





## SECTION 5A - MEDICAL DETAILS

Please complete all questions in full as non-disclosure of material information could prejudice future claims made by you and/or any of your dependants.

|                   | Principal Member | Spouse/Partner | Dependant 1 | Dependant 2 | Dependant 3 | Dependant 4 | Dependant 5 |
|-------------------|------------------|----------------|-------------|-------------|-------------|-------------|-------------|
| Height (cm)       |                  |                |             |             |             |             |             |
| Weight (kg)       |                  |                |             |             |             |             |             |
| Smoker/Non Smoker |                  |                |             |             |             |             |             |

Please give the name of your general practitioner and/or specialist, you or any of your dependants have consulted recently

| Name of General Practitioner/ Specialist | Telephone No. | No. of Years Consulted |
|--|---------------|------------------------|
|  | Code (      ) |                        |
|  | Code (      ) |                        |
|  | Code (      ) |                        |
|  | Code (      ) |                        |

## SECTION 5B - MEDICAL HISTORY QUESTIONNAIRE

It is most important that the questions on the following page 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 or 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 | Name of member/ dependant |
|-----|---|-----|----|---------------------------|
| 1.  | <b>Heart &amp; Vascular System</b><br>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.                 |     |    |                           |
| 2.  | <b>Lungs</b><br>Asthma; emphysema; chronic bronchitis, TB; chronic infections - bronchitis & pneumonia.   |     |    |                           |
| 3.  | <b>Digestive System, Gallbladder, Liver</b><br>Dyspeptic disease (heartburn; hiatus hernia; peptic ulcers; reflux); irritable bowel syndrome (spastic colon; inflammatory bowel disease e.g. Crohn's & ulcerative colitis; chronic diarrhoea/constipation); gallstones & jaundice; hepatitis; pancreatitis; haemorrhoids; incontinence; bowel prolapse. |     |    |                           |
| 4.  | <b>Nervous System</b><br>Persistent headaches, epilepsy; paralysis; degenerative diseases - Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).   |     |    |                           |
| 5.  | <b>Bone; Muscle &amp; Joints</b><br>Arthritis; rheumatism; gout; back or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease, osteoporosis; previous amputations/artificial limbs; birth defects; joint replacements.   |     |    |                           |
| 6.  | <b>Urinary Tract</b><br>Infections; stones; albumin/blood in urine; urinary incontinence; prolapsed bladder.  |     |    |                           |
| 7.  | <b>Gynaecological System</b><br>Menopause, female hormone replacement, irregular menses; infertility; breast tumours (benign/malignant); ovarian tumours, cysts; prolapsed uterus / rectum / bladder; miscarriage; caesarean section.   |     |    |                           |
| 8.  | <b>Male Genital System</b><br>Prostate problems (hypertrophy/cancer or infections); infertility; hernias - groin; scrotal swellings; testicular tumours; abnormalities of the penis.  |     |    |                           |
| 9.  | <b>Gland/ Hormonal</b><br>Over/ under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.  |     |    |                           |
| 10. | <b>Blood</b><br>Anaemia; bleeding disorders (haemophilia), leukaemia; Hodgkin's disease.  |     |    |                           |
| 11. | <b>Ear, Nose &amp; Throat</b><br>Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness - hearing aids.   |     |    |                           |
| 12. | <b>Eyes</b><br>Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus), allergies - pteryguims; anticipated/ previous laser surgery; artificial eyes.   |     |    |                           |
| 13. | <b>Emotional (psychological, psychosomatic problems)</b><br>Depression; bipolar disorder; anxiety; stress, previous treatment for post traumatic stress syndrome; eating disorders - bulimia & anorexia; mental retardation; alcoholism; drug abuse.  |     |    |                           |
| 14. | <b>Infections/ Tropical Diseases</b><br>Sexually transmitted diseases; genital warts; HIV/AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzias; cholera; typhoid.  |     |    |                           |
| 15. | <b>Skin Disorders</b><br>Acne; eczema; psoriasis; lesions (keloid hypertrophic scars), skin rashes; shingles; kaposi sarcoma - tumours.   |     |    |                           |



## SECTION 7 - ELECTRONIC TRANSFER INFORMATION

### PERSONAL BANKING DETAILS

Electronic transfer of payments to you and collection of members portion's (co-payment's) where applicable.

#### PAYMENTS (Claims refunds)

#### COLLECTIONS (Members portions)

Name of account holder



Account holders ID no.

Name of bank

Branch

IBT number

 -  - 
 -  - 

Account number



Type of account

Current  Savings  Transmission

Current  Savings  Transmission

**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.

\_\_\_\_\_  
Authorised Signature/s

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorised Signature/s

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member's Signature  
(if different from the authorised signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member's Signature  
(if different from the authorised signature)

\_\_\_\_\_  
Date

## SECTION 8 - METHOD OF PAYMENT OF CONTRIBUTION

Please select method of payment (please tick)

Debit Order

Employer Deduction

Direct Payment via cheque / EFT

If paying by debit order, please fill in the following:

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

Name of bank

Branch code

Account number

Type of account - please tick:

Current  Savings  Transmission

Authorised signatory

## SECTION 9 - MEMBER ACKNOWLEDGEMENT AND DECLARATION

- I, the undersigned, hereby apply for membership of Compcare Wellness Medical Scheme and agree that all answers and information contained in this application completed by me or by any other person/s will be the basis of the proposed agreement.
- I warrant that the contents of this application are true, correct and complete. No cover will be granted unless Compcare Wellness Medical 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.
- 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 portion's) outstanding by myself to Compcare Wellness Medical Scheme, including interest thereon. I further grant my employer the right to pay such monies over to the scheme.
- 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).
- I agree to notify the scheme within 30 days in the event that any alteration 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.
- The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:
  - For the purpose of considering application/s for membership, as well as any claims for benefits, Compcare Wellness Medical Scheme and any medical personnel authorised by Compcare Wellness Medical Scheme has the right to obtain or forward any medically relevant information including the HIV/AIDS status, which it may deem necessary from or to any medical practitioner or institution or nominee that possesses or needs such information, and that party may disclose such information to Compcare Wellness Medical Scheme and any party duly authorised by Compcare Wellness Medical Scheme.
  - The information may be requested and supplied at any time, including after the death of the member or dependants, and will include accounts from service providers, indicating diagnoses, and medical or clinical reports when indicated. Such information will, however, be treated as confidential at all times by the party to whom it is supplied.
  - By agreeing to sign the application form/s the applicant/member and dependants thereby waives his/her right to privacy in terms of the abovementioned clauses.
- I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the scheme.
- Neither the applicant nor any of his/ her dependant/s will/ are be beneficiaries of another registered medical scheme, on the date of registration with Compcare Wellness Medical Scheme.
- I hereby indemnify and hold harmless the scheme and administrator against any and/or claims that may result due to the use of preferred providers.
- I hereby acknowledge that I must give 3 (three) months written notice when I voluntarily resign from the Medical Scheme.
- I hereby give the scheme permission to communicate to me by SMS  Email

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.

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

DATE \_\_\_\_\_

## SECTION 10 - 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

R

Date

Employer's name

Employer's signature

Capacity

## SECTION 11 - MEDICAL SCHEME CONFIDENTIALITY DECLARATION

**Compcare Wellness Medical Scheme confirms that:**

1. All personal details and medical information shall be kept confidential.
2. Personal and medical information will not be sold for commercial purposes or used for related scheme business.
3. Compcare Wellness Medical Scheme has taken adequate security measures to protect the confidentiality of the said information.
4. Limited controlled access is granted to employees and third parties, for the medical scheme to fulfil its obligations towards its beneficiaries.
5. Personal and medical information will be used for processing this application, reimbursement of claims, determining member entitlement to benefits and risk management practice.
6. Compcare Wellness Medical Scheme confirms that it has entered into confidentiality agreements with all contracted third parties who have access to beneficiary information for the purposes of data transfer management, scheme administration and managed care arrangements.

## SECTION 12 - BROKER DECLARATION AND DETAILS

**WHERE A BROKER HAS BEEN USED, THE BROKER MUST COMPLETE THE FOLLOWING BROKER DECLARATION SECTION:**

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 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.

**DISCLAIMER: The scheme shall not be held responsible for any misrepresentation made by any of its agents/ representatives/ consultants.**

## SECTION 13 - BROKER DETAILS

Brokerage name

Broker code

Broker's name

Broker's cell

Brokers Tel: (Code )

**SIGNATURE OF BROKER**

## SECTION 14 - BROKER CONSULTANT

Broker consultant name

BC code

**SIGNATURE OF BROKER CONSULTANT**

**DATE**