



Registration of my new-born baby

Enquiries: 086 0100 678

Fax: 012 336 9534 Email: newbusiness@medihelp.co.za

Postal address: PO Box 26004, ARCADIA, 0007

www.medihelp.co.za

How to complete this form:

- We recommend that you register your new-born baby online by making use of our Member Zone at <https://toolbox.medihelp.co.za/>. You can also use our 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, fax 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.

Important information that you should note before you complete and submit your form:

- Read and make sure you understand the rules for membership in section 4 before you sign the form.
- Email the completed and signed form to newbusiness@medihelp.co.za or fax the form to 012 336 9534.

For use by corporate clients

Payroll number

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Employer's office stamp

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1. Details of the main member

Member number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Initials _____ Title

Mr	Mrs	Ms	Other (specify)
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First names _____

Surname _____

Cell 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)
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Date of marriage

y	y	y	y	m	m	d	d
---	---	---	---	---	---	---	---

Please indicate your race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

2. Date on which my new-born baby should be registered

2	0	y	y	m	m	d	d
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3. Details of my new-born baby

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 1

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 (please select one by marking with an X)

Child dependant Own child Child born in terms of a surrogate motherhood agreement Other relative Grandchild

If you are registering a grandchild as dependant, is the dependant:

Financially dependent on you? Yes No Living with you? Yes No

NB: Your grandchild will pay adult dependant membership fees, unless legally adopted.

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

3. Details of my new-born baby (continued)

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 2

Surname _____

First names in full _____

Known as _____

ID/passport number Gender

Male	Female
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Date of birth

y	y	y	y	m	m	d	d
---	---	---	---	---	---	---	---

Relationship to member (please select one by marking with an X)

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild

If you are registering a grandchild as dependant, is the dependant:

Financially dependent on you?

Yes	No
-----	----

 Living with with you?

Yes	No
-----	----

NB: Your grandchild will pay adult dependant membership fees, unless legally adopted.

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

Dependant 3

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 (please select one by marking with an X)

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild

If you are registering a grandchild as dependant, is the dependant:

Financially dependent on you?

Yes	No
-----	----

 Living with with you?

Yes	No
-----	----

NB: Your grandchild will pay adult dependant membership fees, unless legally adopted.

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

Dependant 4

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 (please select one by marking with an X)

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild

If you are registering a grandchild as dependant, is the dependant:

Financially dependent on you?

Yes	No
-----	----

 Living with with you?

Yes	No
-----	----

NB: Your grandchild will pay adult dependant membership fees, unless legally adopted.

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

Black Coloured Indian/Asian White Other

4. Conditions of membership, declaration by member 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 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 new-born baby, 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/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 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 new-born, 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.
9. I declare that the information provided in this application to register my new-born baby 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 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 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.
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 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.
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 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 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 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 that –
- 20.1 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;
- 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 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 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.

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

21. I understand that the information 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 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 the registration of my new-born baby 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.
24. I further consent, and declare that I have obtained the consent of all 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

Should you be applying on behalf of another person as guardian or curator, please complete the following:

In your capacity as ID/passport number Title

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator, must accompany this application.

First name Surname Tel No. Code No. Fax No. Code No. Cell number **5. 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 –

- the member has appointed me as his/her adviser and is entitled to cancel my services at any time;
- I have signed a valid contract with my Medihelp-contracted brokerage; and
- 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 Adviser code Name and surname of adviser Tel No. Code No. Fax No. Code No. Email address

Signature of adviser

Date

Lead reference number

For office use only

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

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Enquiries: 086 1123 267, Website: www.medicalschemes.co.za

Medihelp is an authorised financial services provider (FSP No 15738)