



# Registration of my new-born baby

| For office use only |   |   |  |  |  |  |  |  |  |
|---------------------|---|---|--|--|--|--|--|--|--|
| Membership number   |   |   |  |  |  |  |  |  |  |
|                     | M | H |  |  |  |  |  |  |  |

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 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:**

1. Please complete in print using black ink, and email, fax or post all pages of the form to Medihelp.
2. Please complete all sections in full and sign the application form.
3. Never sign a blank application form.

| 1. Details of member |  |               |    |     |    |                 |  |  |  |
|----------------------|--|---------------|----|-----|----|-----------------|--|--|--|
| Member number        |  |               |    |     |    |                 |  |  |  |
| Initials             |  | Title         | Mr | Mrs | Ms | Other (specify) |  |  |  |
| First names          |  |               |    |     |    |                 |  |  |  |
| Surname              |  |               |    |     |    |                 |  |  |  |
| Cell No.             |  |               |    |     |    |                 |  |  |  |
|                      |  | Tel: (W) Code |    | No. |    |                 |  |  |  |
|                      |  | Tel: (H) Code |    | No. |    |                 |  |  |  |
| Email address        |  |               |    |     |    |                 |  |  |  |

|   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|
| 2. Date on which my new-born baby(ies) should be registered | 2 | 0 | y | y | m | m | d | d |
|---|---|---|---|---|---|---|---|---|

| 3. Details of my new-born baby(ies) |  |  |  |  |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|--|--|--|--|
|-------------------------------------|--|--|--|--|--|--|--|--|--|

In the case of dependants who are not South African citizens, a copy of their passport must be submitted with the completed application form.

**Dependant**

|                        |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
|------------------------|---|--------|------|---|--------|---|---|---|--|--|--|--|--|--|--|--|--|--|--|
| Surname                |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| First names in full    |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| Known as               |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| ID/passport number     |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
|                        |   | Gender | Male |   | Female |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth          | y | y      | y    | y | m      | m | d | d |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to member |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |

**Dependant**

|                        |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
|------------------------|---|--------|------|---|--------|---|---|---|--|--|--|--|--|--|--|--|--|--|--|
| Surname                |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| First names in full    |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| Known as               |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| ID/passport number     |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
|                        |   | Gender | Male |   | Female |   |   |   |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth          | y | y      | y    | y | m      | m | d | d |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to member |   |        |      |   |        |   |   |   |  |  |  |  |  |  |  |  |  |  |  |



#### 4. Conditions of membership, declaration by member and consent for Medihelp to process personal information

##### Medihelp confirms that –

1. your and your registered dependant's(s') 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 staff 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 dependant(s), paying your medical claims, determining whether you are entitled to benefits, managing risks, and for any communication purposes;
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/dependant of Medihelp:

6. I will ensure that I know all the provisions of Medihelp's Rules and will read all the correspondence from Medihelp, such as newsletters and statements, and I will study my benefit guide and familiarise myself with the coverage offered by the benefit option 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](http://www.medihelp.co.za) on the secured website for members, and not to submit any fraudulent claims or commit any fraudulent acts. I understand that on approval of my application for the registration of my dependant(s), the Rules of Medihelp will be binding on my registered dependant(s), 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 dependant(s) and to act for those that I apply for, in any matter relating to this application.
9. I declare that the information provided in this application for the registration of my dependant(s) 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 dependant(s) 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 dependant(s), 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 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 90 days, whereafter the application form will be cancelled and I will be required to submit a new application form.
11. I confirm that my dependant(s) 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 subscription 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 subscriptions 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 subscriptions: 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 should I terminate my membership of Medihelp.
13. I confirm that I am responsible for giving advance notice of termination of membership, and that my dependant(s) will not be registered as beneficiaries of another registered medical scheme while still members of Medihelp.



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| <b>4. Conditions of membership, declaration by member and consent for Medihelp to process personal information (continued)</b> |
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**Medihelp's rights as a medical scheme:**

14. I am 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 designated service providers.
16. Medihelp may also restrict interchanges between benefit options 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 membership may be suspended should I not pay my contributions or debt in full for a period of one month, and that my membership may be terminated should I be in arrears for a period of two months, and that my account will be handed over for collection.
19. I am aware that Medihelp may increase its subscriptions annually at the beginning of the year.

**Protection of information:**

20. I hereby give permission that –
  - 20.1 Medihelp may enquire about the health status of my dependant(s) 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 dependant(s) may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;
  - 20.3 an adviser in the service of a Medihelp contracted brokerage, should I make such an appointment and use their services, may have access to my personal and medical information and that of any of my registered dependant(s) 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 dependant's(s') medical and personal information to medical service providers for the purpose of delivering medical services to me and my dependant(s) and to pay for such services; and
  - 20.5 Medihelp may share my information for statistical analysis and academic research purposes.
21. I understand that the information contemplated in paragraph 20 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.
22. 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 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 registration of my dependant(s) or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependant(s) from medical practitioners, financial advisers, industry regulatory bodies or employers.

