed the amount of my monthly contribution (current and arrears) as applicable from time to time.

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

Authorisation for deduction granted:

Signature (contribution payer) _____

Date signed

OR: If joint or company bank account (at least two persons who have signing powers must sign this debit order):

Stamp: Company (if applicable)

Date stamped

1st signature _____

2nd signature _____

Authorised capacity _____

Authorised capacity _____

Date

Date

NOTE: Please check all details and attach supporting documentation e.g. cancelled cheque, copy of bank statement etc. If you transfer your account at any time, or if your banking details change, please advise Selfmed immediately.

H Bank Details for Benefit Refunds

(what Selfmed must pay you)

Bank name

Branch name

Branch number

Type of account Savings account Cheque account Transmission account

Account number

NB: Please verify all details and attach supporting documentation, e.g. cancelled cheque, copy of bank statement. I hereby request and authorise you to credit any Medical Scheme benefits which may accrue to me to the account mentioned above.

Signature _____

Date

I Declaration by Applicant

I, the undersigned, apply for the membership as set out in this application for myself (and the registration of my dependants).

I acknowledge that I (and my dependants) will not be considered as members of Selfmed until I receive written confirmation of membership.

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 and accept that, once I receive written confirmation of membership of the Scheme, 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 undertake to advise Selfmed of any change in my state of health (or that of any of my dependants) which occurs prior to my inception date. If any of the medical details that I have supplied in this application change before my membership starts, the Scheme may reconsider my application. The Scheme, at its own discretion and even after my membership has started, may reconsider the full application, or only that of a certain dependant. If this is the case, the terms as explained in this declaration will apply.

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. In the event that I, or any of my dependants, sustain personal injuries pursuant to which I have a claim against the Road Accident Fund ("RAF"), I undertake to, in terms of the rules of the Scheme, lodge the claim against the RAF within the prescribed period and in the prescribed manner and, upon receipt of any payment from the RAF to reimburse the Scheme. I understand that should I fail to do so, the Scheme will be entitled to cancel or suspend my membership and to institute legal proceedings against me for the payment of any amount received by me from the RAF.

I undertake to give the Scheme one (1) calendar months' notice should I decide to cancel my membership.

I also confirm that I have appointed the intermediary as set out in this application as my healthcare consultant. This healthcare consultant or any other healthcare consultant appointed by me may also request the Scheme to provide any information about my membership and claims history or that of any of my dependants.

Signature _____

Date

D	D	M	M	Y	Y	Y	Y
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