My Medihelp application form 2022

medihelp
Medical Aid in Action

Enquiries: 086 0100 678
Email: newbusiness@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007
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:

- Complete this editable PDF form and add your signature electronically before you email the form to us. If you prefer to complete a print version, please complete the form in print using black ink, and email or post all pages of the form to Medihelp.
- Please complete all sections in full and sign the application form, also where your signature is required at Sections 5, 7, 10 and 12. Read and make sure you understand the conditions for membership in Section 10 before you sign the form. Incomplete information may delay the application process.
- Email the completed and signed form to newbusiness@medihelp.co.za.

The next steps after we receive your application:

- We will contact you should we require any details that were omitted on the application form or if we require any additional information to determine the conditions of your membership. You can also use the Application in Motion (AiM) functionality on our website at https://onlineapplication.medihelp.co.za to track your application and to provide further details, if necessary.
- If we offer you membership under the standard terms, your membership will be activated without issuing enrolment conditions. We will notify you and/or your adviser by letter.
- If we offer you membership under any non-standard terms (waiting periods and/or late-joiner penalties apply) we will notify you and/or your adviser by letter and stipulate the conditions that will be applicable to your membership. If you accept these terms, you must sign the letter and return it to us, after which we will activate your membership. The terms can also be accepted on AiM.
- We will send a welcome letter, SMS or email to you and/or your adviser to let you know when your application has been completed.

1. When would you like your cover to start?

2 0 y y m m d d

2. Your information (person who requests membership)

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

A copy of your passport must be attached if you use your passport number.

Surname _____ Initials _____

First names _____ Gender: Male | Female

_____ Known as _____

Marital status: Married in community of property | Married out of community of property | Single | Divorced | Widow | Widower | Other (specify)

Date of birth y y y y m m d d Date of marriage y y y y m m d d

Income tax number _____ Language: Afrikaans | English

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

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

3. Your contact information

Residential address _____ Tel No. (W) Code _____ No. _____

_____ Tel No. (H) Code _____ No. _____

_____ Code _____ Cell phone number _____

Is your postal address the same as your residential address? Yes | No Email address _____

We will use this email address to keep you up to date with important information on your journey to good health.

Postal address _____

_____ Code _____

May Medihelp use your and your dependants' personal details to get your opinion on the quality of our service? Yes | No

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

Visually impaired: Yes | No Hearing impaired: Yes | No

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

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

Name of employer/institution _____ Campus/site _____

Branch code/employer group number _____

Payroll number _____

Appointment date | y | y | y | y | m | m | d | d |

Pay area _____

Appointment: Permanent | Temporary

Office stamp of employer

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

5.1 Plans

Note:

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

Vital plans	Saving plans	Comprehensive plans	
☐ MedMove!	☐ MedAdd	☐ MedPrime	☐ MedElite
☐ MedVital	☐ MedAdd Elect	☐ MedPrime Elect	☐ MedPlus
☐ MedVital Elect	☐ MedSaver	☐ MedElect	

5.2 Students – MedElect only

Please provide proof of your enrolment as a student. Proof of your monthly income may also be requested.

- Acceptable proof of enrolment as a student is proof of registration for studies on an official letterhead of the tertiary institution or vocational training college where you are registered as a student.
- Acceptable proof of income, should Medihelp request this, is the past three months' official bank statements containing the initials and surname of the account holder and reflecting your income. Other additional proof of income may also be required.

5.3 Utilisation of savings account funds

MedAdd, MedAdd Elect and MedSaver

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

- Pay all qualifying day-to-day and hospital related medical expenses from my savings account. ☐
- Pay only selected qualifying day-to-day medical expenses from my savings account (excluding certain in-hospital expenses such as co-payments). ☐

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

I confirm that I am aware of the following:

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

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

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

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

6. Your dependants that you wish to register

You may register the following dependants:

- Spouse/partner.
- Father/mother/brothers/sisters/grandchildren of the applicant and whose financial care is entrusted to the applicant (**PLEASE NOTE**: These dependants of the spouse/partner cannot be registered as dependants of the applicant, and grandchildren of the applicant pay the same contribution as that of an adult dependant, unless legally adopted).
- Dependent own children (of the applicant and spouse/partner).
- Dependent stepchildren (of the applicant and spouse/partner).
- Adopted children/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement (of the applicant and spouse/partner). 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 – foster children and children in temporary safe care may be registered as dependants only up to the age of 21 years in terms of legislation.
- In the case of dependants who are not South African citizens, a copy of their passport must be submitted with the completed application.

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

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

First names in full _____

Known as _____

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d | Cell phone number | | | | | | | | | | |

Email address _____

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

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

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

Dependant 2

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

First names in full _____

Known as _____

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d | Cell phone number | | | | | | | | | | |

Email address _____

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

Child dependant
- ☐ Own child
- ☐ Adopted child
- ☐ Foster child
- ☐ Child born in terms of a surrogate motherhood agreement
- ☐ Stepchild
- ☐ Child in temporary safe care

Other relative
- ☐ Grandchild
- ☐ Brother
- ☐ Mother
- ☐ Sister
- ☐ Father

If you have marked one of the options at "**Other relative**" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

Married? | Yes | No | Financially dependent on you? | Yes | No |

Does the dependant earn an income? | Yes | No | If so, how much does the dependant earn per month? R | | | | | | | |

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

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

6. Your dependants that you wish to register (continued)

Dependant 3

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

First names in full _____

Known as _____

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d | Cell phone number | | | | | | | | | | |

Email address _____

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

Child dependant

- ☐ Own child
- ☐ Adopted child
- ☐ Foster child
- ☐ Child born in terms of a surrogate motherhood agreement
- ☐ Stepchild
- ☐ Child in temporary safe care

Other relative

- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

If you have marked one of the options at "**Other relative**" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

Married? | Yes | No | Financially dependent on you? | Yes | No |

Does the dependant earn an income? | Yes | No | If so, how much does the dependant earn per month? R | | | | | | | |

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

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

Dependant 4

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

First names in full _____

Known as _____

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d | Cell phone number | | | | | | | | | | |

Email address _____

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

Child dependant

- ☐ Own child
- ☐ Adopted child
- ☐ Foster child
- ☐ Child born in terms of a surrogate motherhood agreement
- ☐ Stepchild
- ☐ Child in temporary safe care

Other relative

- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

If you have marked one of the options at "**Other relative**" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

Married? | Yes | No | Financially dependent on you? | Yes | No |

Does the dependant earn an income? | Yes | No | If so, how much does the dependant earn per month? R | | | | | | | |

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

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

7. Banking details

7.1 Complete this section if you will pay your own contributions:

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

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

☐	On the first workday of the month in which I requested enrolment and thereafter on the first workday of every subsequent month.
☐	On the 25th day of the month prior to my enrolment and thereafter on the 25th day of the subsequent months of my membership.
☐	On the last workday of the month prior to my enrolment and thereafter on the last workday of the subsequent months of my membership.

Note:

- **Your contributions are payable in advance, and if your membership cannot be finalised in time for the deduction date chosen above, Medihelp will make two separate debit order deductions in your first month of membership, namely on the first available workday following the activation of your membership AND on the actual date you have chosen in the same month. Medihelp will thereafter collect your contributions monthly on the date you have chosen above.**
- **If the debit order deduction date falls on a weekend or a public holiday, your contributions will be deducted on the first workday after the selected deduction date.**
- **If no debit order deduction date is selected, Medihelp will make the deduction on the first workday of the month.**

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

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

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

☐ 1. Use the account below for all transactions

☐ 2. Use the account below only for the recovery of contributions
NB: If you select this option, please complete your banking details for credit refunds in the table on the right.

Bank _____

Branch _____

Branch code | | | | | | | | | | | |

Type of account Savings | Cheque

Name of account holder _____

Account number _____

☐ Use the account below for credit refunds only
NB: If you selected option 2 on the left, please complete your banking details below.

Bank _____

Branch _____

Branch code | | | | | | | | | | | |

Type of account Savings | Cheque

Name of account holder _____

Account number _____

If you provide only one bank account number, we will use this account for both the recovery of contributions and refunding credit amounts. In the case of a trust, the responsible trustee must sign this section and submit a copy of the trust deed.

Signature of account holder/authorised signatory for recovery of contributions

Signature of account holder for credit refunds

8. Previous/current membership of medical schemes

8.1 Is your application necessitated by a change in employment which resulted in the cancellation of your membership of a previous medical scheme? (This question is not applicable to employees 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

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

NB:
- The date joined and date ended are important to place you and your dependants in the correct enrolment category.
- Indicate "current" if your and/or your dependants' membership of the particular scheme is still active.
- Ensure that the dates of your and/or your dependants' membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated **separately** for you and 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 contribution of the beneficiary (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 application for membership cannot be finalised.

8.3 Did your or your dependants' previous medical scheme apply any late-joiner penalty?

Yes | No

If "Yes", please provide the following details:

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

8.4 Did your or your dependants' previous medical scheme apply any condition-specific waiting period and was it still active at the time of termination of membership? (The treatment of a specific condition was excluded from benefits for a certain period.)

Yes | No

If "Yes", please 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.

9. Medical history

- Please ensure that you have completed **Section 8** of this application form in full.
- Complete **Section 9.1** only if you and your dependants mentioned in this application form have been members of a medical scheme registered in South Africa for a continuous period of more than 24 months and the lapse between medical schemes is less than 90 days.
- Complete **Section 9.2** in full if you or your dependants mentioned in this application form have not been members of a medical scheme registered in South Africa for a continuous period of more than 24 months or the lapse between medical schemes exceeds 90 days.

NB: Medihelp will review all requests for hospital admission or chronic medicine authorisation made by members during their first year of membership before we authorise benefits. If we find that you did not complete your application form in full, had withheld information or provided inaccurate details, we may terminate your membership.

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

Name and surname _____

Tel No. (W) _____ How long has he or she been your doctor (in years)? ☐☐

Name and surname _____

Tel No. (W) _____ How long has he or she been your doctor (in years)? ☐☐

Name and surname _____

Tel No. (W) _____ How long has he or she been your doctor (in years)? ☐☐

9.1 Applicants who are moving from another medical scheme to Medihelp

1. Have you or any of your dependants been admitted to hospital within the last 12 months prior to submitting this application?	Yes	No
2. Are you or any of your dependants currently taking regular, ongoing medicine and/or receiving treatment for a medical condition or symptom?	Yes	No
3. Are you or any of your dependants planning or expecting to be hospitalised (including for a pregnancy), to receive medical and/or surgical treatment and/or undergo examinations during the next 12 months?	Yes	No

9.2 Medical questionnaire

- 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, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

1. Cancer, tumours and abnormal growths
Cancer of any organ, cancerous tumours, non-cancerous tumours, blood-related cancers, lymphoma, leukaemia, skin lesions, breast disease, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal Pap smear result, abnormal PSA (prostate-specific antigen) result, any other abnormal cancer screening or diagnostic test result.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

2. Blood conditions
Deep vein thrombosis, pulmonary embolism, blood clots, anaemia, ITP and platelet deficiencies, polycythaemia vera, haemophilia, blood clotting diseases, leukaemia, lymphoma, any other bleeding disorders.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

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, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

3. Metabolic and endocrine conditions

Diabetes, thyroid disease, Addison disease, Cushing syndrome, obesity, metabolic syndrome, parathyroid disease, Paget disease, osteoporosis, osteopenia, growth deficiency, Conn syndrome, any other metabolic or endocrine condition.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

4. Mental health

Depression, bipolar disorder, anxiety disorder, post-traumatic stress disorder, obsessive-compulsive disorder, schizophrenia, personality disorders, insomnia, sleeping disorders (e.g. narcolepsy), eating disorders, Alzheimer disease, dementia, autism, attention deficit-hyperactivity disorder, drug or alcohol dependency or abuse, rehabilitation for drug or alcohol dependency or abuse, suicide attempt, counselling, any other psychological condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

5. Brain and nerve conditions

Stroke, bleeding on the brain, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, Parkinson disease, Guillain-Barré syndrome, migraine, chronic headache, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability, any other brain or nerve condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

6. Eye and eyelid conditions

Cataracts, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, cornea transplant, eye surgery, blurry vision, glasses, partial or full blindness, any other eye or eyelid condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

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, and not disclosing all information result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

7. Ear, nose and throat conditions

Chronic otitis media, chronic otitis externa, chronic ear infection, deafness, hearing problems, hearing aid, cochlear implant, chronic tonsillitis, chronic adenoiditis, dizziness, vertigo, tinnitus, sinus problems, nasal surgery, dental or orthodontic treatment, dental surgery, any other ear, nose or throat condition.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

8. Heart and circulation conditions

High blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins, any other condition affecting the heart or blood vessels.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

9. Breathing and respiratory conditions

Asthma, bronchitis, chronic obstructive pulmonary disease, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia, pulmonary embolism, any other breathing or respiratory condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

10. Abdominal and digestive conditions

Hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder conditions, gall stones, reflux, heartburn, hiatus hernia, oesophageal disease, atrophic gastritis, ulcers, abdominal hernia, inguinal hernia, malabsorption, Crohn disease, ulcerative colitis, diverticulitis, any other abdominal or digestive condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

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, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

11. Skin conditions

Chronic wounds, eczema, psoriasis, acne, sunspots, skin cancer, melanoma, any other condition affecting the skin.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

12. Back, bone and muscle conditions

Arthritis, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, lupus, gout, hip problems, knee problems, clubfoot, bunions, back pain, neck pain, Sjögren syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, any other condition affecting the back, bones or muscles.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

13. Gynaecological and obstetric conditions

Abnormal Pap smear result, abnormal menstrual bleeding, endometriosis, polycystic ovarian syndrome, infertility, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, any other gynaecological or obstetric condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

14. Pregnancy

Are you or any of your dependants pregnant or undergoing testing for pregnancy?

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

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, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

15. Kidney and urinary conditions

Kidney or renal failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, any other kidney or bladder problems.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

16. Male urinary and genital conditions

Prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urine retention, any other male urinary or genital condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

17. Chronic illnesses

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

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

18. HIV/Aids

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

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

Yes	No

*If you or any of your dependants prefer not to disclose your HIV status on this application form, you will remain responsible to inform the Scheme and to register on the Medihelp HIV/Aids programme within 21 days from your enrolment date by phoning LifeSense on 0860 50 60 80.

It is important to disclose this information to prevent the possible termination of your membership. When we receive your application to register on the HIV/Aids programme, we will determine whether underwriting conditions must be applied and, if this is the case, issue an amended proof of membership document to you.

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

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, and not disclosing all information may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

19. Planned treatment

Are you and/or your dependants planning to have any examination, treatment and/or procedure done in the next 12 months?

Mark with an "X"	
Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

20. Any other conditions not mentioned

Has any person indicated in this application been examined (e.g. medical tests, X-rays, scans), diagnosed and/or treated (with/without procedures) for any condition or disorder not mentioned in the medical questionnaire (including medicine/ vitamins bought without prescription)?

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy and the name of the medicine used during the past 12 months

Please note that this medical questionnaire does not constitute an application to register or authorise chronic medicine/PMB services/planned procedures/treatment for benefits. Should you need to obtain authorisation for chronic medicine, please phone Medihelp on 086 0100 678 once your membership of Medihelp has been finalised, to obtain an application form for chronic medicine benefits. Alternatively, you can download an application form from the Medihelp website at www.medihelp.co.za by logging on to the secured website for members, the Member Zone.

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

Medihelp confirms that:

1. Your and your registered dependants' personal and medical information will be treated confidentially and will not be sold to a third party or used for commercial or related purposes;
2. Security measures have been implemented to protect your data and that Medihelp employees and contracted parties have access to your data to process and pay claims, among other things, and that they have signed a confidentiality agreement in terms of which they undertake not to disclose your personal information to any unauthorised parties;
3. Your personal information will only be used for purposes such as processing your application for membership, paying your medical claims, determining whether you are entitled to benefits, managing risks, and for any communication purposes or marketing initiatives undertaken by Medihelp;
4. The Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy; and
5. Should you make use of a Medihelp-contracted brokerage's services then relevant membership information will be made available to the appointed brokerage in order to render a service to you, and any authorised person at the brokerage may instruct Medihelp to change any of your personal information except for your banking details, unless you instruct Medihelp otherwise.

Your responsibilities as a member of Medihelp:

6. I will ensure that I know all the provisions of Medihelp's Rules and will read all the correspondence from Medihelp, such as newsletters and statements, and I will study my benefit guide and familiarise myself with the coverage offered by the benefit plan that I have chosen.
7. I undertake to abide by the Rules, as amended from time to time and available at www.medihelp.co.za on the secured website for members, and to not submit any fraudulent claims or commit any fraudulent acts.

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

8. I declare that the information provided in this application for membership is accurate and complete. I understand that any false declaration or omission of information may result in the termination of my membership and that of my registered dependants or any other measures which Medihelp, in its sole discretion, may decide to take, subject to appeal procedures. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by my financial adviser or any other third party on my behalf. **I undertake to notify Medihelp in writing should there be any changes in my health status or that of my dependants after my application for membership has been submitted but prior to my membership commencement date. I confirm that the residential address stated on page 1 is the address that I choose for the purpose of serving any legal documentation. I undertake to notify Medihelp in writing should there be any future changes in my personal details and/or banking details and I understand that any non-adherence hereto may result in my membership being terminated in accordance with the provisions of the Medical Schemes Act and Medihelp's registered Rules.**
9. I understand that this application form is valid for a period of 30 days from the date of signature. The period may be further extended, subject to Medihelp's discretion, up to a maximum of 60 days, whereafter the application form will be cancelled and I will be required to submit a new application form.
10. I confirm that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.
11. I take note that the monthly contribution fees will be due on the date selected by me at Section 7 of this application form or on the first workday after this date, and thereafter on the same day of every subsequent calendar month. Should my employer/institution, as my authorised agent, undertake to pay my contributions to Medihelp, I give permission to my employer/institution to deduct the amount payable to Medihelp from my salary and pay such amount over to Medihelp. I furthermore give permission that Medihelp may provide the following information to my employer/institution in order to pay contributions: my identity number, my tax certificate information, as well as my dependants' dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account, if applicable, should I terminate my membership of Medihelp.
12. I confirm that I am responsible to give advance notice of termination of membership, and that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

Medihelp's rights as a medical scheme:

13. I am aware that a three-month general waiting period and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on my membership and that of my registered dependants in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise my membership without issuing a document containing the conditions of my membership in the event that no waiting period and/or late-joiner penalty is imposed.
14. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid in respect of particular services, for example by enforcing co-payments and exclusions.
15. Medihelp's Rules may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and using designated service providers.
16. Medihelp may also restrict interchanges between benefit plans to the beginning of a year, and require a notice period as set out in the Rules.
17. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
18. I am further aware that my benefits may be suspended should I not pay my contributions or debt in full, that my membership may be terminated should any amount still be outstanding 30 days after the date of suspension, and that my account will be handed over for collection.
19. I am aware that Medihelp may increase its contributions annually at the beginning of the year.

Protection of information:

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

20.1 Medihelp may enquire about my health status or that of my dependants at any medical doctor or any person who is in possession of such information, and give permission for the doctor or person concerned to make such information available to Medihelp and its contracted third parties for the administration of my health plan;

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

20.3 Any adviser appointed by me and whose appointment is accepted by Medihelp, may have access to my personal and medical information and that of any of my registered dependants at Medihelp's disposal, and that such adviser or an authorised person at the brokerage may instruct Medihelp to change any of my personal information for the purpose of proper administration and underwriting, except for my banking details;

20.4 Medihelp may disclose my and my dependants' medical and personal information to medical service providers for the purpose of delivering medical services to me and my dependants and to pay for such services; and

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

21. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
22. I agree that all my telephone conversations and/or that of my dependants with Medihelp and/or its contracted third parties may be recorded for quality control purposes and to help detect and prevent fraud.
23. I agree that Medihelp may, for the purpose of considering my application for membership or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependants from medical practitioners, financial advisers, industry regulatory bodies or employers/institutions.

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

24. I further consent, and declare that I have obtained the consent of my dependants, that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependants' consumer credit record, including and not limited to information about my/my dependants' credit history, financial history, personal information (excluding medical information) and judgment or default history.

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

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

In your capacity as Guardian ☐ Curator (legal appointment) ☐

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

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator, must accompany this application. If you are signing as the applicant's parent, a copy of your passport/ID document and the applicant's birth certificate must accompany this application.

First name _____ Surname _____

Telephone number (W) Code _____ No. _____

Cell phone number _____

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 his or her 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 SOLBROK-SOLMAK CC T/A SOLOMON MAKELAARS

Brokerage code A 0 1 0 4 Adviser code 3 2 6 7

Name and surname of adviser HERMAN SOLOMON

Telephone number Code 0 8 2 No. 9 2 3 3 7 0 2

Email address ADMIN@SOLMAK.CO.ZA

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

For office use only

Lead reference number _____ M H

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

12. Third-party access (optional)

NB: Complete this section only if you wish to give permission to a third party (other than your adviser) to handle your Medihelp affairs on your behalf.

I, the applicant, hereby give permission, and declare that I have obtained the consent of all my dependants, that the person stated below may:

☐ Have access to my personal and medical information and that of any of my registered dependants at Medihelp's disposal, make enquiries about such information and request documentation.

☐ Instruct Medihelp to register or deregister dependants, change my benefit plan, terminate my membership and change my banking details on my behalf.

I grant the person stated below full power of authority to perform the tasks as expressly stated in this paragraph from the date as indicated, as I would have done if I were personally present.

Neither Medihelp nor its affiliates, agents, consultants or employees will be liable for any damages whatsoever, including, without limitations, any direct, indirect, special, incidental, consequential, or punitive damages, either in terms of a contract, act, delict or otherwise, that relate to any information provided to this third party or any amendments made by this third party as a result of this instruction given by me to Medihelp.

Should you provide permission for third-party access on behalf of another person as guardian or curator, please complete the following:

In your capacity as | Guardian ☐ | Curator (legal appointment) ☐

This permission will be valid until I recall it in writing. Details of the third party are as follows:

Initials and surname _____ Title | Mr | Mrs | Ms | Other (specify)

Relation to applicant _____ ID/passport No. | | | | | | | | | | | | | |

Telephone number _____ Cell phone number _____

Email address _____

Signature of applicant _____ Signature of third party _____

Date | 2 | 0 | y | y | m | m | d | d | Date | 2 | 0 | y | y | m | m | d | d |

NB: Kindly submit a certified copy (not older than three months) of the applicant's ID as well as that of the third party mentioned above, together with this form for security reasons.

upper marketing A30137

Enquiries: 086 0100 678 **Email:** newbusiness@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007, **www.medihelp.co.za**

Council for Medical Schemes
Enquiries: 086 1123 267, **Website:** www.medicalschemes.co.za

medihelp
Medical Aid in Action