

4. Details of your employer/the 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 number _____

Payroll number _____

Appointment date

Appointment

Pay area _____

Permanent Temporary

Office stamp of employer

5. Select a plan that will suit your needs by marking your choice with an "X"

5.1 Plans

Note:

- If you choose a plan with a savings option (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect or MedElite), please refer to section 5.3; and
- If you choose MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect, please also refer to section 5.4.

Basic plans

- MedMove!
- MedVital
- MedVital Elect

Saving plans

- MedAdd
- MedAdd Elect
- MedSaver

Comprehensive plans

- MedPrime MedElite
- MedPrime Elect MedPlus
- MedElect

5.2 Students – MedElect only

Please provide proof of your enrolment as a student. Proof of your monthly income may also be requested.

- Acceptable proof of enrolment as a student is proof of registration for studies on an official letterhead of the tertiary institution or vocational training college where you are registered as a student.
- Acceptable proof of income, should Medihelp request this, is the past three months' official bank statements containing the initials and surname of the account holder and reflecting your income. Other additional proof of income may also be required.

5.3 Utilisation of savings account funds

MedAdd, MedAdd Elect and MedSaver

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

- Do you prefer that Medihelp should pay all in-hospital co-payments from your savings account? Yes No

MedPrime, MedPrime Elect and MedElite

- If you enrol on the MedPrime, MedPrime Elect or MedElite plan, all qualifying day-to-day medical expenses will be paid from your savings account first.

5.4 Declaration by applicants who apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect

I confirm that I am aware of the following:

1. I will be liable for co-payments if I do not use Medihelp's network facilities, designated service providers (DSPs) and formulary medicine.
2. I must register my prescribed minimum benefits (PMB) conditions 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 plan.
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 network facilities for all planned admissions. If there is no network facility available near my place of residence, I will need to travel to the nearest network facility to obtain medical services. If I use a non-network facility instead, I will be liable for a co-payment*, unless the treatment required is in respect of an emergency medical condition** which warrants the involuntary use of a non-network facility. I further note that in a medical emergency, authorisation for admission to the network facility should be obtained on the first workday after the admission if I am unable to obtain the authorisation on the day of admission.

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

** Please refer to your plan's guide/brochure for the definition of an emergency medical condition.

Signature of applicant	<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Date	<input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="d"/> <input type="text" value="d"/>
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6. Your dependants that you wish to register (continued)

Dependant 3

Surname _____ Title

Mr	Mrs	Ms	Other (specify)
----	-----	----	-----------------

First names in full _____

Known as _____

ID/passport number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Gender

Male	Female
------	--------

Date of birth

y	y	y	y	m	m	d	d
---	---	---	---	---	---	---	---

 Cell phone number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Email address _____

Relationship to applicant (please select **one** by marking with an X)

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild Brother

Adopted child Stepchild Mother Sister

Foster child Child in temporary safe care Father

If you have marked one of the options at "Other relative" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

Married?

Yes	No
-----	----

 Financially dependent on you?

Yes	No
-----	----

Does the dependant earn an income?

Yes	No
-----	----

 If so, how much does the dependant earn per month? R

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

Is this dependant's residential address the same as the principal member's residential address?

Yes	No
-----	----

If "No", please provide the following details:

Dependant's residential address _____

_____ Code

--	--	--	--

Dependant 4

Surname _____ Title

Mr	Mrs	Ms	Other (specify)
----	-----	----	-----------------

First names in full _____

Known as _____

ID/passport number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Gender

Male	Female
------	--------

Date of birth

y	y	y	y	m	m	d	d
---	---	---	---	---	---	---	---

 Cell phone number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Email address _____

Relationship to applicant (please select **one** by marking with an X)

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild Brother

Adopted child Stepchild Mother Sister

Foster child Child in temporary safe care Father

If you have marked one of the options at "Other relative" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

Married?

Yes	No
-----	----

 Financially dependent on you?

Yes	No
-----	----

Does the dependant earn an income?

Yes	No
-----	----

 If so, how much does the dependant earn per month? R

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

Is this dependant's residential address the same as the principal member's residential address?

Yes	No
-----	----

If "No", please provide the following details:

Dependant's residential address _____

_____ Code

--	--	--	--

7. Banking details

7.1 Complete this section if you will pay your own contributions:

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 (choose only one option by marking an "X"):

<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 calendar day of the month prior to my enrolment and thereafter on the last calendar day 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 Mark this section if your employer/an institution will pay your 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 Complete your banking details for debit order deductions and credit refunds (all applicants must complete this information):

<p><input type="checkbox"/> 1. Use the account below for all transactions</p> <p><input type="checkbox"/> 2. Use the account below only for the recovery of contributions NB: If you select this option, please complete your banking details for credit refunds in the table on the right.</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 the account below for credit refunds only NB: If you selected option 2 on the left, please complete your banking details below.</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>
---	---

If you provide only one bank account number, we will use this account for both the recovery of contributions and refunding credit amounts. In the case of a trust, the responsible trustee must sign this section and submit a copy of the trust deed.

Signature of account holder/authorised signatory for recovery of contributions <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>	Signature of account holder for credit refunds <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>
--	--

9. Medical history

- Please ensure that you have completed **Section 8** of this application form in full.
- You must please complete **Section 9.1** to ensure your quick and easy enrolment.
- We may require you to complete the full medical questionnaire if you answered “Yes” to any of the questions in **Section 9.1**.

NB: Medihelp will review all requests for hospital admission or chronic medicine authorisation made by members during their first year of membership before we authorise benefits. If we find that you did not complete your application form in full, had withheld information or provided inaccurate details, we may terminate your membership.

Doctors consulted in the past 12 months

If your family has consulted a doctor in the past 12 months, please provide us with the details:

Name and surname _____

Tel No. (W) _____ How long has he or she been your doctor (in years)?

Name and surname _____

Tel No. (W) _____ How long has he or she been your doctor (in years)?

Name and surname _____

Tel No. (W) _____ How long has he or she been your doctor (in years)?

9.1 Short medical questionnaire

1. Have you or any of your dependants been admitted to hospital and/or diagnosed with an illness within the last 12 months prior to submitting this application?	Mark with an “X”		
	<table border="1" style="display: inline-table;"><tr><td>Yes</td><td>No</td></tr></table>	Yes	No
Yes	No		
2. Are you or any of your dependants currently taking regular and/or ongoing medicine and/or receiving treatment for a medical condition or symptom?	<table border="1" style="display: inline-table;"><tr><td>Yes</td><td>No</td></tr></table>	Yes	No
Yes	No		
3. Are you or any of your dependants currently in hospital or planning or expecting to undergo any examination, treatment and/or procedure in hospital during the next 12 months? If you or any of your dependants are currently pregnant or planning a pregnancy please complete question 14 at Section 9.2 .	<table border="1" style="display: inline-table;"><tr><td>Yes</td><td>No</td></tr></table>	Yes	No
Yes	No		

9.2 Full medical questionnaire

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 by logging on to the secured website for members, the Member Zone.

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details as all applications for pre-authorisation are reviewed, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

1. Cancer, tumours and abnormal growths

Cancer of any organ, cancerous tumours, non-cancerous tumours, blood-related cancers, lymphoma, leukaemia, skin lesions, breast disease, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal Pap smear result, abnormal PSA (prostate-specific antigen) result, any other abnormal cancer screening or diagnostic test result.

Yes	No
-----	----

Name of patient	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. Blood conditions

Deep vein thrombosis, pulmonary embolism, blood clots, anaemia, ITP and platelet deficiencies, polycythaemia vera, haemophilia, blood clotting diseases, leukaemia, lymphoma, any other bleeding disorders.

Yes	No
-----	----

Name of patient	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 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details as all applications for pre-authorisation are reviewed, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

3. Metabolic and endocrine conditions

Diabetes, thyroid disease, Addison disease, Cushing syndrome, obesity, metabolic syndrome, parathyroid disease, Paget disease, osteoporosis, osteopenia, growth deficiency, Conn syndrome, any other metabolic or endocrine condition.

Mark with an “X”

Yes	No
-----	----

Name of patient	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

4. Mental health

Depression, bipolar disorder, anxiety disorder, post-traumatic stress disorder, obsessive-compulsive disorder, schizophrenia, personality disorders, insomnia, sleeping disorders (e.g. narcolepsy), eating disorders, Alzheimer disease, dementia, autism, attention deficit-hyperactivity disorder, drug or alcohol dependency or abuse, rehabilitation for drug or alcohol dependency or abuse, suicide attempt, counselling, any other psychological condition.

Yes	No
-----	----

Name of patient	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. Brain and nerve conditions

Stroke, bleeding on the brain, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, Parkinson disease, Guillain-Barré syndrome, migraine, chronic headache, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability, any other brain or nerve condition.

Yes	No
-----	----

Name of patient	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 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details as all applications for pre-authorisation are reviewed, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

6. Eye and eyelid conditions

Mark with an “X”

Cataracts, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, cornea transplant, eye surgery, blurry vision, glasses, partial or full blindness, any other eye or eyelid condition.

Yes	No
-----	----

Name of patient	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. Ear, nose and throat conditions

Chronic otitis media, chronic otitis externa, chronic ear infection, deafness, hearing problems, hearing aid, cochlear implant, chronic tonsillitis, chronic adenoiditis, dizziness, vertigo, tinnitus, sinus problems, nasal surgery, dental or orthodontic treatment, dental surgery, any other ear, nose or throat condition.

Yes	No
-----	----

Name of patient	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. Heart and circulation conditions

High blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins, any other condition affecting the heart or blood vessels.

Yes	No
-----	----

Name of patient	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. Breathing and respiratory conditions

Asthma, bronchitis, chronic obstructive pulmonary disease, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia, pulmonary embolism, any other breathing or respiratory condition.

Yes	No
-----	----

Name of patient	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 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details as all applications for pre-authorisation are reviewed, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

10. Abdominal and digestive conditions

Hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder conditions, gall stones, reflux, heartburn, hiatus hernia, oesophageal disease, atrophic gastritis, ulcers, abdominal hernia, inguinal hernia, malabsorption, Crohn disease, ulcerative colitis, diverticulitis, any other abdominal or digestive condition.

Mark with an “X”

Yes	No
-----	----

Name of patient	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. Skin conditions

Chronic wounds, eczema, psoriasis, acne, sunspots, skin cancer, melanoma, any other condition affecting the skin.

Yes	No
-----	----

Name of patient	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

12. Back, bone and muscle conditions

Arthritis, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, lupus, gout, hip problems, knee problems, clubfoot, bunions, back pain, neck pain, Sjögren syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, any other condition affecting the back, bones or muscles.

Yes	No
-----	----

Name of patient	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

13. Gynaecological and obstetric conditions

Abnormal Pap smear result, abnormal menstrual bleeding, endometriosis, polycystic ovarian syndrome, infertility, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, any other gynaecological or obstetric condition.

Yes	No
-----	----

Name of patient	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 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details as all applications for pre-authorisation are reviewed, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

14. Pregnancy

Are you or any of your dependants pregnant or undergoing testing for pregnancy?

Mark with an “X”

Yes	No
-----	----

Name of patient	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

15. Kidney and urinary conditions

Kidney or renal failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, any other kidney or bladder problems.

Yes	No
-----	----

Name of patient	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

16. Male urinary and genital conditions

Prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urine retention, any other male urinary or genital condition.

Yes	No
-----	----

Name of patient	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

17. Chronic illnesses

Are you or any of your dependants currently taking regular, ongoing medicine, and/or are you receiving treatment for a medical condition or symptom not mentioned in the medical questionnaire?

Yes	No
-----	----

Name of patient	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 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details as all applications for pre-authorisation are reviewed, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

18. HIV/Aids

Mark with an “X”

Are you or any of your dependants mentioned on this application HIV positive or have you been diagnosed with Aids?*

Yes	No
-----	----

Please note that if you do not make a selection, Medihelp will regard your answer as “No”.

*If you or any of your dependants prefer not to disclose your HIV status on this application form, you will remain responsible to inform the Scheme and to register on the Medihelp HIV/Aids programme within 21 days from your enrolment date by phoning LifeSense on 0860 50 60 80.

It is important to disclose this information to prevent the possible termination of your membership. When we receive your application to register on the HIV/Aids programme, we will determine whether underwriting conditions must be applied and, if this is the case, issue an amended proof of membership document to you.

Name of patient	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

19. Planned treatment

Are you and/or your dependants planning to have any examination, treatment and/or procedure done in the next 12 months?

Yes	No
-----	----

Name of patient	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

20. Any other conditions not mentioned

Has any person indicated in this application been examined (e.g. 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
-----	----

Name of patient	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. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information

Medihelp confirms that:

1. Your and your registered dependants' 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 employees 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 or marketing initiatives undertaken by Medihelp;
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 plan 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 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 dependants 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 dependants, 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 the 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 dependants 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 first day of enrolment and thereafter on the first day of each subsequent calendar month, and it shall be payable on the date selected by me at Section 7. 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 dependants' dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account, if applicable, 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 dependants 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 dependants 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-authorization and using designated service providers.
16. Medihelp may also restrict interchanges between benefit plans 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.

10. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information

Protection of information:

- 20. I hereby give permission, and declare that I have obtained the consent of all my dependants, that –
- 20.1 Medihelp may enquire about my health status or that of my dependants 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 dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp’s disposal;
- 20.3 Any adviser appointed by me and whose appointment is accepted by Medihelp, may have access to my personal and medical information and that of any of my registered dependants 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;
- 20.4 Medihelp may disclose my and my dependants’ medical and personal information to medical service providers for the purpose of delivering medical services to me and my dependants and to pay for such services; and
- 20.5 Medihelp may share my information for statistical analysis and academic research purposes.
- 21. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
- 22. I agree that all my telephone conversations and/or that of my dependants with Medihelp and/or its contracted third parties may be recorded for quality control purposes and to help detect and prevent fraud.
- 23. I agree that Medihelp may, for the purpose of considering my application for membership or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependants from medical practitioners, financial advisers, industry regulatory bodies or employers/institutions.
- 24. I further consent, and declare that I have obtained the consent of my dependants, that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependants’ consumer credit record, including and not limited to information about my/ my dependants’ credit history, financial history, personal information (excluding medical information) and judgment or default history.

Signature of applicant		Date	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; text-align: center;">2</td> <td style="width: 10%; text-align: center;">0</td> <td style="width: 10%; text-align: center;">y</td> <td style="width: 10%; text-align: center;">y</td> <td style="width: 10%; text-align: center;">m</td> <td style="width: 10%; text-align: center;">m</td> <td style="width: 10%; text-align: center;">d</td> <td style="width: 10%; text-align: center;">d</td> </tr> </table>	2	0	y	y	m	m	d	d
2	0	y	y	m	m	d	d				

Should you be applying on behalf of another person as guardian or curator, please complete the following:

In your capacity as	Guardian	<input type="checkbox"/>	Curator (legal appointment)	<input type="checkbox"/>													
ID/passport number	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%;"></td> </tr> </table>											Title	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; text-align: center;">Mr</td> <td style="width: 10%; text-align: center;">Mrs</td> <td style="width: 10%; text-align: center;">Ms</td> <td style="width: 10%; text-align: center;">Other (specify)</td> </tr> </table>	Mr	Mrs	Ms	Other (specify)
Mr	Mrs	Ms	Other (specify)														

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator, must accompany this application. If you are signing as the applicant’s parent, a copy of your passport/ID document and the applicant’s birth certificate must accompany this application.

First name _____ Surname _____

Telephone number (W) Code _____ No. _____

Cell phone number _____

11. Undertaking and declaration by adviser

NB: If this section is not completed in full by the adviser, no commission will be paid.

I declare that –

- 1. the applicant has appointed me as his or her adviser and is entitled to cancel my services at any time;
- 2. I have signed a valid contract with my Medihelp–contracted brokerage; and
- 3. the applicant has signed the application in person.

I take note that the adviser/brokerage indemnifies Medihelp against any non-adherence to the legal requirements as quoted above.

Name of brokerage _____

Brokerage code	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; text-align: center;">A</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>	A					Adviser code	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%;"></td> </tr> </table>					
A													

Name and surname of adviser _____

Telephone number Code _____ No. _____

Email address _____

Signature of adviser		Date	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; text-align: center;">2</td> <td style="width: 10%; text-align: center;">0</td> <td style="width: 10%; text-align: center;">y</td> <td style="width: 10%; text-align: center;">y</td> <td style="width: 10%; text-align: center;">m</td> <td style="width: 10%; text-align: center;">m</td> <td style="width: 10%; text-align: center;">d</td> <td style="width: 10%; text-align: center;">d</td> </tr> </table>	2	0	y	y	m	m	d	d
2	0	y	y	m	m	d	d				

Lead reference number	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%;"></td> </tr> </table>											For office use only	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; text-align: center;">M</td> <td style="width: 10%; text-align: center;">H</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>	M	H				
M	H																		

In case of a dispute, the registered Rules of Medihelp will apply.



Enquiries: 086 0100 678 **Email:** newbusiness@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007, www.medihelp.co.za

Medihelp is an authorised financial services provider (FSP No 15738)

Council for Medical Schemes

Enquiries: 086 1123 267, **Website:** www.medicalschemes.co.za



Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: and membership number:

I have also been informed that the commission due to Aon, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT).

Signed at (Town or City): on yy/mm/dd:

Signature:

Permission to make certain information available to Aon South Africa (Pty) Ltd

I give consent for the disclosure of information about me.

Membership number:

ID or passport number:

Title: Initials: Surname:

First name(s) (as per identity document):

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
Name and Surname Membership number Date of birth ID number Postal Address Physical address E-mail Address Telephone numbers Cellular Number Number of dependents	Plan type Medical Savings Account (MSA) Balance Medical Scheme benefits Spent for the year Accumulated Medical scheme Savings Account Medical Savings Carry over from previous year MSA reimbursement, Scheme Rate or Cost Self-payment Gap Above Threshold Benefit Waiting period details Late joiner penalty indicator Wellness benefits	Total contribution Contribution breakdown	Chronic Indicator/confirmation (Yes/No) In Hospital Indicator/confirmation (Yes/No) Confirmation of claims paid and from what benefit Claims transaction history Procedures done in doctor's rooms paid from Hospital Benefit

When you sign this document, you confirm that you have read and understood the contents of this document as well as the benefits of appointing Aon document. This letter of appointment will be valid for the duration of the active membership or when you send a specific instruction in writing to terminate the appointment.

Signed at (Town or City): on yy/mm/dd:

Signature:



Benefits of appointing Aon South Africa Healthcare as your intermediary

Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:



Guide:

our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.



Educate:

our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.



Protect:

the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
 - Flash Alert - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
 - Member letter - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
 - Guidance letter - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
 - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to www.aon.co.za

<http://www.facebook.com/Aonhealthcare>
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

<http://www.aon.co.za/disclaimer>

On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at

<http://www.aon.co.za/terms-of-trade> or will be sent to you upon request.

[Privacy Notice](#)

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Disclaimer:

The Benefits and contributions are subject to approval by the council for medical schemes. Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.