Registration of my dependants

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

For use by corporate clients
Payroll number

Employer's office stamp

How to complete this form:

- We recommend that you use the Member Zone at https://toolbox.medihelp.co.za/login. You can also use the editable PDF form and add your signature electronically before you email the form to us, but if you prefer to complete a print version, please complete the form in print using black ink and email or post all pages of the form to Medihelp.
- Please complete all sections in full and sign the application form. Incomplete information may delay the application process.
- Never sign a blank application form.

The next steps after we receive your application:

- We will contact you should we require any details that were omitted on the application form or if we require any additional information to determine the conditions of your dependants' membership.
- If we offer your dependants membership under the standard terms, their membership will be activated without issuing enrolment conditions.
- If we offer your dependants 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. If you accept these terms, you must sign the letter and return it to us, after which we will activate your dependants' membership.
- We will notify you by letter, SMS or email to let you know when your application has been completed.

1. Your information (member that registers dependant)

ID/passport number

Member number Initials _____ Title | Mr | Mrs | Ms | Other (specify)

First names _____

Surname _____

Cell phone number _____ Tel No. (W) Code _____ No. _____

Tel No. (H) Code _____ No. _____

Email address _____

We will use this email address to keep you up to date with important information on your journey to good health.

Marital status

Married in community of property	Married out of community of property	Single	Divorced	Widow	Widower	Other (specify)

Date of marriage y y y y m m d d

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

2. Date on which my dependants' cover should start 2 0 y y m m d d

3. Details of dependants I wish to register

You may register the following dependants:

- Spouse/partner.
- Father/mother/brothers/sisters/grandchildren of the member and whose financial care is entrusted to the member (**PLEASE NOTE:** These dependants of the spouse/partner cannot be registered as dependants of the member, and grandchildren of the member pay the same contribution as that of an adult dependant, unless legally adopted).
- Dependent own children (of the member and spouse/partner).
- Dependent stepchildren (of the member and spouse/partner).
- Adopted children/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement (of the member and spouse/partner). Official proof of the Court, clerk of 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 form.

Spouse/partner

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

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 | | | | |

3. Details of dependants I 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 born in terms of a surrogate motherhood agreement
- ☐ Stepchild
- ☐ Child in temporary safe care

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 born in terms of a surrogate motherhood agreement
- ☐ Stepchild
- ☐ Child in temporary safe care

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 | | | | |

4. My dependants' previous/current membership of medical schemes

4.1 Has this application been necessitated by a change in employment which resulted in the cancellation of your dependants' membership of a previous medical scheme? (Not applicable to dependants 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

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

NB:
- The date joined and date ended are important to place your dependants in the correct enrolment category.
- Indicate "current" if your dependants' membership of the particular scheme is still active.
- Ensure that the dates of your dependants' membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated separately for each of 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 to register your dependants cannot be finalised.

4.3 Did your dependants' previous medical scheme apply a late-joiner penalty? If "Yes", please provide the following details:

Yes	No

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

4.4 Did 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.) If "Yes", please provide the following details:

Yes	No

Name of 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
		y y y y m m d d

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

5. Medical history (complete this section only if your dependants have been members of a medical scheme registered in South Africa)

- Please ensure that you have completed **Section 4** of this application form in full.
- You must please complete **Section 5.1** to ensure your dependants' quick and easy registration.
- You are not obligated to complete **Section 5.2** and you may provide details of your dependants' medical history only if you wish to do so at this stage. Once your dependants are registered, we will require you to complete the medical questionnaire if you answered "Yes" to any of the questions in **Section 5.1** in order to ensure that your dependants are registered on the appropriate care programmes, including our post-operative care programme, chronic medication and disease management programmes, and the maternity programme, to proactively manage your dependants care, if applicable.

NB: Medihelp will review all requests for hospital admission or chronic medicine authorisation made by dependants 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 dependants' membership.

Doctors consulted in the past 12 months
If your dependants have 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 dependant's doctor (in years)? ☐☐

Name and surname _____

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

Name and surname _____

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

5.1 Dependants who are moving from another medical scheme to Medihelp

	Mark with an "X"	
1. Have any of your dependants been admitted to hospital within the last 12 months prior to submitting this application?	Yes	No
2. Are any of your dependants currently taking regular, ongoing medicine and/or receiving treatment for a medical condition or symptom?	Yes	No
3. Are any of your dependants planning or expecting to be hospitalised, to receive medical and/or surgical treatment and/or undergo examinations during the next 12 months? If any of your dependants are currently pregnant or planning a pregnancy please complete question 14 at **Section 5.2**.	Yes	No

5.2 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 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 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

Mark with an "X": Yes | No

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.

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

Yes | No

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

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

5.2 Medical questionnaire (continued)

- 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 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 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

Mark with an "X"

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

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 or contact lenses, 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

5.2 Medical questionnaire (continued)

- 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 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 your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

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.

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

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

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, oesophageal disease, atrophic gastritis, ulcers, hiatus hernia, 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

5.2 Medical questionnaire (continued)

- 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 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 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"

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

14. Pregnancy

Are 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

5.2 Medical questionnaire (continued)

- 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 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 your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

15. Kidney and urinary conditions

Mark with an "X"

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 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

18. HIV/Aids

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

Yes	No

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

*If any of your dependants prefer not to disclose their 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 their enrolment date by phoning LifeSense on 0860 50 60 80.

It is important to disclose this information to prevent the possible termination of your dependants' 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

5.2 Medical questionnaire (continued)

- 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 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 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"

19. Planned treatment

Are 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 (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

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 dependants' 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.

6. 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 the registration of your dependants, 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 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. I understand that on approval of my application for the registration of my dependants, the Rules of Medihelp will be binding on my registered dependants, as the Rules are binding on me.
8. By signing this application I confirm that I have the right to apply for the registration of my dependants and to act for those that I apply for, in any matter relating to this application.

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

9. I declare that the information provided in this application for the registration of my dependants 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 the health status of my dependants after my application for the registration of my dependants has been submitted but prior to their membership commencement date. I undertake to notify Medihelp in writing should there be any future changes in my personal 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.**
10. 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.
11. I confirm that my dependants will not be registered as beneficiaries of another registered medical scheme on the date on which I request their registration at Medihelp.
12. I take note that the monthly contribution fees will be due as per arrangement with Medihelp 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.
13. I confirm that I am responsible to give advance notice of termination of membership, and that my dependants will not be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

Medihelp's rights as a medical scheme:

14. I am aware that a three-month general and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on the membership of my registered dependants in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise their membership without issuing a document containing the conditions of their membership in the event that no waiting period and/or late-joiner penalty is imposed.
15. 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.
16. 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.
17. Medihelp may also restrict interchanges between plans to the beginning of a year, and require a notice period as set out in the Rules.
18. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
19. 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.
20. I am aware that Medihelp may increase its contributions annually at the beginning of the year.

Protection of information:

21. I hereby give permission, and declare that I have obtained the consent of my dependants, that –

21.1 Medihelp may enquire about the health status 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;

21.2 My dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;

21.3 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;

21.4 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

21.5 Medihelp may share my information for statistical analysis and academic research purposes.

22. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
23. 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.
24. I agree that Medihelp may, for the purpose of considering my application for the registration of my dependants 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.

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

25. 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 member

Date 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 ☐ Curator (legal appointment) ☐

ID/passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Title 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 Code _____ No. _____

Cell phone number _____

7. 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 member 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 member 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

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

M H ☐☐☐☐☐☐

uppe marketing A30138

Enquiries: 086 0100 678, **Email:** newbusiness@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
Medihelp is an authorised financial services provider (FSP No 15738)

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Medical Aid in Action