

3. Your contact information (continued)

To improve the quality of our communication to you, please indicate if the following applies to you:

Visually impaired Yes No Hearing impaired Yes No

Is your postal and residential address the same? Yes No

Residential address

House/unit number and building name _____ House/building number and street name _____

Suburb _____ City _____

Province _____ Postal code

Postal address

House/unit number and building/organisation name _____ PO Box/house/building number and street name _____

Suburb _____ City _____

Province _____ Postal code

This information is compulsory. If not completed, your application for membership cannot be finalised. Refer to paragraph 8 of Section 8 of this application.

4. Details of your employer or the institution responsible for paying your subscriptions

Name of employer/institution _____

Campus/site _____

Branch code/employer group number _____

Payroll number _____

Appointment date Appointment

Pay area _____ Permanent Temporary

Office stamp of employer
d

5. Select a plan that will suit your needs by marking your choice with an "X"

5.1 Plans

Note

- If you choose a plan with a savings option (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect or MedElite), please refer to Section 5.3; and
- If you choose MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect, please refer to Section 5.4.

Basic plans

MedMove!

MedVital

MedVital Elect

Saving plans

MedAdd

MedAdd Elect

MedSaver

Comprehensive plans

MedPrime

MedPrime Elect

MedElect

MedElite

MedPlus

5.2 Students with a monthly income of no more than R800 – MedElect only

Do you want to enrol as a student member on the MedElect plan? Yes No

If "Yes", please provide proof of your enrolment as a student. Proof of your monthly income may also be requested.

- 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, should Medihelp request this, is the past three months' official bank statements containing the initials and surname of the account holder and reflecting your income. Other additional proof of income may also be required.

5.3 Utilisation of savings account funds

MedAdd, MedAdd Elect, and MedSaver

Please indicate your preference. If you do not select an option, Medihelp will pay all qualifying medical expenses from your savings account.

• Do you prefer that Medihelp should pay all in-hospital co-payments from your savings account? Yes No

MedPrime, MedPrime Elect, and MedElite

- If you enrol on the MedPrime, MedPrime Elect or MedElite plan, all qualifying day-to-day medical expenses will be paid from your savings account first.

5. Select a plan that will suit your needs by marking your choice with an "X" (continued)

5.4 Declaration by applicants who apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect

I confirm that I am aware of the following:

1. I will be liable for co-payments if I do not use Medihelp's network facilities, designated service providers (DSPs) and formulary medicine.
2. I must register my prescribed minimum benefits (PMB) conditions with Medihelp and my PMB chronic medicine must be pre-authorized by Medihelp. Medihelp uses a DSP for PMB chronic medicine and a formulary applies. I will be responsible for a co-payment* on my PMB chronic medicine should I fail to get this medicine from the DSP or deviate from the formulary for my plan.
3. My treating specialists should form part of Medihelp's DSP specialist network to prevent co-payments on PMB treatments.
4. I must use Medihelp's network facilities for all planned admissions. If there is no network facility available near my place of residence, I will need to travel to the nearest network facility to obtain medical services. If I use a non-network facility instead, I will be liable for a co-payment*, unless the treatment required is for an emergency medical condition** which warrants the involuntary use of a non-network facility. I further note that in a medical emergency, authorisation for admission to the network facility should be obtained on the first workday after the admission if I am unable to get the authorisation on the day of admission.

* Please refer to your plan's guide/brochure for all applicable co-payments.

** Please refer to your plan's guide/brochure for the definition of an emergency medical condition.

Signature of applicant		Date	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">2</td> <td style="width: 20px; text-align: center;">0</td> <td style="width: 20px; text-align: center;">y</td> <td style="width: 20px; text-align: center;">y</td> <td style="width: 20px; text-align: center;">m</td> <td style="width: 20px; text-align: center;">m</td> <td style="width: 20px; text-align: center;">d</td> <td style="width: 20px; text-align: center;">d</td> </tr> </table>	2	0	y	y	m	m	d	d
2	0	y	y	m	m	d	d				

6. Your dependants whom you want to register

You may register the following persons as 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, they may be registered as dependants:

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

PLEASE NOTE

- Grandchildren of the applicant pay the same contribution as that of an adult dependant, unless legally adopted.
- 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.

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

- Stepbrothers and stepsisters
- Step-grandchildren
- Stepparents
- Grandchildren of the applicant's partner
- In-laws
- Godchildren
- Cousins

We require the following supporting documents to ensure your quick enrolment:*

Dependants	Document required
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Legal documentation confirming that the child was 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.
<ul style="list-style-type: none"> • Child (if surname differs from the applicant's surname). 	<ul style="list-style-type: none"> • Unabridged birth certificate confirming the birth parents of the child.

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

Spouse/partner (complete only if applying for registration as a dependant)

Surname		Title	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">Mr</td> <td style="width: 20px; text-align: center;">Mrs</td> <td style="width: 20px; text-align: center;">Ms</td> <td style="width: 40px; text-align: center;">Other (specify)</td> </tr> </table>	Mr	Mrs	Ms	Other (specify)																								
Mr	Mrs	Ms	Other (specify)																												
First names in full																															
Known as																															
ID/passport number	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																					Gender	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 40px; text-align: center;">Male</td> <td style="width: 40px; text-align: center;">Female</td> </tr> </table>	Male	Female						
Male	Female																														
Date of birth	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">y</td> <td style="width: 20px; text-align: center;">y</td> <td style="width: 20px; text-align: center;">y</td> <td style="width: 20px; text-align: center;">y</td> <td style="width: 20px; text-align: center;">m</td> <td style="width: 20px; text-align: center;">m</td> <td style="width: 20px; text-align: center;">d</td> <td style="width: 20px; text-align: center;">d</td> </tr> </table>	y	y	y	y	m	m	d	d	Cell phone number	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																				
y	y	y	y	m	m	d	d																								
Email address																															

6. Your dependants whom you 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 _____

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired

Yes	No
-----	----

 Hearing impaired

Yes	No
-----	----

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/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), 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", provide your dependant's residential address.

House/unit number and building name _____ House/building number and street name _____

Suburb _____ City _____

Province _____ Postal 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 _____

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired

Yes	No
-----	----

 Hearing impaired

Yes	No
-----	----

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

7. Banking details

7.1 Complete this section if you will pay your own contributions

I hereby authorise Medihelp to recover the applicable contributions payable by me to Medihelp by debit order from my bank account, monthly on the date indicated below. I further authorise Medihelp to increase or decrease the contribution, should it be necessary, and recover the amended amount, or any contributions in arrears, from my bank account.

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

<input type="checkbox"/>	On the first workday of the month in which I requested enrolment and thereafter on the first workday of every subsequent month.
<input type="checkbox"/>	On the 25th day of the month prior to my enrolment and thereafter on the 25th day of the subsequent months of my membership.
<input type="checkbox"/>	On the last calendar day of the month prior to my enrolment and thereafter on the last calendar day of the subsequent months of my membership.

Note

- Your contributions are payable in advance, and 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, namely on the first available workday following the activation of your membership AND on the actual date you have chosen in the same month. Medihelp will thereafter collect your contributions monthly on the date you have chosen above.
- If the debit order deduction date falls on a weekend or a public holiday, your contributions 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.

7.2 Mark this section if your employer/an institution will pay your contributions

My employer/institution as my authorised agent hereby authorises Medihelp to recover the applicable contributions payable by my employer/institution as my authorised agent to Medihelp by debit order from my employer/institution as my authorised agent's bank account monthly on the last workday of each month as from the date of enrolment. I authorise Medihelp to increase or decrease the contributions, should it be necessary, and recover the amended amount, or any contributions in arrears, from my employer/institution as my authorised agent's bank account.

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

<input type="checkbox"/> 1. Use the account below for all transactions	<input type="checkbox"/> Use the account below for credit refunds only																														
<input type="checkbox"/> 2. Use the account below only for the recovery of contributions	NB: If you selected option 2 on the left, you must complete your banking details below.																														
NB: If you select this option, you must complete your banking details for credit refunds in the table on the right.																															
Bank _____	Bank _____																														
Branch _____	Branch _____																														
Branch code <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																Branch code <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
Type of account <table border="1"><tr><td>Savings</td><td>Cheque</td></tr></table>	Savings	Cheque	Type of account <table border="1"><tr><td>Savings</td><td>Cheque</td></tr></table>	Savings	Cheque																										
Savings	Cheque																														
Savings	Cheque																														
Name of account holder _____	Name of account holder _____																														
Account number _____	Account number _____																														

If only one bank account number is provided, this account will be used both for the recovery of contributions and for refunding credit amounts. In the case of a trust, a copy of the trust deed must be submitted and the responsible trustee must sign.

Signature of account holder/authorised signatory for recovery of contributions

Signature of account holder for credit refunds

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 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 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. Should you make use of a Medihelp-contracted brokerage's services then relevant membership information will be made available to the appointed brokerage 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 Medihelp's Rules and will read all the correspondence from Medihelp, such as newsletters and statements. I will also 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.
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 myself and my dependants, even if my financial adviser or any other third party completed this application on my behalf. **I undertake to notify Medihelp in writing should there be any changes in my health status or that of my dependants after my application for membership has been submitted but prior to my membership commencement date.** I confirm that the residential address stated on page 1 is the address that I choose for the purpose of serving any legal documentation. 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.
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, whereafter 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 at Section 7. 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 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.
12. 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

13. I am aware that any unexpired period of an existing general or condition-specific waiting period previously imposed may be maintained by Medihelp. Medihelp shall continue to apply a late-joiner penalty that was applied on a beneficiary during the initial enrolment. Medihelp may finalise my membership without issuing a document containing the conditions of my membership in the event that no waiting period and/or late-joiner penalty is imposed.
14. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid for 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 using 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, and declare that I have obtained the consent of all my dependants, that:
 - 20.1 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 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 Any adviser whom I appointed 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;

Enquiries: 086 0100 678, **Email:** newbusiness@medihelp.co.za
189 Clark Street, Brooklyn, Pretoria, 0181, www.medihelp.co.za

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