Registration of my dependants

medihelp
Medical Aid in Action

Enquiries: 086 0100 678
Email: newbusiness@medihelp.co.za
www.medihelp.co.za

For use by corporate clients
Payroll number

Employer's office stamp

How to complete this form

- Please complete the editable PDF form and add your signature electronically before you email it to us. Printed forms must be completed in print using black ink. Please make sure to email all pages of the form to Medihelp. For your convenience, you can also complete this form online on the Member Zone at https://toolbox.medihelp.co.za/login.
- Please read the conditions for membership in section 6 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 your dependants membership under the standard terms, their membership will be activated without issuing enrolment conditions.
- If we offer your dependants membership under any non-standard terms (waiting periods and/or late-joiner penalties) we will notify you and/or your adviser by letter and stipulate the conditions that will apply. If you accept these terms, you must sign the letter and return it to us, after which we will activate your dependants' membership.
- We will notify you when we have finalised your application.

1. Your information (member that registers dependant)

Member number

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

ID/passport number Title: Mr | Mrs | Ms | Other (specify)

First names in full

Surname

Telephone number (W) Telephone number (H)

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 registration of dependant cannot be finalised.

Marital status: Married | Unmarried Date of marriage: y y y y m m d d

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

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

2. Date on which my dependants' cover should start

2 0 y y m m d d

Please note that no person may be enrolled as a member/dependant of Medihelp while such person is a beneficiary of another medical scheme. Refer to paragraph 11 of section 6 of this application form.

3. Dependants 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, you may register them as dependants:

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

3. Dependants you want to register (continued)

PLEASE NOTE

- Foster children and children in temporary safe care may be registered as dependants only up to the age of 26 years in terms of legislation.
- If a dependant is not a South African citizen, a copy of their passport must be submitted with the completed application.
- When registering a partner as a dependant, you confirm that you are in a domestic partnership, and undertake to inform Medihelp within 30 days if your relationship status changes.

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

- Stepbrothers and stepsisters
- Stepparents
- In-laws
- Godchildren
- Cousins
- Grandparents
- Nieces and nephews

To avoid delays in your enrolment process, please attach the following supporting documents:*

Dependant	Document required
• 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.	• Legal documentation confirming that the child has been 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.
• Child or grandchild • If surname differs from the applicant's surname	• Unabridged birth certificate • For Grandchildren the unabridged birth certificates or an affidavit confirming family care and support.

*This information is compulsory. If not submitted, your registration of dependant cannot be finalised.

Dependant 1

Surname _____ Title | Mr | Mrs | Ms | Other (specify) |

First names in full _____

Preferred name _____

If a passport number is used, please attach a copy of the passport

ID/passport number | | | | | | | | | | | | | |

Gender | Male | Female |

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 | Hearing impaired* | Yes | No |

*If "Yes", please complete section 5 of the medical questionnaire part of this form.

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 used for national statistical purposes by the Council for Medical Schemes.

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

Dependant 2

Surname _____ Title | Mr | Mrs | Ms | Other (specify) |

First names in full _____

Preferred name _____

ID/passport number | | | | | | | | | | | | | |

Gender | Male | Female |

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.

3. Dependants you want to register (continued)

Dependant 2 (continued)

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

Visually impaired* Yes No Hearing impaired* Yes No

*If "Yes", please complete section 5 of the medical questionnaire part of this form.

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

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 3

Surname _____ Title Mr Mrs Ms Other (specify)

First names in full _____

Preferred name _____

ID/passport number _____ Gender Male Female

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 Hearing impaired* Yes No

*If "Yes", please complete section 5 of the medical questionnaire part of this form.

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

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)

First names in full _____

Preferred name _____

ID/passport number _____ Gender Male Female

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 Hearing impaired* Yes No

*If "Yes", please complete section 5 of the medical questionnaire part of this form.

3. Dependants you want to register (continued)

Dependant 4 (continued)

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	

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

4. Previous and/or current membership of medical schemes

4.1 Has this application been necessitated by a change in employment which resulted in the cancellation of your dependants' membership of a previous medical scheme? (Not applicable to dependants who have retired and are entitled to remain at their previous/current medical scheme.)

Yes	No

Who was the principal member of the previous scheme? Name and surname _____

4.2 Please provide details of ALL the medical schemes where your dependants are currently or have previously been enrolled:

- Ensure that the dates of your dependants' membership at the different schemes do not overlap.
- Information about previous and current membership must be indicated separately for your dependants.
- The Medical Schemes Act makes provision for a late-joiner penalty (LJP) to be imposed on an applicant who is 35 years or older at the time of joining a scheme and has not enjoyed previous coverage with a medical aid. The penalty, which is added to the member's monthly contribution, is calculated as a percentage of the member's contribution based on the total number of years without creditable coverage since the age of 35 years, as shown below:

LJP intervals and penalty percentages	
1 – 4 years	5%
5 –14 years	25%
15 – 24 years	50%
25 years +	75%

of the beneficiary's contribution
(excluding savings account contribution)

Name of medical scheme*	Name and surname*	Membership number	Date joined*	Date ended*

*This information is compulsory. If not completed, your registration of dependant cannot be finalised.

4.3 Did your or your dependants' previous medical scheme apply any late-joiner penalties?

Yes	No

If "Yes", provide the following details:

Name of applicant/dependant	Late-joiner penalty			
	5%	25%	50%	75%
	5%	25%	50%	75%
	5%	25%	50%	75%

4.4 Did your or your dependants' previous medical scheme apply any condition-specific waiting periods (meaning treatment of any specific conditions were excluded from benefits for a certain period) and were they still active at the time of termination of membership?

Yes	No

If "Yes", provide the following details:

Name of applicant/dependant	Condition-specific waiting period (CSW)	End date of CSW
		y y y y m m d d
		y y y y m m d d
		y y y y m m d d

Note: If the space provided is insufficient, please provide additional information on a separate page.

5. Medical history

- If you answer "Yes" to any of the questions in section 5.1, please complete the full medical questionnaire in section 5.2.

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

5.1 General medical questionnaire

Mark with an "X"

1. Have 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 **section 5.2, 5.3 and 5.4.**

Yes	No

2. Are 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 5.2). If "Yes", please complete **section 5.2, 5.3 and 5.4.**

Yes	No

3. Are any of your dependants currently pregnant, suspect pregnancy 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 obtain medical advice that could result in a claim in the next 12 months? If "Yes", please complete **section 5.2, 5.3 and 5.4.**

Yes	No

5.2 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 the Medihelp website at 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 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	

5.2 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.)

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 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: 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	

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	

5.2 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.)

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	

6. Eye and eyelid conditions

Examples: vision loss or impairment (partial or full blindness), cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachment, retinal vein occlusion, keratoconus, corneal ulcer, squint, ptosis, and uveitis. Examples of procedures or devices include cornea transplant, eye surgery including blepharoplasty, glasses, or any other eye or eyelid 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	

7. Ear, nose, and throat conditions

Examples: hearing impairment, hearing loss, middle-ear infection (otitis media), external ear infection (otitis externa), any chronic ear infection or ear discharge, perforated eardrum, tonsillitis or enlarged tonsils, adenoid problems, dizziness, vertigo, tinnitus, blocked nose, sinus problems or allergies, any other ear, nose or throat condition, jaw problems, and impacted teeth. Examples of procedures or devices include hearing aid, cochlear implant, nasal surgery, dental or orthodontic treatment, and dental surgery. This may include any other anticipating or current orthodontic, dental, or maxillofacial treatment.

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	

5.2 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.)

8. Heart conditions and heart-or peripheral related circulation conditions

Examples: high blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, heart failure, palpitations, arrhythmia, shortness of breath, cardiomyopathy, aneurysm, valvular heart disease or heart murmurs, congenital heart disease, rheumatic fever, arterial disease, chronic venous insufficiency, varicose veins, any other condition affecting the heart or blood vessels. Examples of procedures include stents, coronary artery bypass surgery, heart valve replacement, previous heart surgery, pacemaker, any catheter-based vascular procedures like angiograms, angioplasty, and grafts.

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	

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	

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	

5.2 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.)

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	

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

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	

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 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	

5.2 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.)

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 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	

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	

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, 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	

5.2 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.)

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

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	

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	

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	

5.2 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.)

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	

5.3 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)

5.4 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 _____

5.4 Doctors consulted for medical conditions (continued)

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.

6. 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 registration of dependant, 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.

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 on the self-service platform for members and not submit any fraudulent claims or commit any fraudulent acts. I understand that on approval of my application for the registration of my dependants, the Rules of Medihelp will be binding on my registered dependant, as the Rules are binding on me.
8. By signing this application form, I confirm that I have the right to apply for the registration of my dependants and to act for those that I apply for, in any matter relating to this application.
9. I declare that the information provided in this registration of dependant 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 registration of dependant 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.
10. I understand that this application form is valid for a period of 30 days from the date of signature. The period may be further extended, subject to Medihelp's discretion, up to a maximum of 60 days, after which the application form will be cancelled and I will be required to submit a new application form.
11. I confirm that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.

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

Your responsibilities as a member of Medihelp (continued)

12. 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. 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.
13. 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.
14. 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

15. 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.
16. 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.
17. 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.
18. Medihelp may also restrict interchanges between plans to the beginning of a year and require a notice period as set out in the Rules.
19. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
20. 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.
21. 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

22. I hereby give permission and declare that I have obtained the consent of all my dependants, that –

22.1 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;

22.2 My dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;

22.3 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;

22.4 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

22.5 Medihelp may share my information for statistical analysis and academic research purposes.

23. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
24. 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.
25. I agree that Medihelp may, for the purpose of considering my registration of dependant 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.
26. 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.
27. 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@inforegulator.org.za.
28. 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.

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

Protection of information (continued)

Signature of member _____ Date 2 0 y y m m d d

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 Mr Mrs Ms Other (specify)

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 registration of dependant cannot be finalised.

Relationship to dependant _____

7. 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.

MHNN005 SEPTEMBER 2024