Application for change in membership

Enquiries: 086 0100 678
Email: newbusiness@medihelp.co.za
www.medihelp.co.za

How to apply

- Submitting your application online on Medihelp's website allows for immediate confirmation of receipt and faster processing. Please visit https://onlineapplication.medihelp.co.za.
- If you use the printed form, please complete all sections in full using black ink, write clearly, and sign all relevant sections. Please read the conditions for membership in section 8 carefully before you sign the form. Incomplete information may delay the application process.

Next steps after we receive your application

- Medihelp will contact you from 012 336 9000 if we need any additional information. Please save this number to recognise it as a legitimate call and not spam. 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.
- Once you receive communication with a link to register on the Member Zone, you can download your digital membership card.

You must complete this form only if the conditions below are applicable. In all other cases, please complete the My Medihelp application form (form 4216)

- Continued membership for existing dependants of a deceased member.
- Membership for dependants who no longer qualify as dependants in terms of Medihelp's Rules.
- Status change on the same plan – spouse/partner on previous membership becomes the principal member with new membership.
- Principal member and dependant split membership and both remain on the same plan.
- Request a new membership number due to a stolen membership card or identity theft.

1. When would you like your cover to start?

y y y y m m d d

No person may be enrolled as a member of Medihelp while they are a member of another medical scheme. Please refer to paragraph 10 of section 8 of this application form.

2. Your information (person who requests membership)

Previous membership number

If you use your passport number, please attach a copy of your passport.

ID/passport number

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

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

Surname

Initials

First names

Gender: Male | Female

Preferred name

Marital status: Married | Unmarried

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 used for national statistical purposes by the Council for Medical Schemes.

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

3. Your contact details

Please note: We communicate with our members exclusively through electronic channels.

Residential address*

House/unit number

Complex/building name

Street name

Suburb

City

Province

Postal code

Cell phone number*

Alternative contact number

Personal email address*

*All contact information is compulsory, as we need it to communicate important information about your rights, benefits, and duties as a member. Without this information, we will not be able to finalise your application for membership.

To enable us to communicate effectively with you, we would like to know if the following applies to you:

Visually impaired: Yes | No

Hearing impaired: Yes | No

4. Details of your employer/the institution responsible for paying your contribution

NB: Complete only if your contribution is paid, either in full or in part, 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 |

Appointment type: Permanent | Temporary

Pay area _____

Office stamp of employer

5. Mark your plan choice with an "X"

5.1 Plans

Note

- **All benefit-related information can be obtained in your 2026 member guide.**
- **If you choose a plan with a savings account (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect, or MedElite), please read section 5.3.**

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

5.2 Students (MedMove! only)

If you want to enrol on MedMove! as a student, please provide the following:

- Acceptable proof of enrolment as a student is proof of registration for studies on an official letterhead of the tertiary institution or vocational training college where you are registered as a student.
- Acceptable proof of income, if Medihelp requests this, is the past three months' official bank statements containing the initials and surname of the accountholder reflecting your income. Other additional proof of income may also be required.
- Acceptable proof of continued studies must be provided to Medihelp annually by the requested date, or more frequently if requested by Medihelp.

5.3 Utilisation of savings account funds

MedAdd, MedAdd Elect, and MedSaver

SavingsNow preferences

Please indicate how you would like Medihelp to use your SavingsNow account.

By default:

All eligible day-to-day out-of-hospital medical services are paid from SavingsNow.

Specialised radiology is not included in this automatic payment.

Your choice (please select):

• Pay in-hospital specialised radiology co-payments and shortfalls from SavingsNow.	Yes	No
• Pay out-of-hospital specialised radiology co-payments and shortfalls from SavingsNow.	Yes	No
• Pay all other in-hospital co-payments and shortfalls (excluding specialised radiology) from SavingsNow.	Yes	No

If you do not indicate your preference, these costs will not be paid from your SavingsNow account until you give us your instruction.

You can change your preferences on the Member Zone at any time.

6. Dependants you want to register

You may register the following dependants:

- Spouse/partner
- Own children of the applicant and spouse/partner
- Stepchildren of the applicant and spouse/partner
- Adopted children or in the process of adoption/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner

If any of the following persons are dependent on the applicant for family care and support, you may register them as dependants:

- Father/mother/brother/sister of the applicant
- Grandchildren of the applicant

Please note

- Foster children and children in temporary safe care may be registered as dependants only up to the age of 26 years in terms of legislation.
- If a dependant is not a South African citizen, a copy of their passport must be submitted with the completed application.
- When registering a partner as a dependant, you confirm that you are in a domestic partnership, and undertake to inform Medihelp within 30 days if your relationship status changes.

The following persons may not be registered as dependants of the applicant:

- Stepbrothers and stepsisters
- Stepparents
- In-laws
- Godchildren
- Cousins
- Grandparents
- Nieces and nephews

To avoid delays in your enrolment process, please attach the following supporting documents:*

Dependant	Document required
• Adopted children or children in the process of adoption/ foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner	• Legal documentation confirming that the child has been adopted or in the process of adoption/placed in foster care/temporary safe care of the applicant. • 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
• Child or grandchild. • If surname differs from the applicant's surname	• Unabridged birth certificate. • For grandchildren, the unabridged birth certificates or an affidavit confirming family care and support

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

Dependants

	1	2
Title	Initials	Initials
Relationship to applicant		
Surname		
First names		
Preferred name		
ID/passport number		
Date of birth	y y y y m m d d Gender Male Female	y y y y m m d d Gender Male Female
Cell phone number*		
Personal email address*		
Visually impaired*	Yes No	Yes No
Hearing impaired*	Yes No	Yes No
	Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.	Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.
	Black Coloured Indian/ Asian White Other	Black Coloured Indian/ Asian White Other

	3	4
Title	Initials	Initials
Relationship to applicant		
Surname		
First names		
Preferred name		
ID/passport number		
Date of birth	y y y y m m d d Gender Male Female	y y y y m m d d Gender Male Female
Cell phone number*		
Personal email address*		
Visually impaired*	Yes No	Yes No
Hearing impaired*	Yes No	Yes No
	Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.	Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.
	Black Coloured Indian/ Asian White Other	Black Coloured Indian/ Asian White Other

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

7. Banking details

7.1 Complete this section if you will be paying your own contribution

I authorise Medihelp to deduct the applicable monthly contribution from the bank account specified below by debit order on the indicated date. I further authorise Medihelp to adjust the contribution if necessary and to deduct the amended amount, or any outstanding contribution from the specified bank account.

7.2 Mark this section if your employer or an institution will be paying your contribution

☐ My employer/institution, as my authorised agent, authorises Medihelp to deduct the applicable monthly contribution from my employer/institution's bank account on the last workday of each month, starting from the date of enrolment. I authorise Medihelp to adjust the contribution amount if necessary and to deduct the amended amount, or any outstanding contribution amount from my employer/institution's bank account.

7.3 Complete your banking details for debit order deductions and credit refunds (all applicants must provide this information)

If you provide only one bank account number, we will use this account to deduct your monthly contribution and to refund any credit amounts.

☐ 1. Use account below for all transactions

☐ 2. Use the account below only for the deduction of monthly contribution

NB: If you select option 2, you must complete your banking details for credit refunds in the column on the right.

Bank _____

Branch _____

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

Type of account | Savings | Current |

Initials and surname of accountholder _____

Account number _____

☐ Use the account below for credit refunds only

NB: If you selected option 2 in the column on the left, you must complete your banking details below.

Bank _____

Branch _____

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

Type of account | Savings | Current |

Initials and surname of accountholder _____

Account number _____

Please deduct my monthly contribution by debit order from the bank account on the following date (choose only one option by marking with an "X"):

☐ First workday of the month ☐ Last calendar day of the month ☐ 25th day of the month

Signature of applicant

Signature of accountholder

Note

- Your contribution is payable in advance. If your membership cannot be finalised in time for the deduction date chosen above, Medihelp will make two separate debit order deductions in your first month of membership. These will be the first available workday following the activation of your membership and the actual date you have chosen in the same month.
- After the first month, Medihelp will collect your contribution monthly on the date you have chosen above.
- If the debit order deduction date falls on a weekend or a public holiday, your contribution will be deducted on the first workday after the selected deduction date. If no debit order deduction date is selected, Medihelp will make the deduction on the first workday of the month.
- In the case of a trust, the responsible trustee must sign this section and submit a copy of the trust deed.

Complete this section if a third party pays the contribution on behalf of the applicant

This information is a compulsory requirement for South African Revenue Services (SARS) purposes. I, the undersigned, hereby agree to pay the monthly medical scheme contribution on behalf of the member. I also authorise Medihelp Medical Scheme to deduct the contribution from my bank account.

Nature of payer _____
(for example, individual, company, trust, etc.)

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

Surname _____

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

First name _____

Initials _____

Date of birth | y | y | y | y | m | m | d | d |

Nationality _____

Physical address _____

Registered company name _____

Company registration number | | | | | | | | | | | | | |

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

Signature of third party

8. 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 Medihelp employees and contracted parties have access to your data to process and pay claims, among other things. All employees and contracted parties who have access to your data for these purposes have signed a confidentiality agreement 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.
5. If you make use of a Medihelp-contracted brokerage's services, 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 the Rules of Medihelp and will read all the correspondence from Medihelp, such as newsletters and statements. I will also study my plan guide and familiarise myself with the cover offered by the plan I choose.
7. I will abide by the Rules of Medihelp, as amended from time to time and available at www.medihelp.co.za on the self-service platform for members and 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 me and my dependants, even if this application was completed by my financial adviser or any other third party on my behalf. I will notify Medihelp in writing if there are any changes in my health status or that of my dependants after my application for membership has been submitted, but before my membership start date. I confirm that the e-mail address I have provided in section 3 is the address where I will receive all communication from Medihelp. I will notify Medihelp in writing of any future changes to my personal details and/or banking details. I understand that failure to do so may result in my membership being terminated in accordance with the Medical Schemes Act 131 of 1998 and the registered Rules of Medihelp.
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, after which the application form will be cancelled and I will be required to submit a new application form.
10. I confirm that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.
11. I take note that the monthly contribution fees will be due on the first day of enrolment and thereafter on the first day of each subsequent calendar month, and it shall be payable on the date selected by me in section 7. Should my employer/institution, as my authorised agent, undertake to pay my contribution 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 contribution: 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 note that a third party paying the contribution on my behalf is not part of the contract with Medihelp and will not receive communication regarding changes in the monthly payable contribution. I undertake to inform the third party of any changes in my contribution and accept that I remain responsible for the payment thereof.
13. 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

14. 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 if 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. The Rules of Medihelp 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 if I fail to pay my contribution or debt in full, that my membership may be terminated if any amount remains 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 contribution annually at the beginning of the year. I also authorise Medihelp to adjust the contribution if necessary due to a change in my membership and to deduct the amended amount or any outstanding contribution amounts from me or the third-party payer/employer/institution I indicated as the authorised payer of my contribution.

Protection of information

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

21.1 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 I 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 I appoint and whose appointment Medihelp accepts 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 healthcare 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 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.
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.
26. If you believe that Medihelp has used your personal information contrary to its Privacy Policy, you have the right, under the Protection of Personal Information Act, to lodge a complaint with the Information Regulator, but we encourage you to first follow our internal complaints process to resolve the matter. If, thereafter, you believe that we have not resolved the matter adequately, you can contact the Information Regulator at: The Information Regulator (South Africa), JD House, 27 Stiemens Street, Braamfontein, 2017, telephone number: 010 023 5207, email: POPIAComplaints@inforegulator.org.za.
27. If you believe that Medihelp has not handled your enquiry satisfactorily, please first follow our internal complaints process to resolve the matter. If, thereafter, you believe that we have not resolved the matter adequately, you can contact the Council for Medical Schemes (CMS), as Medihelp is a registered medical scheme and regulated by the CMS. The CMS's contact details are as follows: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, Customer Care Centre: 0861 123 267, email: complaints@medicalschemes.co.za, website: www.medicalschemes.co.za.
28. If you are signing as the applicant's parent and your child is younger than 18, please attach a copy of your passport/ID document and the applicant's birth certificate.

Signature of applicant | Date (y y y y m m d d)

If you are signing as the applicant's parent and your child is 18 years and older, please attach the following:

A copy of your passport/ID document as well as the document confirming your appointment as guardian/curator/power of attorney.

If you are applying on behalf of another person as parent, guardian, curator, or power of attorney, please complete the following:

In your capacity as | Parent (minor child) | Guardian | Curator | Power of attorney (legal appointment)

ID/passport number | Title | Mr | Mrs | Ms | Other (specify)

First name | Surname

Cell phone number* | Alternative contact number

Personal email address*

* This information is compulsory and is required to communicate important information to you about your rights, benefits, and duties as a member. If not completed, your application for membership cannot be finalised.

Relationship to applicant

9. 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 their adviser and is entitled to cancel my services at any time;
2. I have informed the applicant that I am not an agent of Medihelp, but that I am acting in my own capacity, for my own benefit and account, as mandated by the applicant.

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)

Name and surname of adviser | Adviser code

Email address | Contact number

In the event of a dispute, the registered Rules of Medihelp and / or the provisions of Medihelp's independent adviser agreement, as the case may be, shall apply.

Signature of adviser | Date (y y y y m m d d)

Lead reference number

MHNN005 SEPT 2025