



For office use only									
Membership number									

## my medihelp application form

How to complete this form:

1. Please complete this form in print, using black ink, and e-mail, fax or post it to Medihelp.
2. Please complete all sections in full and sign the application form.
3. Never sign a blank application form.

Medihelp confirms that-

1. the personal and medical information of the member and his/her dependant(s) 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 staff and contracted third 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; and
4. Medihelp will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy.

1 date from when membership is required

### 2 details of applicant

Title      ID / passport No.

Surname  Initials

First names  Gender

Marital status

Nickname  Date of marriage

Date of birth           Language

### 3 contact details of applicant

Postal address  Tel: (H) Code  No.

Tel: (W) Code  No.

Code     Fax: Code  No.

Residential address  Cell No.

E-mail address

Code

May Medihelp communicate with you by means of e-mail   and/or SMS?

### 4 details of employer

**NB: Pensioners who are subsidised by their former employers must also complete this section.**

Name of employer  E-mail address

Address of employer

Postal code

Contact person  Tel: code  No.

Branch code/employer group No.

Payroll number

Date of appointment

Appointment

Office stamp





## 10 medical questionnaire

This questionnaire should be completed in respect of **all the persons** indicated on the application form. Accuracy is of the utmost importance, as it influences the conditions of membership. If all questions are not answered with "Yes" or "No", or if you fail to provide details in questions answered "Yes" the questionnaire will be considered incomplete and will be returned to you for completion. Please note that **ALL** the questions must be answered.

**Should the space available be insufficient, additional information must please be provided on a separate page.**

Has ANY person indicated on the application form ever suffered from, or received treatment/a consultation for any of the following medical conditions, illnesses or disorders at ANY time? (Disorder shall mean affection or condition or illness)	Mark with an "X"		Name(s) of patient(s)	Last date on which medical advice, diagnosis, care or treatment was received	Illness/condition/disorder and nature of treatment	Medication used for the treatment of the condition
	Yes	No				
1. Any disorder of the neurological system (brain, spinal cord, epilepsy, tremors, paralysis, weakness, stroke, etc.)?	Yes	No				
2. Any disorder of the skeletal and muscle system (joints, back, rheumatism, spinal column, muscle weakness, osteoporosis, gout, arthritis, etc.)?	Yes	No				
3. Any disorder of the stomach, intestines, liver or other abdominal organ (heartburn, ulcer, infection, hernia, jaundice, irritable bowel syndrome, etc.)?	Yes	No				
4. Any disorder of the kidneys, bladder, or genital organs (kidney stones, infections, dialysis, malformations, etc.)?	Yes	No				
5. In the case of female applicants, is any applicant indicated on this form pregnant?	Yes	No				
6. Any lung disorder (asthma, infections, shortness of breath, emphysema, etc.)?	Yes	No				
7. Heart or circulatory problems (high blood pressure, chest pain, pacemaker, coronary artery disease, etc.)?	Yes	No				
8. Diabetes (Sugar disease)?	Yes	No				
9. High cholesterol?	Yes	No				
10. Other chronic disease(s)?	Yes	No				
11. Haemophilia (blood clotting disorder)?	Yes	No				
12. Any premalignant condition?	Yes	No				
13. Any type of cancer (leukaemia, lymphoma, tissue-specific cancers, etc.)?	Yes	No				

Has ANY person indicated on the application form ever suffered from, or received treatment/a consultation for any of the following medical conditions, illnesses or disorders at ANY time? (Disorder shall mean affection or condition or illness.)	Mark with an "X"		Name(s) of patient(s)	Last date on which medical advice, diagnosis, care or treatment was received	Illness/condition/disorder and nature of treatment	Medication used for the treatment of the condition
	Yes	No				
14. Any psychiatric condition (depression, stress, panic attacks, etc.)?	Yes	No				
15. Any eye disorder (defective vision, cataracts, glaucoma, retinitis, etc.)?	Yes	No				
16. Hernias of any nature (break in abdominal wall, hiatus hernia, etc.)?	Yes	No				
17. Any other metabolic disease (porphyria, lactose intolerance, vitamin D deficiency, etc.)?	Yes	No				
18. Any substance dependency (alcohol, drugs, anabolic steroids, etc.)?	Yes	No				
19. Any disorder of the ears/nose/throat (ear discharge, recurrent infection, tonsillitis, etc.)?	Yes	No				
20. Any abnormality in the results of previous medical tests/examinations?	Yes	No				
21. Has any person indicated on this application form ever been diagnosed with, treated or managed for any condition or disorder not mentioned in the medical questionnaire, or has he/she consulted a medical practitioner for any condition or disorder not mentioned in the questionnaire?	Yes	No				
22. Are any persons indicated on this application form scheduled for any medical test/examination/operation/hospitalisation or awaiting test results in respect of any of the above conditions or disorders?	Yes	No				
23. Do you use any medicine on a regular basis (including medicine bought without prescription)? If "Yes" please indicate.	Yes	No				

**Please note that this medical questionnaire does not constitute an application to register medication for chronic medicine benefits. Should you need to obtain authorisation for chronic medicine benefits, please phone MEDICHRON, Medihelp's chronic medicine management division, on 086 0100 678 to obtain an application form for chronic medicine benefits. Alternatively, you can download an application form from the Medihelp web site ([www.medihelp.co.za](http://www.medihelp.co.za)).**

## 11 conditions of membership and declaration by applicant

1. I am familiar with the conditions and benefits of my chosen benefit option and the Rules of Medihelp, and I undertake to abide by the Rules.
2. 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 dependant(s) or any other measures which Medihelp, in its sole discretion, may decide to take, subject to appeal procedures.
3. I am aware that a general and/or condition-specific waiting period and a late-joiner penalty may be imposed on my membership and that of my dependant(s) in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998).
4. I give permission that my medical doctor or any person who is in possession of information about my health status and/or that of my dependant(s) may make such information available to Medihelp and its contracted third parties, on condition that such information will be treated confidentially at all times.
5. I understand that the information contemplated in paragraph 4 will only be used for the purposes as set out in Medihelp's confidentiality statement (on this application form) and that any deviation will be regarded as a breach of confidence. Should Medihelp wish to use the information for any other purpose, Medihelp must first obtain my approval.
6. I am responsible for paying the monthly subscription fees to Medihelp by no later than the last workday of any given month.
7. Should my employer, as my authorised agent, undertake to pay my subscriptions to Medihelp, I give permission to my employer to deduct the amount payable to Medihelp from my salary and pay such amount over to Medihelp.
8. I confirm that neither my dependant(s) nor I will be registered as beneficiaries of another registered medical scheme from the date on which I request membership of Medihelp.
9. I undertake to notify Medihelp in writing should there be any changes in my health status or that of my dependant(s) after my application for membership has been submitted but not yet finalised.
10. I undertake to notify Medihelp in writing should there be any changes in my personal details and/or banking details.
11. I agree that all my telephone conversations and/or that of my dependant(s) with Medihelp and/or its contracted third parties may be recorded and that all information contained in such conversations will form part of Medihelp's records.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 12 undertaking and declaration by broker

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

I declare that –

1. the applicant has appointed me as his/her broker and is entitled to cancel my services at any time;
2. on the date of the applicant's application, I am a contracted broker;
3. I am licensed with the FSB in terms of FAIS legislation;
4. I have provided my name, telephone number, physical and postal address to the applicant;
5. I have declared the amount of the commission paid by Medihelp to me to the applicant;
6. I have signed a valid contract with Medihelp;
7. advice was given to the applicant as required in terms of the FAIS Act, and the necessary disclosures made; and
8. the applicant has signed the application in person.

Name of broker house

Broker house code

A					
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Broker code

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Tel: Code

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No.

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Fax: Code

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No.

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E-mail address

Signature of broker: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Lead reference number:

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