

B 6	Have you (or any of your dependants) ever undergone any specialised tests or examinations such as the following: ECG, X-rays, ultrasound, CT, MRI scans or any other pathological tests (such as cholesterol tests)? If so, please provide full details of the results.	Y	N
B 7	Are you (or any of your dependants) currently taking any prescribed medication?	Y	N
B 8	Are you (or any of your dependants) receiving any treatment for a medical or other problem?	Y	N
B 9	Have you (or any of your dependants) taken any drugs such as Mandrax, cocaine or marijuana during the past 12 months?	Y	N
B 10	Has any member of your (or your spouse's) immediate family, e.g. parents, brothers, sisters, suffered from diabetes, heart disease, high blood pressure, high cholesterol, mental disease, porphyria, or any other hereditary disease? If "YES", please state which relative, his/her age and type of disease.	Y	N
B 11	Are you or any of your dependants planning to undergo any surgical procedure during the next 12 months?	Y	N
B 12	Is there any other condition or symptom, which is not mentioned above, for which medical advice, diagnosis, care or treatment has already been recommended or received, and could potentially result in a medical aid claim during the next 12 months?	Y	N

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, duration and dates of last symptoms of each illness, ailments or treatments	Name of medication
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name of	Length (in cm)	Weight (in kg)	BMI
Principal Applicant	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 3	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 4	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant 5	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Signature

Date:

F 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 0 1 M M Y Y Y Y

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.

G 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:

H 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 this is only an application for membership and 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 or any of my dependants' 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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