Tel: 0860 787 372
Fax: 0860 288 363
Selfmed Medical Scheme
PO Box 5543
Tygervalley 7536
Reg. No: 1446

APPLICATION FOR MEMBERSHIP

- Use only black ink.
- Use block capital letters to fill in the spaces.
- Use only one character per block.
- Leave one block empty between words.
- Where necessary, mark square clearly with an X.

Member number (office use only)

A DETAILS OF APPLICANT

Surname

Full names

Initials

Title (Mr,Mrs,etc)

Please submit a copy of the first page of your identity document

ID/Passport number

Nickname

Marital status

Language

Physical address

Area code

Postal address

Postal code

E-mail address

Telephone (h)

Telephone (w)

Cellphone number

Fax

Preferred method of communication: Telephone E-mail SMS Ordinary mail

B DETAILS OF THE INTERMEDIARY

Are you accredited with the Council for Medical Scheme? Yes No

Intermediary code

Accreditation number

E-mail address

If your details have changed, or if you have not submitted business within the past six months, please complete the following:

Company

Name and initials

Language E A

Surname

Cellphone number

Fax

I understand that commission will be paid to me in accordance with legislation.

Signature

Date (dd/mm/yyyy)

MEMBER OF THE Ethics Institute of South Africa

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 of a common law spouse or partner

1
Surname
Name and initials
Identity number | Date of birth (dd/mm/yyyy)
Relationship to applicant

2
Surname
Name and initials
Identity number | Date of birth (dd/mm/yyyy)
Relationship to applicant

3
Surname
Name and initials
Identity number | Date of birth (dd/mm/yyyy)
Relationship to applicant

4
Surname
Name and Initials
Identity number | Date of birth (dd/mm/yyyy)
Relationship to applicant

5
Surname
Name and initials
Identity number | Date of birth (dd/mm/yyyy)
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 change of employment? *(If YES, please provide letter of resignation from company)* Y N

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					

E HEALTH STATEMENT

Medical details of the applicant (and any dependants – excluding a child registered within 30 days of date of birth)
Information must be supplied in respect of all the questions below. Please indicate your answers with an "X" in the appropriate block and provide full details below. All questions in this section must be completed or application will be considered incomplete.

General Practitioner's Name

General Practitioner's Contact Number

During the past 12 months, have you (or any of your dependants) been diagnosed with or received treatment/advice for any condition/impairment or illness relating to one of the following categories listed? Indicate specific condition by underscoring the specific condition. As this is not an all inclusive list, if your particular condition does not appear in the list of examples, it is imperative that you insert the condition in the relevant block. Please note all medication must be disclosed in this application for membership, irrespective of the medical facility through which the medication is being obtained e.g. Any State health facility such as Day Hospitals or Clinics, etc.

Section A: Use table on next page to supply detail				
A1	Heart, blood vessels, or circulatory system	e.g. Cardiac murmurs, high blood pressure, chest pain, tightness of chest, palpitations, coronary thrombosis, valve defects, shortness of breath, stroke, high cholesterol, cramps during light exercise or walking, varicose veins, cardiac irregularities, swelling of the legs, or leg ulcers.	Y	N
A2	Respiratory system or lungs	e.g. Asthma, tuberculosis (TB), chronic bronchitis, pneumonia, persistent cough, coughing up blood, emphysema/COPD (Constructive obstructive Pulmonary disease) or bronchospasm.	Y	N
A3	Digestive system or liver	e.g. Ulcers of the stomach or duodenum, chronic indigestion, jaundice, liver disease, Hepatitis B, bleeding from the rectum, any related hernia, ulcerative colitis, Crohn's Disease, gall stones, heartburn, persistent abdominal pain, loss of weight (not due to diet), persistent diarrhoea, or persistent constipation.	Y	N
A4	Kidneys, bladder or sexual organs	e.g. Kidney stones, infections, blood or protein in the urine, or difficulty in passing urine.	Y	N
A5	Nervous system and psychological disorders	e.g. Depression, anorexia, anxiety or stress-related disorders, nervous tension, frequent headaches, psychological disturbances, migraine, fits, fainting, blackouts, multiple sclerosis, epilepsy, paralysis, brain impairment, Alzheimer's or dizziness.	Y	N
A6	Eye, ear, nose, mouth or throat	e.g. Defective sight, glaucoma, retinitis pigmentosa, hearing impairment, recurrent ear infections, balance disturbance, vocal problems, hoarseness, impaired speech, allergies, cataracts, chronic sinusitis, strabismus, ulcer or infection of mouth or gums.	Y	N
A7	Optical	Do you or any of your dependants wear spectacles or contact lenses?	Y	N
A8	Skeleton, vertebral column, joints, muscles, or skin	e.g. Back pain, displacement of the vertebrae and/or discs, any other back or neck trouble or operations, arthritis or arthritic pain, chronic gout, rheumatism, eruptions or diseases of the skin such as porphyria, psoriasis, dermatitis, acne – vulgaris or nodular cystic, any physical disability, any chiropractic treatment, eczema or sciatica.	Y	N
A9	Reproductive system	e.g. Ovarian cysts, hysterectomy, venereal diseases, any condition of the cervix, breast lumps, symptomatic excessive enlargement of breast, prostatitis, testicular tumours, endometriosis, bladder, urological condition or fertility treatment.	Y	N
A10	Dental system	e.g. Poor closure of the jaws, implants, orthodontic, periodontic or maxillo-facial surgery.	Y	N
A11	Tropical or infectious diseases	e.g. Malaria, bilharzia, brucellosis, typhoid fever, HIV/AIDS, etc.	Y	N

Section B: Use table on next page to supply detail			
B1	Are you (or any of your dependants) currently pregnant? If so, please specify the expected date of delivery________________ and specify how many months_____________. I acknowledge that the Scheme has the right to cancel my membership, should an investigation confirm the non-disclosure of a pregnancy gestation of 6 - 8 weeks or more, at the time of signing the application.	Y	N
B2	Have you or any of your dependants had cancer, growths, or any other kind of tumours, lumps (benign or malignant) incl. Hodgkins disease during the past 12 months?	Y	N
B3	Have you or any of your dependants had diabetes, sugar in the urine, leukaemia, haemophilia, bleeding disorders, anaemia, thyroid gland or other glandular or blood diseases and/or any related endocrine disorder during the past 12 months?	Y	N

B4	Have you or any of your dependants had dialysis for renal failure during the past 12 months?	Y	N
B5	Have you (or any of your dependants), during the past 12 months, 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
B6	Are you (or any of your dependants) currently taking any prescribed medication?	Y	N
B7	Are you (or any of your dependants) receiving any treatment for a medical or other problem	Y	N
B8	Are your or any of your dependants planning to undergo any surgical procedure during the next 12 months?	Y	N
B9	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 dependent)	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

Signature

Date (dd/mm/yyyy)

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

Type of contribution payer — Individual — Company

Full name of contribution payer

Identity number of contribution payer (only individuals)

Date of birth (only individuals)

Address of the contribution payer

Area code

Name of bank/building society

Branch

Branch code

Date of first deduction | 0 | 1 |

Type of account   Savings account   Cheque account   Transmission account

Account number

I/We hereby authorise Selfmed Medical Scheme (SELFMED) to issue and deliver payment instruction for collection against my/our above mentioned account at my/our above mentioned bank (or any other bank or branch to which I/we may transfer our account) on condition that the sum of such payment instruction will never exceed my/our obligation as agreed to in the Agreement and commencing on and continuing until this Authority and Mandate is terminated by me/us by giving Selfmed Medical Scheme notice in writing of not less than one month, and sent by prepaid registered post or delivered to Selfmed Medical Scheme address as indicated below.

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I/We also understand that details of each withdrawal will be printed on my/our bank statement. Such must contain a number which must be included in the said payment instruction and provided to me/us to enable me/us to identify the Agreement. This number must be added to this form before the issuing of any payment instruction.

I/We acknowledge that all payment instructions issued by Selfmed Medical Scheme shall be treated by my/our above mentioned bank as if the instructions have been issued by me/us personally.

I/We agree that though this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which Selfmed Medical Scheme have withdrawn while this Authority was in force, if such amounts were legally owing to Selfmed Medical Scheme.

I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to a third party.

In illustration, an example of the Agreement Reference Number that will enable the contribution payer to identify the Agreement payment, is as follows:

SELFMED 49000368725 - The Agreement Reference Number will be communicated to the contribution payer upon registration and issue of membership number.

All enquiries to be referred to:

Selfmed Medical Scheme
South Gate Office Park
First Floor South
Carl Cronje Drive
Southgate
Tyger Waterfront
Bellville
7530

021 943 2300
expert@selfmed.co.za

Authorisation for deduction granted: Signature (contribution payer)   Date signed (dd/mm/yyyy)

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 (dd/mm/yyyy)

1st signature   Authorised capacity   Date (dd/mm/yyyy)

2nd signature   Authorised capacity   Date (dd/mm/yyyy)

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 (Where Selfmed must pay you)

Account holder's name

Name of bank/building society

Branch

Branch code

Type of account Savings account Cheque account Transmission account

Account number

I hereby request and authorise you to credit any Medical Scheme benefits which may accrue to me to the account mentioned above. If you transfer your account at any time, or if your banking details change, please advise Selfmed immediately

NOTE: Please verify all details and attach supporting documentation, e.g. cancelled cheque, copy of bank statement.

Signature

Date signed
(dd/mm/yyyy)

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 above-mentioned 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).

I warrant that the information in this application, whether it is in my own handwriting or not, is to my knowledge, complete and correct. 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 relates to any of the dependants. Otherwise the Scheme may cancel the registration of the dependant regarding whom the information was incomplete or incorrect. If my membership is cancelled in full, I shall also pay back all benefits paid for such a dependant and the Scheme will refund the contributions.

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, to assist the Scheme by lodging 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/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement, this Authority and Mandate cannot be assigned to a third party.

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 the 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 signed (dd/mm/yyyy)