

3. Your contact information (continued)

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 10 of this application.

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

NB: Complete only if contributions are paid in full or partially by your employer or any other institution.

Name of employer/institution _____ Campus/site _____

Branch code/employer group number _____

Payroll number _____

Appointment date Appointment Permanent Temporary

Pay area _____

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 hospital admissions. If there is no network facility available near my place of residence, I will need to travel to the nearest network facility for 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
		2 0 y y m m d d

6. Your dependants whom 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, 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			
	Mr	Mrs	Ms	Other (specify)
First names in full				
Known as				
ID/passport number	Gender			
		Male	Female	
Date of birth	Cell phone number			
y y y y m m d d				
Email address				

6. Your dependants whom you want to register (continued)**Spouse/partner (complete only if applying for registration as a dependant)(continued)**

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

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

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", provide your dependant's residential address.

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

Suburb _____ City _____

Province _____ Postal 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 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

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

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

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild Brother
 Adopted child Stepchild Mother Sister
 Foster child Child in temporary safe care 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

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
-----	----

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

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

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild Brother
 Adopted child Stepchild Mother Sister
 Foster child Child in temporary safe care 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
-----	----

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

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

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild Brother
 Adopted child Stepchild Mother Sister
 Foster child Child in temporary safe care Father

6. Your dependants whom you wish to register (continued)**Dependant 4 (continued)**

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 5

Surname _____ Title Mr Mrs Ms Other (specify) _____

First names in full _____

Known as _____

ID/passport number Gender Male Female

Date of birth 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

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

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

7. Banking details

7.1 Complete this section if you will pay your own contributions

I 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 or an institution will pay your contributions

- My employer/institution as my authorised agent 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 you provide only one bank account number, we will use this account for both the recovery of contributions and refunding credit amounts. In the case of a trust, the responsible trustee must sign this section and submit a copy of the trust deed.

Signature of account holder/authorised signatory for recovery of contributions

Signature of account holder for credit refunds

9. Medical history

- Please ensure that you have completed **Section 8** of this application form in full.
- To ensure quick and easy enrolment, please complete **Section 9.1**.
- If you answered "Yes" to any of the questions in Section 9.1, please complete the full medical questionnaire in **Section 9.2**.

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

Doctors consulted in the past 12 months

If your family has consulted a doctor in the past 12 months, please provide us with the details:

Name and surname						How long has he or she been your doctor (in years)?	
Telephone number (W)							
Name and surname						How long has he or she been your doctor (in years)?	
Telephone number (W)							
Name and surname						How long has he or she been your doctor (in years)?	
Telephone number (W)							

9.1 Short medical questionnaire

- | | | | |
|---|--|-----|----|
| 1. Have you or any of your dependants been admitted to hospital and/or diagnosed with an illness within the last 12 months prior to submitting this application? If "Yes", please complete Section 9.2 . | Mark with an "X" | | |
| | <table border="0" style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">Yes</td> <td style="width: 50%;">No</td> </tr> </table> | Yes | No |
| Yes | No | | |
| 2. Are you or any of your dependants currently taking or should be taking regular and/or ongoing medicine, including homeopathic, natural or over-the-counter medication, and/or receiving treatment for a medical condition or symptom? (Please take note of question 18 in Section 9.2). If "Yes", please complete Section 9.2 . | Mark with an "X" | | |
| | <table border="0" style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">Yes</td> <td style="width: 50%;">No</td> </tr> </table> | Yes | No |
| Yes | No | | |
| 3. Are you or any of your dependants currently pregnant, suspect that you are pregnant or undergoing testing for pregnancy, and/or currently in hospital and/or aware of or planning to have any test, examination, treatment and/or procedure done, and/or to obtain medical advice that could result in a claim in the next 12 months? If "Yes", please complete Section 9.2 . | Mark with an "X" | | |
| | <table border="0" style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">Yes</td> <td style="width: 50%;">No</td> </tr> </table> | Yes | No |
| Yes | No | | |

9.2 Full medical questionnaire

Please note that this medical questionnaire does not constitute an application to register or authorise chronic medicine, PMB services, planned procedures or treatment for benefits. Should you need to get authorisation for chronic medicine, please phone Medihelp on 086 0100 678 once your membership has been finalised and request 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.

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and 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 you and/or 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, non-cancerous growths and related test results

Cancer or tumours of any organ or skin, cancerous tumours, non-cancerous tumours, (also list if removed and enter removal date under last date of follow-up). **Examples:** blood-related cancers, lymphoma, leukaemia, skin lesions, warts or moles, breast disease, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal Pap smear result, abnormal prostate-specific antigen result, any other abnormal cancer screening or diagnostic test result.

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
		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	
		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	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and 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 you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

2. Blood conditions

Examples: blood clots or bleeding problems, high or low iron, anaemia, deep vein thrombosis, lung clots, ITP and platelet deficiencies, any other bleeding or blood-related disorders.

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
		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	
		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	
		y	y	y	y	m	m	d	d	y	y	y	y	m	m	d	d	

3. Metabolic and endocrine conditions

Examples: diabetes, thyroid disease, Addison disease, Cushing syndrome, obesity, growth problems, metabolic syndrome, parathyroid disease, Paget disease, osteoporosis, osteopenia, growth deficiency, 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
		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	
		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	
		y	y	y	y	m	m	d	d	y	y	y	y	m	m	d	d	

4. Mental health

Examples: depression, bipolar disorder, anxiety disorder, panic attacks, post-traumatic stress disorder, obsessive compulsive disorder, schizophrenia, personality disorders, insomnia, sleeping disorders (for example, narcolepsy), eating disorders, Alzheimer disease, dementia, autism, attention deficit hyperactivity disorder, 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
		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	
		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	
		y	y	y	y	m	m	d	d	y	y	y	y	m	m	d	d	

5. Brain and nerve conditions

Examples: migraine, chronic headaches, stroke, weakness or paralysis, bleeding on the brain, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, Parkinson disease, Guillain-Barré syndrome, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability, any other brain or nerve condition or if you had a previous MRI or CT scan.

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
		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	
		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	
		y	y	y	y	m	m	d	d	y	y	y	y	m	m	d	d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and 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 you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

10. Abdominal and digestive conditions

Examples: reflux, heartburn, hiatus hernia, hepatitis, irritable bowel syndrome or chronic bloatedness, previous gastroscopy or colonoscopy, cirrhosis, piles, fistulae or rectal bleeding, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder conditions, gall stones, oesophageal disease, stomach or duodenal ulcers, any hernia, digestive problems or malabsorption, Crohn disease, ulcerative colitis, diverticulitis, any other abdominal or digestive 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
		y	m	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	

11. Skin conditions

Examples: 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
		y	m	y	m	d <th>d </th>	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	

12. Spinal, bone, muscle, and related autoimmune conditions

Examples: lower back, neck or spinal area pain, rheumatoid arthritis, osteoarthritis, knee, hip or shoulder problems or any other joint pain, joint replacements, ankylosing spondylitis, lupus, gout, clubfoot, bunions, Sjögren syndrome, scleroderma, polymyositis, polyarteritis nodosa, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, any other autoimmune conditions, 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
		y	m	y	m	d <th>d </th>	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	

13. Gynaecological and obstetric conditions

Examples: abnormal Pap smear result, menstruation problems or abnormal bleeding, endometriosis, polycystic ovarian syndrome, infertility, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, conditions or complications related to pregnancy, emergency Caesarean section, any other gynaecological or obstetric condition.

Yes	No
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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
		y	m	y	m	d <th>d </th>	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	
		y	y	y	m	d	d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and 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 you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

14. Pregnancy

Mark with an “X”

Are you or any of your dependants pregnant, suspect that you are pregnant or undergoing testing for pregnancy?

Yes	No
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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
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	

15. Kidney and urinary conditions

Examples: 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, sexually transmitted diseases.

Yes	No
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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
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	

16. Male urinary and genital conditions

Examples: prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, and 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
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	

17. Chronic or regular medication

Are you or any of your dependants currently taking regular, ongoing medicine, and/or are you receiving treatment for a medical condition or symptom even for a condition not mentioned in the medical questionnaire, including homeopathic, natural or over the counter medication?

Yes	No
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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
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	
		y	y	m	d	y	y	m	d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a “Yes” or “No”. If you answer “Yes” to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and 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 you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

18. HIV/Aids

Mark with an “X”

Yes	No
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Are you or any of your dependants mentioned on this application HIV positive or have you been diagnosed with Aids?*

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

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

It is important to disclose this information to prevent the possible termination of your 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
		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	
		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	
		y	y	y	y	m	m	d	d	y	y	y	y	m	m	d	d	

19. Possible services

Are you and/or your dependants aware of or planning to have any test, examination, treatment and/or procedure done, or get medical advice that could result in a claim in the next 12 months?

Yes	No
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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
		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	
		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	
		y	y	y	y	m	m	d	d	y	y	y	y	m	m	d	d	

20. Any other conditions not mentioned

Has any person indicated in this application form been examined (for example, medical tests, X-rays, scans), diagnosed and/or treated (with/without procedures) for any condition or disorder not mentioned in the medical questionnaire (including any injuries sustained at home, work or in a vehicle-related accident)?

Yes	No
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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
		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	
		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	
		y	y	y	y	m	m	d	d	y	y	y	y	m	m	d	d	

10. 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.

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

Medihelp confirms that: (continued)

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 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 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 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 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 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.
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 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 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 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 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;
- 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.
21. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).

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

Protection of information (continued)

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 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.
24. 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.
25. 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 Siemens Street, Braamfontein, 2017, Telephone number: 010 023 5207, Email: PAIAComplaints@inforegulator.org.za or POPIAComplaints@inforegulator.org.za.
26. 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' 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.

Signature of applicant	<input type="text"/>	Date	2	0	y	y	m	m	d	d
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Should you be applying on behalf of another person as guardian, curator or authorised representative, please complete the following:

In your capacity as	Guardian	Curator	Power of attorney (legal appointment)
ID/passport number	<input type="text"/>	Title	Mr Mrs Ms Other (specify)

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator/power of attorney, 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	<input type="text"/>	Surname	<input type="text"/>
Telephone number (W)	<input type="text"/>	Cell phone number	<input type="text"/>

11. 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 applicant has appointed me as his or 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 applicant 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	<input type="text"/>									
Brokerage code	A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Adviser code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name and surname of adviser	<input type="text"/>									
Telephone number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>									

Signature of adviser	<input type="text"/>	Date	2	0	y	y	m	m	d	d
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Lead reference number	<input type="text"/>	For office use only	M	H	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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In case of a dispute, the registered Rules of Medihelp will apply.