September 2018

My Medihelp application form 2019

medihelp
medical scheme

Enquiries: 086 0100 678
Fax: 012 336 9534 **Email:** newbusiness@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007

For office use only								
Membership number								
		M	H					

How to complete this form:

1. Please complete in print, using black ink, and email, fax or post all pages of the form to Medihelp.
2. Please complete all sections in full and sign the application form.
3. Note the following at section 5: If you apply for membership of the Necesse benefit option, complete item 5.2
4. Never sign a blank application form.

1. Date from when membership is required 2 0 y y m m d d

2. Details of applicant (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

3. Contact details of applicant

Residential address | Tel: (W) Code | No.

Tel: (H) Code | No.

Code | Fax: Code | No.

Postal address | Cell number

Email address

Code

May Medihelp use your/your dependant's(s') personal details to determine 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 employer/institution responsible for paying your subscriptions

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

Name of employer/institution

Branch code/Employer group No.

Payroll number

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

Pay area | Permanent | Temporary

Office stamp of employer

5. Choice of benefit option (choose only one benefit option by marking an "X" at 5.1)

5.1 Benefit options

Note: If you choose any of the network options, please refer to section 5.3.

Prime 1 | Hospital plan ☐	Prime 1 Network | Hospital plan ☐	Prime 2 | Savings ☐	Prime 2 Network | Savings ☐
Prime 3 | Comprehensive ☐	Prime 3 Network | Comprehensive ☐	Elite | Comprehensive ☐	Plus | Comprehensive ☐
Necesse | Income-based ☐	Unify | Savings ☐		

5.2 Gross monthly income – Necesse only

Gross monthly income of applicant | | | | | | | | Occupation of applicant

Gross monthly income of spouse/partner | | | | | | | | Occupation of spouse/partner

For the purpose of the Necesse option, "monthly income" means the gross monthly income before any deductions.

Proof of income must only be provided if the monthly income of both the applicant and the registered spouse/partner is less than the highest income category, since Medihelp will use the highest of the incomes declared to determine the subscription category.

Acceptable proof of income

Income from investments: This income must be declared by all individuals, if applicable, and includes interest, dividends and rental income. • Letter from an auditor/accountant/income tax adviser • Latest tax assessment – ITA34 • IT3(a) and past **three** months' bank statements • Rental income – rental agreement and past **three** months' bank statements	**Income from full-time employment:** Gross monthly income includes all forms of remuneration, such as basic salary, overtime, commission, bonuses, allowances, fringe benefits and one-off payments. • Past **three** months' official payslips • Latest tax assessment – ITA34 • IRP5 of the previous tax year • Past **three** months' commission and bank statements
Pensioners: (Pension, annuity) • Latest tax assessment – ITA34 • Past **three** months' pension payment advices and additional proof	**Own business:** (Income from vocation/profession, total income from business, irregular income) • Latest tax assessment – ITA34 • Letter from an auditor/accountant/income tax adviser
Unemployed: Individuals who receive no income from a vocation/profession/business, who are unemployed or receive an allowance. • UIF payments	**Employer groups:** • Any proof of income applicable to individuals as indicated above
Full-time students: • A notice or letter on an official letterhead from the tertiary institution where you are registered as a full-time student, confirming your registration • Proof of income applicable to individuals	**Important:** • If you cannot provide acceptable proof of income, your subscription will be calculated according to the highest income category. • Medihelp may require additional proof other than the above. • Only official bank statements on which the account holder's initials and surname are indicated, are acceptable. Please indicate clearly on the bank statements which payment(s) refer to your income.

5.3 Declaration by applicants who apply for enrolment on a network option (including Necesse)

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 benefit option.

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.*

***For all applicable co-payments, please refer to your preferred benefit option guide/brochure.**

Signature of applicant

Date 2 0 y y m m d d

6. Details of dependant(s) you wish to register

The following dependants of an applicant may be registered:

- 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 subscription 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/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 form.

Dependant (spouse/partner)

Surname

First names in full

Known as

ID/passport number | Gender Male ☐ Female ☐

Date of birth (y y y y m m d d) | Cell number

Email address

Relationship to applicant

Dependant

Surname

First names in full

Known as

ID/passport number | Gender Male ☐ Female ☐

Date of birth (y y y y m m d d) | Cell number

Email address

Relationship to applicant

Dependant

Surname

First names in full

Known as

ID/passport number | Gender Male ☐ Female ☐

Date of birth (y y y y m m d d) | Cell number

Email address

Relationship to applicant

Dependant

Surname

First names in full

Known as

ID/passport number | Gender Male ☐ Female ☐

Date of birth (y y y y m m d d) | Cell number

Email address

Relationship to applicant

6. Details of dependant(s) you wish to register (continued)

Dependant

Surname

First names in full

Known as

ID/passport number — Gender: Male ☐ Female ☐

Date of birth (y y y y m m d d) — Cell number

Email address

Relationship to applicant

Dependant

Surname

First names in full

Known as

ID/passport number — Gender: Male ☐ Female ☐

Date of birth (y y y y m m d d) — Cell number

Email address

Relationship to applicant

Dependant

Surname

First names in full

Known as

ID/passport number — Gender: Male ☐ Female ☐

Date of birth (y y y y m m d d) — Cell number

Email address

Relationship to applicant

Dependant

Surname

First names in full

Known as

ID/passport number — Gender: Male ☐ Female ☐

Date of birth (y y y y m m d d) — Cell number

Email address

Relationship to applicant

Dependant

Surname

First names in full

Known as

ID/passport number — Gender: Male ☐ Female ☐

Date of birth (y y y y m m d d) — Cell number

Email address

Relationship to applicant

7. Banking details

7.1 Individual who pays own subscriptions (choose only one option by marking an "X")

I hereby authorise Medihelp to recover the applicable subscriptions 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 subscriptions, should it be necessary, and recover the amended amount, or any subscriptions in arrears, from my bank account.

Please deduct my monthly subscriptions by debit order from my bank account on the following date:

- ☐ 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 subscriptions 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 subscriptions monthly on the date you have chosen above.**
- **If the debit order deduction date falls on a weekend or a public holiday, your subscriptions 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 Individual whose employer/institution pays subscriptions

My employer/institution as my authorised agent hereby authorises Medihelp to recover the applicable subscriptions 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 subscriptions, should it be necessary, and recover the amended amount, or any subscriptions in arrears, from my employer/institution as my authorised agent's bank account.

7.3 Banking details for debit order deductions and credit refunds (must be completed by all applicants)

☐ 1. Use this account for all transactions

☐ 2. Use this account only for the recovery of subscriptions
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 this account 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 only one bank account number is provided, this account will be used both for the recovery of subscriptions and for refunding credit amounts.
In the case of a trust, a copy of the trust deed must be submitted and the responsible trustee must sign.

Signature of account holder/authorised signatory for recovery of subscriptions

Signature of account holder for credit refunds

8. Previous/current membership of medical scheme(s)

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

Yes | No   Who was the member of the previous scheme? Name and surname

8.2 **Please provide details of ALL the medical schemes where you and your dependant(s) 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/your dependant's(s') membership of the particular scheme is still active.
- Ensure that the dates of your/your dependant's(s') membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated separately for you and your dependant(s).

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 dependant's(s') previous medical scheme apply any late-joiner penalty?

Yes | No

If "Yes", please provide the following details:

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

8.4 Did your or your dependant's(s') 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(s)	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

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

9. Medical questionnaire

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **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 dependant(s) mentioned on this application form have a history of any of the following medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

Mark with an "X"

1. Muscle and skeletal/bone system, brain, nerve and skin conditions (e.g. back and neck problems, including injuries, arthritis, gout, multiple sclerosis, hip and knee problems, osteoporosis, dermatitis, stroke, epilepsy, paralysis, tremors)?

Yes	No

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

2. Gastrointestinal system (e.g. gastro-oesophageal reflux, heartburn, ulcer, Crohn's disease, ulcerative colitis, diverticulitis, spastic colon, liver conditions, hernias, piles)?

Yes	No

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

3. Urinary tract system and/or genital disorders (e.g. kidney stones, renal failure, dialysis, prostate disorders, endometriosis, ovarian cysts, menstrual disorders, pelvic inflammatory conditions, miscarriages)?

Yes	No

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

4. Chronic illness (e.g. elevated cholesterol, chest pain, heart diseases, pacemaker, diabetes, high blood pressure, asthma, bronchitis, obstructive lung disease, emphysema, systemic lupus erythematosus, thyroid, porphyria)?

Yes	No

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

5. Is any female beneficiary indicated in this application currently pregnant or is pregnancy suspected?

Yes	No

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

9. Medical questionnaire (continued)

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **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 dependant(s) mentioned on this application form have a history of any of the following medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

Mark with an "X"

6. Blood conditions/disorders and/or any type of cancer (e.g. haemophilia, leukaemia, lymphoma, tissue-specific cancers)? Yes / No

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

7. Psychiatric conditions and/or any substance dependency (e.g. depression, bipolar mood disorder, stress, panic attacks, alcohol and/or drug abuse)? Yes / No

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

8. Any disorder of the ears, nose, throat, eyes and/or teeth (e.g. glaucoma, cataracts, glasses or contact lenses, deafness, retinal conditions, orthodontics, crowns and bridges, maxillofacial and oral surgery)? Yes / No

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

9. If you or any of your dependant(s) are **HIV positive or have Aids**, you must phone LifeSense on **0860 50 60 80** within 21 days from your enrolment date to register on Medihelp's HIV/Aids programme. Should you fail to adhere to this condition, it will be considered as the non-disclosure of information, which may result in the termination of your membership. On receipt of this request, Medihelp will determine whether underwriting conditions will be applied, and if this is the case, you will receive an amended Proof of membership document.

10. Are you/your dependant(s) planning to have any examination, treatment and/or procedure done in the next 12 months? Yes / No

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

9. Medical questionnaire (continued)

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **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 dependant(s) mentioned on this application form have a history of any of the following medical conditions, illnesses or disorders (disorder includes affection or condition of illness). Be advised that any request for hospital admission or chronic medicine authorisation during the first 12 months of membership will be subject to a non-disclosure of information investigation before the hospital admission or chronic medication will be authorised.

Mark with an "X"

	Yes	No
11.		

11. Has any person indicated in this application ever been examined (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) and/or that could potentially result in a medical claim in the next 12 months?

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or 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 registering on the secured website for members.

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

Medihelp confirms that –

1. your and your registered dependant's(s') 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 staff 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;
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 option 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.
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 dependant(s) 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 dependant(s), 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 provisions of the Medical Schemes Act and Medihelp's registered Rules.

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

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 90 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 dependant(s) 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 subscription 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 subscriptions 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 subscriptions: my identity number, my tax certificate information, as well as my dependant's(s') dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account 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 dependant(s) 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 dependant(s) 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 designated service providers.
16. Medihelp may also restrict interchanges between benefit options 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 membership may be suspended should I not pay my contributions or debt in full for a period of one month, and that my membership may be terminated should I be in arrears for a period of two months, and that my account will be handed over for collection.
19. I am aware that Medihelp may increase its subscriptions 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 dependant(s), that –

20.1 Medihelp may enquire about my health status or that of my dependant(s) 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 dependant(s) may enquire about my personal and medical information and that of any of my dependant(s) at Medihelp's disposal;

20.3 an adviser in the service of a Medihelp contracted brokerage, should I make such an appointment and use their services, may have access to my personal and medical information and that of any of my registered dependant(s) 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 dependant's(s') 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 understand that the information contemplated in paragraph 20 will only be used for the purposes as set out in Medihelp's confidentiality statement (on this application form) and that any deviation will be regarded as a breach of confidence. Should Medihelp wish to use the information for any other purpose, Medihelp must first obtain my approval.
22. I agree that all my telephone conversations and/or that of my dependant(s) 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 dependant(s) 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 dependant(s), that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependant's(s') consumer credit record, including and not limited to information about my/my dependant's(s') 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 ☐

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.

First name

Surname

Tel: Code No.

Fax: Code No.

Cell 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/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

Brokerage code A

Adviser code

Name and surname of adviser

Tel: Code No.

Fax: Code No.

Email address

Signature of adviser

Date 2 0 y y m m d d

Lead reference number

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

Additional information (if necessary)

Membership number | | | | | | | |

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

Initials | |

Surname | |

Medihelp
Enquiries: 086 0100 678
Fax: 012 336 9534
Email: newbusiness@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007
Website: www.medihelp.co.za

Council for Medical Schemes
Enquiries: 086 1123 267
Website: www.medicalschemes.com

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