Broker House: Aon South Africa (Pty) Ltd
House Code: A0276
Tel No: 0860 100 404
Broker Code: 0075

Medihelp application form 2023

Corporate

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

Thank you for choosing to join Medihelp medical scheme. Medihelp is registered with the Council for Medical Schemes in terms of the Medical Schemes Act 131 of 1998 and is a self-administered non-profit scheme.

How to complete this form:

- Complete the editable PDF form and add your signature electronically before you email it to us. Printed forms must be completed in print using black ink. Please make sure to email or post all pages of the form to Medihelp.
- Please complete all sections in full and sign the application form, also at Sections 5, 7 and 10. Please read the conditions for membership in Section 10 carefully before you sign the form and make sure you have completed all the details. Incomplete information may delay the application process.
- Email the completed and signed form to corpapps@medihelp.co.za.

The next steps after we receive your application:

- Medihelp will contact you should any details be omitted on the application form or if any additional information is required. You can also use the Application in Motion (AiM) functionality on our website at https://onlineapplication.medihelp.co.za to track your application and provide further details, if necessary.
- If we offer you membership under the standard terms, your membership will be activated without issuing enrolment conditions. We will notify you and/or your adviser by letter.
- If we offer you membership under any non-standard terms (waiting periods and/or late-joiner penalties apply), we will notify you and/or your adviser by letter and stipulate the conditions that will be applicable to your membership. If you accept these terms, you must sign the letter and return it to us, after which we will activate your membership. The enrolment conditions can also be accepted on AiM.
- You will be notified when your application has been completed.

1. When would you like your cover to start?

2 0 y y m m d d

2. Your information (person who requests membership)

ID/passport number | | | | | | | | | | | | | |

Title: Mr | Mrs | Ms | Other (specify)

A copy of your passport must be attached if you use your passport number.

Surname _____ Initials _____

First names _____ Gender: Male | Female

_____ Known as _____

Marital status:

Married in community of property/ Customary marriage	Married out of community of property	Single/ Not married	Engaged/ Cohabitant/ Life partner	Divorced	Widow/ Widower	Other (specify)

Date of birth: y y y y m m d d

Date of marriage: y y y y m m d d

Income tax number | | | | | | | | | | | | | |

Language: Afrikaans | English

Please indicate your 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

3. Your contact information

Cell phone number: _____

Email address: _____
Medihelp will use this email address to keep you up to date with important information.

Tel No. (W): _____ Code No. _____

Tel No. (H): _____ Code No. _____

Residential address: _____

_____ Code | | | | |

Is your postal and residential address the same? Yes | No

Postal address: _____

_____ Code | | | | |

May Medihelp use your and your dependants' personal details to get your opinion on the quality of our service? Yes | No

To improve the quality of our communication to you, please indicate if the following is applicable to you:

Visually impaired: Yes | No

Hearing impaired: Yes | No

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 | y | y | y | y | m | m | d | d |

Pay area _____

Appointment

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 5.2; and**
- **If you choose MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect, please refer to section 5.3.**

Basic plans	Savings plans	Comprehensive plans	
☐ MedMove!	☐ MedAdd	☐ MedPrime	☐ MedElite
☐ MedVital	☐ MedAdd Elect	☐ MedPrime Elect	☐ MedPlus
☐ MedVital Elect	☐ MedSaver	☐ MedElect	

5.2 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 MedPrime, MedPrime Elect or MedElite, all qualifying day-to-day medical expenses will be paid from your savings account first.

5.3 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 benefit (PMB) conditions with Medihelp and my PMB chronic medicine must be pre-authorised 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 a 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 _____ Date | 2 | 0 | y | y | m | m | d | d |

6. Your dependants that you wish to register

You may register the following dependants:

- Spouse/partner.
- Father/mother/brothers/sisters/grandchildren of the applicant and whose financial care is entrusted to the applicant (**PLEASE NOTE**: These dependants of the spouse/partner cannot be registered as dependants of the applicant, and grandchildren of the applicant pay the same contribution as that of an adult dependant, unless legally adopted).
- Dependent own children (of the applicant and spouse/partner).
- Dependent stepchildren (of the applicant and spouse/partner).
- Adopted children/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement (of the applicant and spouse/ partner). Official proof of the Court, clerk or the Court or appointed social worker must be provided in terms of the set criteria determined by Medihelp – foster children and children in temporary safe care may be registered as dependants only up to the age of 21 years in terms of legislation.
- In the case of dependants who are not South African citizens, a copy of their passport must be submitted with the completed application.

6. Your dependants that you wish to register (continued)

Spouse/partner (complete only if applying for registration as a dependant)

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) Spouse ☐ Partner ☐

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 2

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
- ☐ Adopted child
- ☐ Foster child
- ☐ Child in temporary safe care
- ☐ Child born in terms of a surrogate motherhood agreement s
- ☐ Stepchild

Other relative
- ☐ Grandchild
- ☐ Brother
- ☐ Mother
- ☐ Sister
- ☐ 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 | | | | |

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
- ☐ Adopted child
- ☐ Foster child
- ☐ Child in temporary safe care
- ☐ Child born in terms of a surrogate motherhood agreement s
- ☐ Stepchild

Other relative
- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

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
- ☐ Adopted child
- ☐ Foster child
- ☐ Child in temporary safe care
- ☐ Child born in terms of a surrogate motherhood agreement s
- ☐ Stepchild

Other relative
- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

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 | | | | |

6. Your dependants that you wish to register (continued)

Dependant 5

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
- ☐ Adopted child
- ☐ Foster child
- ☐ Child in temporary safe care
- ☐ Child born in terms of a surrogate motherhood agreement s
- ☐ Stepchild

Other relative
- ☐ Grandchild
- ☐ Brother
- ☐ Mother
- ☐ Sister
- ☐ 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 for recovery of contributions by debit order and credit refunds

Bank _____

Branch _____

Branch code | | | | | | | | | | | |

Type of account _____

Name of account holder _____

Account number _____

This account will be used both for the recovery of contributions and for refunding credit amounts. In case of a trust, a copy of the trust deed must be submitted and the responsible trustee must sign.

If your employer pays your monthly subscription in full, the banking details supplied will only be utilised for credit refunds.

Signature of account holder for credit refunds and recovery of contributions

8. Previous/current membership of medical schemes

8.1 Is your application necessitated by a change in employment which resulted in the cancellation of your membership of a previous medical scheme? (This question is not applicable to employees who have retired and are entitled to remain at their previous/current medical scheme.)

Yes | No

Who was the principal member of the previous scheme? Name and surname

8.2 Please provide details of ALL the medical schemes where you and your dependants are currently or have previously been enrolled:

NB:
- The date joined and date ended are important to place you and your dependants in the correct enrolment category.
- Indicate "current" if your and/or your dependants' membership of the particular scheme is still active.
- Ensure that the dates of your and/or your dependants' membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated **separately** for you and your dependants.
- The Medical Schemes Act makes provision for a late-joiner penalty (LJP) to be imposed on an applicant who is 35 years or older at the time of joining a scheme and has not enjoyed previous coverage with a medical aid. The penalty, which is added to the member's monthly contribution, is calculated as a percentage of the member's contribution based on the total number of years without creditable coverage since the age of 35 years, as shown below:

LJP intervals and penalty percentages

1 – 4 years	5%
5 –14 years	25%
15 – 24 years	50%
25 years +	75%

of the contribution of the beneficiary
(excluding savings account contribution)

Name of medical scheme*	Name and surname*	Membership number	Date joined*	Date ended*

* This information is compulsory. If not completed, your application for membership cannot be finalised.

8.3 Did your or your dependants' previous medical scheme apply a late-joiner penalty? Yes | No

If "Yes", please provide the following details:

Name of applicant/dependant	Late-joiner penalty			
	5%	25%	50%	75%
	5%	25%	50%	75%
	5%	25%	50%	75%

8.4 Did your or your dependants' previous medical scheme apply any condition-specific waiting periods and were these still active at the time of termination of membership? (The treatment of a specific condition was excluded from benefits for a certain period.) Yes | No

If "Yes", please provide the following details:

Name of applicant/dependant	Condition-specific waiting period (CSW)	End date of CSW
		y y y y m m d d
		y y y y m m d d
		y y y y m m d d

Note: If the space provided is insufficient, please provide additional information on a separate page.

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

	Mark with an "X"	
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?	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?	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**.	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

9. Medical history (continued)

9.2 Full medical questionnaire

- 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).

Mark with an "X"

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

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.

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 (ADHD), 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. Medical history (continued)

9.2 Full medical questionnaire

- Should you choose to complete the medical questionnaire, please answer all questions 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 failing to disclose all information may potentially result in the termination of your and/or your dependants' 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

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

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. Medical history (continued)

9.2 Full medical questionnaire

- 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).

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.

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

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.

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

9. Medical history (continued)

9.2 Full medical questionnaire

- 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).

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.

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

14. Pregnancy

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

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

9. Medical history (continued)

9.2 Full medical questionnaire

- 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).

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?

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

18. HIV/Aids

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

9. Medical history (continued)

9.2 Full medical questionnaire

- 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).

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)?

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

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

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 date of my enrolment, and thereafter on the same day of every subsequent calendar month. 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-authorisation and using designated service providers.

16. Medihelp may also restrict interchanges between 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.

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.

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

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 2 0 y y m m d d

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 A _____ Adviser code _____

Name and surname of adviser _____

Telephone number Code _____ No. _____

Email address _____

Signature of adviser _____ Date 2 0 y y m m d d

For office use only

Lead reference number _____ M H _____

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

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

Council for Medical Schemes
Enquiries: 086 1123 267, **Website:** www.medicalschemes.co.za

uppe marketing A33058

medihelp
Medical Aid in Action

Contact us on: **0860 100 404,** P.O. Box 78367, Sandton, 2146, www.aon.co.za
FSP number: 20555; CMS number: ORG895
Follow our website link for further information on Aon's processing of your personal information

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

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.

16 May 2022 | V1 | DD