

NEW MEMBER AND NEW DEPENDANT APPLICATION FORM

NEW APPLICATION

NEW DEPENDANT

Name of company _____

Name of individual _____

Date of commencement

D D

M M

Y Y

Option (please tick the appropriate box)

Accolade

Mumed

Pinnacle

Axis

Dynamix

NetworX (please complete schedule below)

Symmetry

NetworX Option: Members are required to nominate a General Practitioner (per beneficiary) from the list of approved network service providers.

Beneficiary name	Name of nominated GP	Address of nominated GP	GP Practice Number	GP Telephone Number

CHECKLIST

Copy of recent salary slip/ IRP5/ IT34

Adult dependant 21 years and over – Proof of registration/ Affidavit of dependency

Membership certificate/s from previous medical aid/s

Proof of adopted/ Foster/ Child status – legal documents

Copy of identity documents/ copy of passport to accompany form

PLEASE ATTACH A CERTIFICATE OF MEMBERSHIP FROM THE PREVIOUS MEDICAL SCHEME/S TO THIS APPLICATION

FOR OFFICE USE ONLY

Member Number <input type="text"/>	Company Code <input type="text"/>	Race (for statistical use only)	Language	Subs table
Persal Number <input type="text"/>	Code <input type="text"/>			

your medical scheme of choice just got better

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.	Heart & Vascular System 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.	Lungs Asthma; emphysema; chronic bronchitis, TB; chronic infections – bronchitis & pneumonia.			
3.	Digestive System, Gallbladder; Liver 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.	Nervous System Persistent headaches, epilepsy; paralysis; degenerative diseases – Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).			
5.	Bone; Muscle & Joints Arthritis; rheumatism; gout; back or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease, osteoporosis; previous amputations/artificial limbs; birth defects; joint replacements.			
6.	Urinary Tract Infections; stones; albumin/blood in urine; urinary incontinence; prolapsed bladder.			
7.	Gynaecological System Menopause, female hormone replacement, irregular menses; infertility; breast tumours (benign/malignant); ovarian tumours, cysts; prolapsed uterus / rectum / bladder; miscarriage; caesarean section.			
8.	Male Genital System Prostate problems (hypertrophy/cancer or infections); infertility; hernias - groin; scrotal swellings; testicular tumours; abnormalities of the penis.			
9.	Gland/ Hormonal Over/ under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.			
10.	Blood Anaemia; bleeding disorders (haemophilia), leukaemia; Hodgkin's disease.			
11.	Ear, Nose & Throat Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness - hearing aids.			
12.	Eyes Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus), allergies – pteryguims; anticipated/ previous laser surgery; artificial eyes.			
13.	Emotional (psychological, psychosomatic problems) Depression; bipolar disorder; anxiety; stress, previous treatment for post traumatic stress syndrome; eating disorders – bulimia & anorexia; mental retardation; alcoholism; drug abuse.			
14.	Infections/ Tropical Diseases Sexually transmitted diseases; genital warts; HIV/AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzias; cholera; typhoid.			
15.	Skin Disorders 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

1. I, the undersigned, hereby apply for membership of Compicare 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.
2. I warrant that the contents of this application are true, correct and complete. No cover will be granted unless Compicare 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.
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 portion's) outstanding by myself to Compicare Wellness Medical Scheme, including interest thereon. I further grant my employer the right to pay such monies over to the scheme.
4. 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).
5. 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.
6. The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:
 - 6.1. For the purpose of considering application/s for membership, as well as any claims for benefits, Compicare Wellness Medical Scheme and any medical personnel authorised by Compicare 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 Compicare Wellness Medical Scheme and any party duly authorised by Compicare Wellness Medical Scheme.
 - 6.2. 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.
 - 6.3. 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.
7. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the scheme.
8. 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 Compicare Wellness Medical Scheme.
9. 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 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 Date

Employer's name

Employer's signature _____ Capacity _____

SECTION 11 – MEDICAL SCHEME CONFIDENTIALITY DECLARATION

CompCare Wellness Medical Schemes 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.
7. The scheme accepts liability for any breach of confidentiality resulting from its negligence or that of its employees.

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 Scheme
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.

Brokerage name Broker code

Broker's name

Broker's cell Brokers Tel: (Code)

SIGNATURE OF BROKER _____

DATE _____

