

## MEMBER AND DEPENDANT APPLICATION FORM

Please ensure that when completing this form you provide complete, up to date and accurate information at all times. Any non-disclosure of material information or any other fraudulent act, may result in cancellation or suspension of your membership. You also may be guilty of an offence as provided for in the Medical Schemes Act 131 of 1998 and liable on conviction to a fine or imprisonment or both.

**NEW APPLICATION**

Name of employer

Join date

D D M M Y Y

**NEW DEPENDANT**

Name of individual

Membership number

Option (please tick the appropriate box)

<input type="checkbox"/> Pinnacle	<input type="checkbox"/>
<input type="checkbox"/> Dynamix	<input type="checkbox"/>
<input type="checkbox"/> Symmetry	<input type="checkbox"/>
<input type="checkbox"/> Mumed	<input type="checkbox"/>
<input type="checkbox"/> Axis	<input type="checkbox"/>
<input type="checkbox"/> NetworX	<input type="checkbox"/>
<input type="checkbox"/> UniSave	<input type="checkbox"/>

**CHECKLIST DOCUMENTATION TO ACCOMPANY THIS APPLICATION**

NetworX Applications – Copy of 3 latest salary slips, IRP 5 or IT 34	<input type="checkbox"/>	
Membership certificate / s from previous medical aid / s*	<input type="checkbox"/>	Adult dependant 21 years and over – Proof of registration / Affidavit of dependency <input type="checkbox"/>
Copy of Identity Documents / copy of passport	<input type="checkbox"/>	Proof of adopted / Foster / Child status – legal documents <input type="checkbox"/>

**\*PLEASE ATTACH CERTIFICATES OF MEMBERSHIP FROM THE PREVIOUS MEDICAL SCHEME /S TO THIS APPLICATION**

**FOR OFFICE USE ONLY**

Member number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Company code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Race (for statistical use only)	Language	Subs table
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**SECTION 1 - EMPLOYER DETAILS**

Name of employer

Contact person

Postal address  Postal code

Email address

Telephone details Tel: Code ( )  Fax: Code ( )  Cell:

**SECTION 2 - PRINCIPAL MEMBER DETAILS**

Surname

First name / s

Title  Marital status  Nationality  Present age

Date of birth  ID/Passport number

Tax number  Race  African  Coloured  Indian /Asian  White

Postal address  Postal code

Physical address

Email address

Telephone details (B) Code ( )  (H) Code ( )

Facsimile details (B) Code ( )  Cell

Occupation  Date employed

Gross monthly earnings (all income including salary, commission, fringe benefits, interest, dividends etc) R

Name of GP:  GP Telephone No.:  GP Practitioner No.:

**SECTION 3 - SPOUSE / PARTNER DETAILS**

Surname

First name / s

Title  Marital status  Nationality  Present age

Date of birth  ID/Passport number

Tax number  Race  African  Coloured  Indian /Asian  White

Telephone details (B) Code ( )  (H) Code ( )

Facsimile details (B) Code ( )  Cell

Occupation  Date employed

Gross monthly earnings (all income including salary, commission, fringe benefits, interest, dividends etc) R

Name of GP:  GP Telephone No.:  GP Practitioner No.:

**SECTION 4 - DEPENDANT DETAILS (INCLUDING SPOUSE / PARTNER)**

No	Gender	Race	First name/s & Surname																		Living-in	
																						R

**PLEASE NOTE:** For any dependant / s other than your direct family, provide affidavits / legal documents.


	Code ( )	
	Code ( )	
	Code ( )	
	Code ( )	

It is most important that the questions listed below be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit. Please advise whether you and any of your dependants suffer from, or have suffered from, or received treatment / consultation for any of the following conditions. Please ensure that you **underline** the appropriate condition, tick and complete the appropriate block / s.

	YES	NO
High blood pressure; high cholesterol; angina; heart attack; angiogram; previous coronary artery bypass; rheumatic fever; heart murmurs; valve problems / replacement; arrhythmias – insertion of pacemakers; heart failure; stroke; varicose veins; DVTs (deep vein thrombosis); pulmonary emboli.		
Asthma; emphysema; chronic bronchitis; TB; chronic infections - bronchitis & pneumonia.		
Dyspeptic disease (heartburn; hiatus hernia; peptic ulcers; reflux); irritable bowel syndrome (spastic colon; inflammatory bowel disease e.g. CHRON'S & ulcerative colitis; chronic diarrhoea / constipation); gallstones & jaundice; hepatitis; pancreatitis; haemorrhoids; incontinence; bowel prolapse.		
Persistent headaches; epilepsy; paralysis; degenerative diseases – Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).		
Arthritis; rheumatism; gout; back, knee or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease; osteoporosis; previous amputations / artificial limbs; birth defects; joint replacements.		
Infections; stones; albumin / blood in urine; urinary incontinence; prolapsed bladder.		
Menopause; female hormone replacement; irregular menses; infertility; breast tumours (benign / malignant); ovarian tumours; cysts; prolapsed uterus / rectum / bladder; miscarriage; caesarean section.		
Prostate problems (hypertrophy / cancer or infections); infertility; hernias – groin; scrotal swellings; testicular tumours; abnormalities of the penis.		
Over / under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.		
Anaemia; bleeding disorders (haemophilia); leukaemia; Hodgkin's disease.		
Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness – hearing aids.		
Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus); allergies – pterygiums; anticipated / previous laser surgery; artificial eyes.		
Depression; bipolar disorder; anxiety; stress; previous treatment for post traumatic stress syndrome; eating disorders – bulimia & anorexia; mental retardation; alcoholism; drug abuse.		
Sexually transmitted diseases; genital warts; HIV / AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzias; cholera; typhoid.		
Acne; eczema; psoriasis; lesions (keloid hypertrophic scars); skin rashes; shingles; Kaposi sarcoma – tumours.		

**Diseases**

**YES NO**

	Systemic lupus erythromatosis; scleroderma.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Impacted molars (wisdoms); previous / current orthodontic treatment; braces; crowns; recurrent infections- gums.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cysts; growths; tumours of any kind.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Are you or any of your dependants allergic to any specific type of medication (e.g. penicillin, aspirin, sulphas, morphine, NSAIDS); pollen dust; animals; specific food types (e.g. nuts).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Have you or any of your dependants ever had or expecting to undergo an organ treatment transplant? Have you or any of your dependants ever suffered from any condition requiring immunosuppressive treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Have you or any of your dependants ever received any form of physiotherapy, occupational therapy or chiropractic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Are you or any of your dependants pregnant? If <b>yes</b> - how many weeks? Please give expected date of delivery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Have you or any of your dependants had any previous or pending claims for which any other party may be liable e.g. MVA (Motor Vehicle Accident) claims? If <b>yes</b> please give details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Are you or any of your dependants expecting to undergo any medical treatment, e.g. hospitalisation, operation, specialised dentistry etc, within the next twelve months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.	Do you or any of your dependants have a chronic condition requiring ongoing medication? If <b>yes</b> please give the name and dosage of all the medication you or any of your dependants are currently taking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	Have you or any of your dependants ever received any medical attention of any nature, e.g., hospitalisation, operation, specialised dentistry etc, not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	Have you and any dependants ever appeared before a medical board in view of early retirement and declared medically unfit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	Are you or any of your dependants organ donors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**yes**

No				

**IMPORTANT!** The Board may exclude from benefits or terminate the membership of a member or dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making misrepresentation or the non-disclosure of factual information. In such an event, the member may be required by the Board to refund the Scheme any sum which, but for his abuse of the benefits or privileges of the Scheme, would not have been disbursed on his behalf (You can refer to the last page of the Massmart application form – the blue block – this is where I got this from).

**SECTION 6 - LIVING WILL**

At CompCare Wellness Medical Scheme we strive for your rights to good health, and will protect and fight for that right. However, we also respect your right to dignity, and respect your right to a living will. Do you have a living will?

Yes I do       No, I don't, but would like to find out more

**SECTION 7 - PREVIOUS MEMBERSHIP**

			Date terminated

## SECTION 8 - ELECTRONIC TRANSFER INFORMATION

### PERSONAL BANKING DETAILS

#### CREDIT CARD AND TRANSMISSION ACCOUNTS ARE NOT ACCEPTED

Name of account holder	<input type="text"/>	<input type="text"/>
Account holders ID no	<input type="text"/>	<input type="text"/>
Name of bank	<input type="text"/>	<input type="text"/>
Branch	<input type="text"/>	<input type="text"/>
IBT number	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
Account number	<input type="text"/>	<input type="text"/>
Type of account	Current <input type="checkbox"/> Savings <input type="checkbox"/>	Current <input type="checkbox"/> Savings <input type="checkbox"/>

**DISCLAIMER:** It is the member's responsibility to advise the administrator in writing of any change in banking details. Neither the Scheme nor its administrators will be held liable should an incorrect account be credited under any circumstances.

I / We hereby authorise the Scheme to debit my / our bank account, the amount necessary for amounts owed by the member to the Scheme to the maximum value of R500 or as arranged with the Scheme.

<input type="text"/>	Authorised Signature / s	<input type="text"/>	Date	<input type="text"/>	Authorised Signature / s	<input type="text"/>	Date
<input type="text"/>	Member's Signature (if different from the authorised signature)	<input type="text"/>	Date	<input type="text"/>	Member's Signature (if different from the authorised signature)	<input type="text"/>	Date

## SECTION 9 - METHOD OF PAYMENT OF CONTRIBUTION

Please note that contributions are paid in arrears (at the end of the month for the month). Credit card and transmission accounts are not accepted

Debit order  Employer deduction  Direct payment via cheque / EFT

I / We hereby authorise the Scheme to debit my / our banking account (wherever it may be), the amount necessary for any contributions and changes in relation to this agreement, incorporating the contribution rate changes.

Name of account holder	<input type="text"/>	<input type="text"/>
Name of bank	<input type="text"/>	Branch <input type="text"/>
Type of account	<input type="text"/>	Branch code <input type="text"/>
Account number	<input type="text"/>	Type of account- please tick: Current <input type="checkbox"/> Savings <input type="checkbox"/>
Authorised signatory	<input type="text"/>	

## SECTION 10 - COMPCARE WELLNESS MEDICAL SCHEME DECLARATION

1. CompCare Wellness Medical Scheme, hereafter referred to as "the Scheme", confirms that your and your dependants' personal details and medical information shall be kept confidential and the Scheme shall take all reasonable steps to comply with the provisions of any legislation applicable to the protection of your and your dependants' personal information.
2. The Scheme confirms that your and your dependants' identifiable information (personal and health information) will neither be used for purposes of related company business nor sold for commercial purposes.
3. The Scheme confirms that it has data security measures in place, including restricted access to your and your dependants' data, data back-up systems and data recovery systems.
4. The Scheme shall take all reasonable steps to ensure that all staff within the Scheme and all third parties who have access to beneficiary information for the purpose of data transfer and management, Scheme administration, managed care agreements and compliance with applicable legislation, keep the personal information of beneficiaries confidential and comply with applicable legislation.
5. The Scheme confirms it has granted access to certain persons within the Scheme and its contracted third parties to your and your dependants' personal and health information. The use of relevant personal information and/or personal health information provided is for the following purposes: verifying your identity; processing your application for membership; administration of your medical scheme membership; membership verification and eligibility checking; assessment, processing and reimbursement of claims for medical expenses; determining your entitlement to benefits; underwriting or risk assessments; providing relevant information to a healthcare provider who requires this information to provide a healthcare service to you or any of your dependants; providing managed care services to you or any of your dependants; sharing your information with service providers, including electronic switching houses, for the purpose of processing it and rendering services to you such as electronic submission of claims to us; risk management practices; fraud prevention and detection, audit and record keeping purposes; compliance with applicable legal and regulatory requirements; population of the beneficiary registry as required by the Council for Medical Schemes and the Department of Health; collection of monies owed by you or healthcare providers to us; statistical analysis (this will always be on an anonymous basis, which means that data about you that is relevant to the analysis is used but it is not linked to your name or membership number).
6. In the event of a breach of confidentiality, the Scheme shall assume responsibility if the Scheme is at fault and will manage the breach according to its internal protocols and disciplinary procedures.
7. The Scheme will ensure that underwriting is applied to all members in a consistent and equitable manner.

## SECTION 11 - MEMBER ACKNOWLEDGEMENT AND DECLARATION

Please read the declarations below carefully. These contain acknowledgements of fact that may impact on your rights. These declarations must be read in conjunction with the rules of CompCare Wellness Medical Scheme (hereafter referred to as "the Scheme"), and the Medical Schemes Act No. 131 of 1998 (hereafter referred to as "the MSA"), and all these provisions shall be binding on you and your dependants. Please tick the boxes to acknowledge that you have read each declaration:

1. I, the undersigned hereby apply for membership of CompCare Wellness Medical Scheme and agree that all answers and information relating to my dependants and I, contained in this application completed by me or by any other person / s will be the basis of the proposed agreement.
2. I warrant that the contents of this application are true, correct and complete, whether the information is relating to myself or any of my listed dependants. No cover will be granted unless the Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
3. I agree to abide by and undertake to familiarise myself with the rules of the Scheme as amended from time to time and grant my employer the right to deduct from my remuneration any amounts (including members portions) outstanding by myself to the Scheme. I further grant my employer the right to pay such monies over the Scheme.
4. I confirm that I have received a copy of the current Member Benefit Guide and understand the contents therein.
5. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the Scheme. Furthermore, I understand that I will be liable for any legal costs incurred in the recovery of any amount owing to the Scheme on the attorney and own client scale.
6. I agree that contribution late joinder penalties may apply to my adult dependants 35 years and older if they have not been a member or a dependant of any previous medical scheme(s) or existing dependant at time of registration.
7. I understand that the Scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998).

8. I agree to notify the Scheme within 30 days in the event that any alternation in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk.
9. I declare that neither the applicant nor any of his / her dependant/s are beneficiaries of another registered medical scheme, on the date of registration with CompCare Wellness Medical Scheme.
10. I hereby give the Scheme permission to communicate to me by SMS or Email
11. I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the Scheme from liability and subject my membership to cancellation. I warrant that I am authorised to sign on behalf of my dependant / s. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.
12. I also authorise any doctor or other person, who may be in possession of or hereafter acquire information about my health or the health of my dependants, to disclose the information to the Scheme and its contracted third parties, provided such information shall be treated as confidential at all times. I confirm that I have the required consent of my dependants to share information of such dependants with the Scheme and its contracted third parties.
13. I understand that my confidential health and personal information will only be used for the purposes as outlined by the Scheme on the application form and any deviation from this constitutes a breach of confidentiality.
14. In the event that the Scheme wishes to use my (or my dependants') confidential information for purposes other than those outlined in the application form, the rules of the Scheme and the MSA, the Scheme is required to obtain further consent from me (or my dependants).
15. I agree to inform the Scheme of any changes in my or my dependants' personal status, as required by the Scheme rules, within 30 days of the change in circumstances.
16. I shall ensure that the Scheme is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of my application for membership, the administration of my membership, payment of claims and communication by the Scheme with me.
17. I acknowledge that my dependants and I may have access to our personal information held by the Scheme and request the Scheme to correct any inaccurate information as prescribed by applicable legislation.
18. I further acknowledge that the personal information of my dependants and I shall be retained as part of the records of the Scheme for as long as it is required by the Scheme for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of applicable law.
19. If any of my dependants or I have any concern about the processing of our personal information, we can raise the matter with the Scheme by contacting the Principal Officer.
20. I consent to all conversations between myself and the Scheme or its contracted third parties being recorded.
21. I confirm that I am familiar with the terms of this agreement, being the conditions, limits and benefits of the Scheme.
22. I hereby guarantee that as the main member of the Scheme, to the extent that it may be required by law, that I have received the necessary consent from my dependants to access and view their healthcare claims made on my membership and deal with all matters relating to their claims on my membership as set out in this section.
23. I agree that in the event that I, or my Employer have appointed an accredited broker to provide intermediary services, the Scheme shall be entitled to pay over to the broker the agreed fee for such services.
24. Failure to provide proof of income on an annual basis when required by the Scheme, will result in my contributions to default to the highest income category, which will not be backdated when proof is submitted.
25. I confirm that I am aware that my contributions will change according to my monthly income including commissions and other earnings should I join the NetworX or NetworX ED options.
26. I accept that penalties may be applied in terms of the Medical Schemes Act. I understand that these penalties include a 3 month general waiting period, a 12 month waiting period on pre-existing conditions and, where applicable, a late joiner penalty fee.
27. I confirm that I have received a current copy of the benefits and understand the contents therein.
28. I confirm that once I am enrolled as a member who has not joined as part of an employer group, that I may terminate membership to the Scheme by giving 3 months written notice in terms of the Scheme Rules.

I confirm that I have read and understood the above acknowledgements and declarations. I have had the opportunity to question and consider these and I agree to them. My signature below confirms that I voluntarily give consent to the above on behalf of myself and my dependants.

SIGNATURE OF APPLICANT \_\_\_\_\_ DATE \_\_\_\_\_

### SECTION 12 - EMPLOYER

This application form has been scrutinised, and we are not aware of any facts other than those stated which should be made known to the Scheme. We certify that the applicant is on our permanent staff and confirm the salary details are correct.

Contribution amount  Date

Employer's name

Employer's signature \_\_\_\_\_ Capacity \_\_\_\_\_

### SECTION 13 - BROKER DECLARATION

1. I hereby confirm that I have been appointed by the member applicant, and acknowledge that the member applicant may terminate my services at any time.
2. I confirm that I am fully accredited in terms of relevant legislation, on date of my signature, of this document.
3. Financial Services Board: Accreditation number  Council for Medical Schemes: Accreditation number
4. I confirm that I have provided the member applicant with my full name, physical and postal address and telephone number.
5. The commission payable upon completion of the transaction by the: Member applicant R  Scheme R
6. I confirm that I have a valid contract with the Scheme.
7. I confirm that the information provided by me, to the member applicant and the Scheme is true and correct to the best of my knowledge.
8. I confirm that where I have completed this application form on behalf of the applicant member, the applicant member is familiar with the information requested and responses provided.
9. The advice and assistance provided to the applicant member was impartial and in his / her best interests.
10. In the event of a material misrepresentation being made by me or engagement in unlawful conduct I undertake to refund all monies paid by the applicant member and / or the Scheme in consequence of such misrepresentation or conduct.
11. I confirm that the member applicant has personally signed the form.

### SECTION 14 - BROKER DETAILS

Brokerage name  Broker code

Broker's name

Broker's cell  Brokers Tel: Code ( )

SIGNATURE OF BROKER \_\_\_\_\_

Broker consultant name  BC code

SIGNATURE OF BROKER CONSULTANT \_\_\_\_\_ DATE \_\_\_\_\_