

# Medihelp application form 2025

**Enquiries:** 086 0100 678

**Email:** newbusiness@medihelp.co.za

**www.medihelp.co.za**

**Thank you for choosing to join Medihelp Medical Scheme. Medihelp is registered with the Council for Medical Schemes in terms of the Medical Schemes Act 131 of 1998 and is a self-administered non-profit scheme.**

## How to complete this form

- Submitting your application online on Medihelp's website allows for immediate confirmation of receipt and faster processing. Please visit <https://onlineapplication.medihelp.co.za>.
- Complete all sections in full using black ink and sign sections 5, 7, and 10. Please read the conditions for membership in section 10 carefully before you sign the form. Incomplete information may delay the application process.
- Email the completed and signed form to newbusiness@medihelp.co.za.

## Next steps after we receive your application

- Medihelp will contact you if we need any additional information. You can also use the Application in Motion (AiM) functionality on our website at <https://onlineapplication.medihelp.co.za> to track your application and provide further details, if necessary.
- If we offer you membership with standard terms, your membership will be activated without issuing enrolment conditions. We will notify you and/or your adviser in writing.
- If we offer you membership with any non-standard terms (with waiting periods and/or late-joiner penalties), we will notify you and/or your adviser in writing, and stipulate the conditions that will apply to your membership. To accept these terms, you can go to AiM and accept the enrolment conditions to activate your membership.
- We will notify you when we have finalised your application.
- Once you receive communication with a link to register on the Member Zone, you can download your digital membership card.

## 1. When would you like your cover to start?

2	0	y	y	m	m	d	d
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No person may be enrolled as a member of Medihelp while they are a member of another medical scheme. Please refer to paragraph 10 of section 10 of this application form.

## 2. Your information (person who requests membership)

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

ID/passport number	<input type="text"/>	Title	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text"/>						
Surname	<input type="text"/>	Initials	<input type="text"/>				
First names	<input type="text"/>	Gender	<input type="text"/>	<input type="text"/>			
Marital status	<input type="text"/>	Preferred name	<input type="text"/>				
Income tax number	<input type="text"/>	Date of marriage	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	Language	<input type="text"/>	<input type="text"/>			

Please indicate your race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black
  Coloured
  Indian/Asian
  White
  Other

## 3. Your contact information

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

### Residential address\*

House/unit number	<input type="text"/>	Complex/building name	<input type="text"/>
Street name	<input type="text"/>		
Suburb	<input type="text"/>	City	<input type="text"/>
Province	<input type="text"/>	Postal code	<input type="text"/>
Cell phone number*	<input type="text"/>		
Personal email address*	<input type="text"/>		
Telephone (W)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>

**3. Your contact information (continued)**

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

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

Visually impaired\*\*  Yes  No      Hearing impaired\*\*  Yes  No

\*\* If "Yes", please complete section 9 of the medical questionnaire part of this form

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

NB: Complete only if your contribution is paid, either in full or in part, by your employer or any other institution.

Name of employer/institution \_\_\_\_\_ Campus/site \_\_\_\_\_

Branch code/employer group number \_\_\_\_\_

Payroll number \_\_\_\_\_

Appointment date 

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

 Appointment type 

Permanent	Temporary
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Pay area \_\_\_\_\_

Office stamp of employer

**5. Mark your plan choice with an "X"**

**5.1 Plans**

Note

- If you choose a plan with a savings account (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect, or MedElite), please read section 5.3; and
- If you choose MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect, or MedElect, please read section 5.4.

<p>Basic plans</p> <p><input type="checkbox"/> MedMove!</p> <p><input type="checkbox"/> MedVital</p> <p><input type="checkbox"/> MedVital Elect</p>	<p>Saving plans</p> <p><input type="checkbox"/> MedAdd</p> <p><input type="checkbox"/> MedAdd Elect</p> <p><input type="checkbox"/> MedSaver</p>	<p>Comprehensive plans</p> <p><input type="checkbox"/> MedPrime</p> <p><input type="checkbox"/> MedPrime Elect</p> <p><input type="checkbox"/> MedElect</p>	<p><input type="checkbox"/> MedElite</p> <p><input type="checkbox"/> MedPlus</p>
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**5.2 Students with a monthly income of no more than R900 (MedMove! only)**

Do you want to join as a student member on the MedMove! plan? 

Yes	No
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If "Yes", please provide proof of your enrolment as a student. If necessary, we will let you know if we require proof of your monthly income.

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

**5.3 Utilisation of savings account funds**

**MedAdd, MedAdd Elect, and MedSaver**

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

• Do you want Medihelp to pay all in-hospital co-payments from your savings account? 

Yes	No
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**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.

**5.4 Declaration if you apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect, or MedElect**

I confirm that I am aware of the following:

- Co-payments:** I will be liable for co-payments if I do not use Medihelp's network facilities, designated service providers (DSPs), and formulary medicine.
- Chronic medicine:** I must register my prescribed minimum benefit (PMB) conditions with Medihelp and my PMB chronic medicine must be pre-authorised by Medihelp. Medihelp uses a DSP for PMB chronic medicine and a formulary (medicine list) applies. If I do not get my PMB chronic medicine from the DSP or if I deviate from the formulary for my plan, I will be responsible for a co-payment\* on my PMB chronic medicine.
- Network doctors:** To avoid co-payments on PMB treatments, any specialists consulted must form part of Medihelp's DSP specialist network.





**6. Dependants you want to register (continued)**

**Dependant 3 (continued)**

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

<b>Child dependant</b>	<input type="checkbox"/> Own child	<input type="checkbox"/> Child born in terms of a surrogate motherhood agreement	<b>Other relative</b>	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Brother
	<input type="checkbox"/> Adopted child	<input type="checkbox"/> Stepchild		<input type="checkbox"/> Mother	<input type="checkbox"/> Sister
	<input type="checkbox"/> Foster child	<input type="checkbox"/> Child in temporary safe care		<input type="checkbox"/> Father	

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black
  Coloured
  Indian/Asian
  White
  Other

**Dependant 4**

Surname \_\_\_\_\_ Title 

Mr	Mrs	Ms	Other (specify)
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First names in full \_\_\_\_\_

Preferred name \_\_\_\_\_

ID/passport number 

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 Gender 

Male	Female
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Date of birth 

y	y	y	y	m	m	d	d
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 Cell phone number \* 

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Personal email address \* \_\_\_\_\_

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

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

Visually impaired \* 

Yes	No
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      Hearing impaired \* 

Yes	No
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\* If "Yes", please complete section 9 of the medical questionnaire part of this form.

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

<b>Child dependant</b>	<input type="checkbox"/> Own child	<input type="checkbox"/> Child born in terms of a surrogate motherhood agreement	<b>Other relative</b>	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Brother
	<input type="checkbox"/> Adopted child	<input type="checkbox"/> Stepchild		<input type="checkbox"/> Mother	<input type="checkbox"/> Sister
	<input type="checkbox"/> Foster child	<input type="checkbox"/> Child in temporary safe care		<input type="checkbox"/> Father	

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black
  Coloured
  Indian/Asian
  White
  Other

**Dependant 5**

Surname \_\_\_\_\_ Title 

Mr	Mrs	Ms	Other (specify)
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First names in full \_\_\_\_\_

Preferred name \_\_\_\_\_

ID/passport number 

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 Gender 

Male	Female
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Date of birth 

y	y	y	y	m	m	d	d
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 Cell phone number \* 

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Personal email address \* \_\_\_\_\_

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

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

Visually impaired \* 

Yes	No
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      Hearing impaired \* 

Yes	No
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\* If "Yes", please complete section 9 of the medical questionnaire part of this form.

**6. Dependants you want to register (continued)**

**Dependant 5 (continued)**

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

<b>Child dependant</b>	<input type="checkbox"/> Own child	<input type="checkbox"/> Child born in terms of a surrogate motherhood agreement	<b>Other relative</b>	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Brother
	<input type="checkbox"/> Adopted child	<input type="checkbox"/> Stepchild		<input type="checkbox"/> Mother	<input type="checkbox"/> Sister
	<input type="checkbox"/> Foster child	<input type="checkbox"/> Child in temporary safe care		<input type="checkbox"/> Father	

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black
  Coloured
  Indian/Asian
  White
  Other

**Dependant 6**

Surname \_\_\_\_\_ Title 

Mr	Mrs	Ms	Other (specify)
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First names in full \_\_\_\_\_

Preferred name \_\_\_\_\_

ID/passport number 

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 Gender 

Male	Female
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Date of birth 

y	y	y	y	m	m	d	d
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 Cell phone number \* 

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Personal email address \* \_\_\_\_\_

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

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

Visually impaired \* 

Yes	No
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 Hearing impaired \* 

Yes	No
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\* If "Yes", please complete section 9 of the medical questionnaire part of this form.

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

<b>Child dependant</b>	<input type="checkbox"/> Own child	<input type="checkbox"/> Child born in terms of a surrogate motherhood agreement	<b>Other relative</b>	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Brother
	<input type="checkbox"/> Adopted child	<input type="checkbox"/> Stepchild		<input type="checkbox"/> Mother	<input type="checkbox"/> Sister
	<input type="checkbox"/> Foster child	<input type="checkbox"/> Child in temporary safe care		<input type="checkbox"/> Father	

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black
  Coloured
  Indian/Asian
  White
  Other

**Dependant 7**

Surname \_\_\_\_\_ Title 

Mr	Mrs	Ms	Other (specify)
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First names in full \_\_\_\_\_

Preferred name \_\_\_\_\_

ID/passport number 

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 Gender 

Male	Female
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Date of birth 

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

 Cell phone number \* 

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

Personal email address \* \_\_\_\_\_

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

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

Visually impaired \* 

Yes	No
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 Hearing impaired \* 

Yes	No
-----	----

\* If "Yes", please complete section 9 of the medical questionnaire part of this form.

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

<b>Child dependant</b>	<input type="checkbox"/> Own child	<input type="checkbox"/> Child born in terms of a surrogate motherhood agreement	<b>Other relative</b>	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Brother
	<input type="checkbox"/> Adopted child	<input type="checkbox"/> Stepchild		<input type="checkbox"/> Mother	<input type="checkbox"/> Sister
	<input type="checkbox"/> Foster child	<input type="checkbox"/> Child in temporary safe care		<input type="checkbox"/> Father	

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black
  Coloured
  Indian/Asian
  White
  Other







## 9. Medical history

- If you answer "Yes" to any of the questions in section 9.1, please complete the full medical questionnaire in sections 9.2, 9.3, and 9.4.

**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 you have not completed your application form in full, withheld information, or provided inaccurate details, we may terminate your membership.

### 9.1 General medical questionnaire

1. Have you or any of your dependants been admitted to hospital and/or diagnosed with any illness within the last 12 months prior to submitting this application? If "Yes", please complete sections 9.2, 9.3, and 9.4. Mark with an "X"
- |     |    |
|-----|----|
| 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 questions 17 and 18 in section 9.2). If "Yes", please complete sections 9.2, 9.3, and 9.4. Mark with an "X"
- |     |    |
|-----|----|
| 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 sections 9.2, 9.3, and 9.4. Mark with an "X"
- |     |    |
|-----|----|
| Yes | No |
|-----|----|

### 9.2 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. If 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](http://www.medihelp.co.za) by logging in to our self-service platform 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. (Disorders include affection or condition of illness.)

#### 1. Cancer and cancerous growths

Cancer or tumours of any organ or skin, including all stages of cancer, or historic cancer that is now in remission. Examples may include breast cancer, prostate cancer, gastro-intestinal cancer, lung cancer, and skin cancer such as melanoma or basal cell carcinoma. Cancer also includes any blood-related cancers such as lymphoma, leukaemia, aplastic anaemia, myeloma, myelodysplastic syndromes, or others. Cancer may have been diagnosed through abnormal test results, for example, abnormal mammogram result, abnormal Pap smear result, abnormal prostate-specific antigen result, any other abnormal cancer screening, etc.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis				Last date of follow-up consultation, tests, medicines, procedures				Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

#### 2. Blood conditions

**Examples:** blood clots, bleeding problems, high or low iron, anaemia, deep vein thrombosis, lung clots, ITP and platelet deficiencies, any other bleeding or blood-related disorders that may not be included in the examples provided.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis				Last date of follow-up consultation, tests, medicines, procedures				Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

**3. Metabolic and endocrine conditions**

Examples: obesity (BMI ≥ 35), diabetes type 1, diabetes type 2, diabetes insipidus, thyroid disease, metabolic syndrome, parathyroid disease, osteoporosis, osteopenia, growth problems or deficiency, Paget’s disease, Addison’s disease, Cushing’s syndrome, or any other metabolic or endocrine condition.

Mark with an “X”

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 (including behaviour disorders, substance dependency, and other psychosocial conditions)**

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. Furthermore, examples include Alzheimer’s disease, dementia, as well as autism and attention deficit hyperactivity disorder. Examples also include drug or alcohol dependency or abuse, rehabilitation for drug or alcohol dependency or abuse, suicide attempt(s), counselling, or any other psychological condition. Admissions to any facility for the treatment of any mental health conditions, not limited to the examples mentioned above, must be indicated in the column “indicate type of treatment” below.

Mark with an “X”

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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: multiple sclerosis, stroke, weakness or paralysis, bleeding on the brain, epilepsy, polyneuropathy, motor neuron disease, myasthenia gravis, Parkinson’s disease, Guillain-Barré syndrome, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, migraine, chronic headaches, or any other brain or nerve condition.

Mark with an “X”

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

**9. Breathing and respiratory conditions**

Examples: asthma, bronchitis, chronic cough, chronic obstructive pulmonary disease, emphysema, bronchiectasis, pneumonia, tuberculosis, interstitial lung disease, cystic fibrosis, sarcoidosis, any other breathing or respiratory condition. If you work in a specific occupation or industry that may affect your lungs, please specify.

Mark with an “X”

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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. Abdominal and digestive conditions**

Examples: reflux, heartburn, hiatus hernia, hepatitis, Crohn’s disease, ulcerative colitis, irritable bowel syndrome or chronic bloatedness, 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, diverticulitis, and any other abdominal or digestive condition. Examples of procedures may include previous gastroscopy or colonoscopy.

Mark with an “X”

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

**11. Skin conditions and non-cancerous growths**

Examples: abscesses, cysts, wounds, eczema, psoriasis, acne, sunspots, any non-cancerous lesions such as skin lesions, warts, moles, or any other conditions affecting the skin.

Mark with an “X”

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

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

Examples: knee, hip or shoulder problems or any other joint pain, tendon and soft tissue injuries, gout, clubfoot, bunions, osteoarthritis and procedures such as joint replacements, prosthesis or removal of prosthesis, and amputation. Related auto-immune conditions may include rheumatoid arthritis, ankylosing spondylitis, lupus gout, Sjögren's syndrome, scleroderma, polymyositis, polyarteritis nodosa, fibromyalgia, prosthesis, any other autoimmune conditions, any other condition affecting the back, bones, or muscles.

Mark with an "X"

Yes	No
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Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis				Last date of follow-up consultation, tests, medicines, procedures				Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

**13. Gynaecological conditions**

Examples: menstruation problems or abnormal bleeding, endometriosis, polycystic ovarian syndrome, myomas, cervical dysplasia or abnormalities, infertility, ovarian cysts, any other gynaecological condition, or procedures that may include previous cervical biopsies (including cone biopsies and large loop excision of the transformation zone procedures).

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis				Last date of follow-up consultation, tests, medicines, procedures				Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

**14. Pregnancy and obstetric (pregnancy-related) conditions**

Please confirm if you or any of your dependants are pregnant, if you or any of your dependants suspect that you are pregnant, or are undergoing testing for pregnancy. Examples of pregnancy-related conditions also include ectopic pregnancy, miscarriage, missed periods, conditions or complications related to pregnancy, emergency Caesarean section, etc.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis				Last date of follow-up consultation, tests, medicines, procedures				Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

**15. Kidney and urinary conditions**

Examples: kidney or renal failure, kidney stones, urinary incontinence, urinary tract infections, bladder infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, sexually transmitted diseases, any other kidney or bladder problems. Examples of procedures include acute or chronic renal dialysis, cystoscopy, stents, or any other procedure related to your kidneys and urinary system.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

**16. Male urinary and genital conditions**

Examples: prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urinary retention, and any other male urinary or genital condition. Examples of procedures include biopsies, transurethral resection of the prostate, and hormone therapy for prostate conditions, etc.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

**17. HIV/Aids**

Are you or any of your dependants mentioned on this application HIV-positive or have you been diagnosed with Aids?\*

Please note: 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 must still inform the Scheme and 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. If underwriting conditions are applied, we will issue an amended proof of membership document to you.

Mark with an "X"

Yes	No
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Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis								Last date of follow-up consultation, tests, medicines, procedures								Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

**18. Chronic or regular medication**

Please list all the medicine that you or your dependants have been using over the past 12 months. It also includes prescription medication or any other medication you have been using over a period of more than 30 days. This includes over-the-counter medicines, natural or homeopathic medicines, etc.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis										Last date of follow-up consultation, tests, medicines, procedures						Indicate type of treatment such as hospital admission, surgery or procedure, type of 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. Potential future services, treatments, procedures, tests, or medical advise**

Are you and/or your dependants aware of, or planning to have any tests, examinations, treatments and/or procedures done in the next 12 months? If this is the case, please provide all relevant reports, referral letters, and relevant blood tests results.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis										Last date of follow-up consultation, tests, medicines, procedures.						Indicate type of treatment such as hospital admission, surgery or procedure, type of 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? This may include any injuries sustained at home or work, or specifically sustained in a vehicle-related accident.

Mark with an "X"

Yes	No
-----	----

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis										Last date of follow-up consultation, tests, medicines, procedures.						Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

**9.3 Disability**

This information is compulsory as this is a requirement for South African Revenue Services (SARS) purposes. Declare any disability, for example, hearing, vision, speech, mental, physical, and intellectual.

Name of beneficiary	Specify disability	Nature: temporary or permanent	Date of diagnosis	End date of disability (if temporary)	Limitation of disability: mild, moderate or severe	Practice number (HPCSA number)

**9.4 Doctors consulted for medical conditions**

- Doctors consulted in the past 12 months
- Doctors who diagnosed and treated disability

 General consultations

 Disability consultation

Name and surname \_\_\_\_\_

Telephone number (W)

           

How long have this been your doctor (in years)?

\_\_\_\_\_

Cell phone number

              

Email address

\_\_\_\_\_

\*If disability was selected, please complete the following information according to SARS requirements.

 General consultations

 Disability consultation

Name and surname \_\_\_\_\_

Telephone number (W)

           

How long have this been your doctor (in years)?

\_\_\_\_\_

Cell phone number

              

Email address

\_\_\_\_\_

\*If disability was selected, please complete the following information according to SARS requirements.

 General consultations

 Disability consultation

Name and surname \_\_\_\_\_

Telephone number (W)

           

How long have this been your doctor (in years)?

\_\_\_\_\_

Cell phone number

              

Email address

\_\_\_\_\_

\*If disability was selected, please complete the following information according to SARS requirements.

**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 Medihelp employees and contracted parties have access to your data to process and pay claims, among other things. All employees and contracted parties who have access to your data for these purposes have signed a confidentiality agreement not to disclose your personal information to any unauthorised parties.
3. Your personal information will only be used for purposes such as processing your application for membership, paying your medical claims, determining whether you are entitled to benefits, managing risks, and for any communication purposes or marketing initiatives undertaken by Medihelp.
4. The Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy.
5. Should you make use of a Medihelp-contracted brokerage's services, relevant membership information will be made available to the appointed brokerage in order to render a service to you, and any authorised person at the brokerage may instruct Medihelp to change any of your personal information except for your banking details, unless you instruct Medihelp otherwise.



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

### Your responsibilities as a member of Medihelp

6. I will ensure that I know all the provisions of the Rules of Medihelp and will read all the correspondence from Medihelp, such as newsletters and statements. I will also study my plan guide and familiarise myself with the cover offered by the plan I choose.
7. I will abide by the Rules of Medihelp, as amended from time to time and available at [www.medihelp.co.za](http://www.medihelp.co.za) on the self-service platform for members and not submit any fraudulent claims or commit any fraudulent acts.
8. I declare that the information provided in this application for membership is accurate and complete. I understand that any false declaration or omission of information may result in the termination of my membership and that of my registered dependants or any other measures which Medihelp, in its sole discretion, may decide to take, subject to appeal procedures. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for me and my dependants, even if this application was completed by my financial adviser or any other third party on my behalf. I will notify Medihelp in writing if there are any changes in my health status or that of my dependants after my application for membership has been submitted, but before my membership start date. I confirm that the residential address stated in section 3 is the address I choose for serving any legal documentation. I will notify Medihelp in writing of any future changes to my personal details and/or banking details. I understand that failure to do so may result in my membership being terminated in accordance with the Medical Schemes Act 131 of 1998 and the registered Rules of Medihelp.
9. I understand that this application form is valid for a period of 30 days from the date of signature. The period may be further extended, subject to Medihelp's discretion, up to a maximum of 60 days, after which the application form will be cancelled and I will be required to submit a new application form.
10. I confirm that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.
11. I take note that the monthly contribution fees will be due on the first day of enrolment and thereafter on the first day of each subsequent calendar month, and it shall be payable on the date selected by me in section 7. Should my employer/institution, as my authorised agent, undertake to pay my contribution to Medihelp, I give permission to my employer/institution to deduct the amount payable to Medihelp from my salary and pay such amount over to Medihelp. I furthermore give permission that Medihelp may provide the following information to my employer/institution in order to pay contribution: my identity number, my tax certificate information, as well as my dependants' dates of birth, ages, and relationship. I am also responsible for repaying any debt outstanding on my medical savings account, if applicable, should I terminate my membership of Medihelp.
12. I note that a third party paying the contribution on my behalf is not part of the contract with Medihelp and will not receive communication regarding changes in the monthly payable contribution. I undertake to inform the third party of any changes in my contribution and accept that I remain responsible for the payment thereof.
13. I confirm that I am responsible to give advance notice of termination of membership, and that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

### Medihelp's rights as a medical scheme

14. I am aware that a three-month general waiting period and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on my membership and that of my registered dependants in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise my membership without issuing a document containing the conditions of my membership if no waiting period and/or late-joiner penalty is imposed.
15. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid in respect of particular services, for example by enforcing co-payments and exclusions.
16. The Rules of Medihelp may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and using designated service providers.
17. Medihelp may also restrict interchanges between plans to the beginning of a year and require a notice period as set out in the Rules.
18. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
19. I am further aware that my benefits may be suspended if I fail to pay my contribution or debt in full, that my membership may be terminated if any amount remains outstanding 30 days after the date of suspension, and that my account will be handed over for collection.
20. I am aware that Medihelp may increase its contribution annually at the beginning of the year. I also authorise Medihelp to adjust the contribution if necessary due to a change in my membership and to deduct the amended amount or any outstanding contribution amounts from me or the third-party payer/employer/institution I indicated as the authorised payer of my contribution.

### Protection of information

21. I hereby give permission and declare that I have obtained the consent of all my dependants, that –
  - 21.1 Medihelp may enquire about my health status or that of my dependants at any medical doctor or any person who is in possession of such information, and I give permission for the doctor or person concerned to make such information available to Medihelp and its contracted third parties for the administration of my health plan;
  - 21.2 My dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;
  - 21.3 Any adviser I appoint and whose appointment Medihelp accepts may have access to my personal and medical information and that of any of my registered dependants at Medihelp's disposal, and that such adviser or an authorised person at the brokerage may instruct Medihelp to change any of my personal information for the purpose of proper administration and underwriting, except for my banking details;
  - 21.4 Medihelp may disclose my and my dependants' medical and personal information to healthcare providers for the purpose of delivering medical services to me and my dependants, and to pay for such services; and
  - 21.5 Medihelp may share my information for statistical analysis and academic research purposes.
22. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
23. I agree that all my telephone conversations and/or that of my dependants with Medihelp and/or its contracted third parties may be recorded for quality control purposes and to help detect and prevent fraud.
24. I agree that Medihelp may, for the purpose of considering my application for membership or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependants from medical practitioners, financial advisers, industry regulatory bodies, or employers/institutions.

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

25. I further consent and declare that I have obtained the consent of my dependants that Medihelp may provide any credit bureau or credit providers' industry association with any information about my/my dependants' consumer credit record, including and not limited to information about my/ my dependants' credit history, financial history, personal information (excluding medical information), and judgment or default history.
26. If you believe that Medihelp has used your personal information contrary to its Privacy Policy, you have the right, under the Protection of Personal Information Act, to lodge a complaint with the Information Regulator, but we encourage you to first follow our internal complaints process to resolve the matter. If, thereafter, you believe that we have not resolved the matter adequately, you can contact the Information Regulator at: The Information Regulator (South Africa), JD House, 27 Stiemens Street, Braamfontein, 2017, telephone number: 010 023 5207, email: POPIAComplaints@infoeregulator.org.za.
27. If you believe that Medihelp has not handled your enquiry satisfactorily, please first follow our internal complaints process to resolve the matter. If, thereafter, you believe that we have not resolved the matter adequately, you can contact the Council for Medical Schemes (CMS), as Medihelp is a registered medical scheme and regulated by the CMS. The CMS's contact details are as follows:  
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, Customer Care Centre: 0861 123 267,  
email: complaints@medicalschemes.co.za, website: www.medicalschemes.co.za.

If you are signing as the applicant's parent and your child is younger than 18, please attach a copy of your passport/ID document and the applicant's birth certificate.

Signature of applicant	Date
	2 0 y y m m d d

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

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

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

In your capacity as	Parent	Guardian	Curator	Power of attorney (legal appointment)
ID/passport number				Title
First name				Surname
Telephone number (W)				Cell phone number *
Personal email address*				

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

Relationship to applicant \_\_\_\_\_

**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:

1. The applicant has appointed me as their adviser and is entitled to cancel my services at any time;
2. I have signed a valid contract with my Medihelp-contracted brokerage; and
3. 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				
Brokerage code	A			
	Adviser code			
Name and surname of adviser				
Telephone number				
Email address				

Signature of adviser	Date
	2 0 y y m m d d

Lead reference number

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

**Email:** [newbusiness@medihelp.co.za](mailto:newbusiness@medihelp.co.za)

189 Clark Street, Brooklyn, Pretoria, 0181, [www.medihelp.co.za](http://www.medihelp.co.za)

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