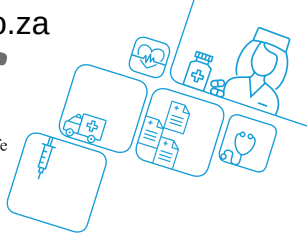
Please fax completed applications to 021 7978856 or email it to enquiries@classmed.co.za

Postal address PO Box 16148, Doornfontein, 2028
Share Call 0860 00 0048
Fax 086 608 0771
E-mail membership@hosmed.co.za

CLASSIQUE MEDICAL AID CONSULTANTS
AUTHORISED FSB 7761
7 TORRENS ROAD WYNBERG, 7800
Tel. (021) 797 8885 Fax (021) 7978856
Website : www.classmed.co.za

hosmed medical scheme
care for life
Established IN 1988



ADDITIONAL DEPENDANTS APPLICATION FORM

PLEASE PRINT IN CAPITAL LETTER. USE A BLACK PEN ONLY. PLEASE MARK APPROPRIATE CHOICE USING A CROSS (x)
THIS FORM SHOULD BE COMPLETED IN RESPECT OF SUBSEQUENT ADDITIONS TO THE FAMILY UNIT

Membership Number	
Broker Code	H O S M E D 1 0 0 1 3 4

DOCUMENTS REQUIRED

	Yes	No
• Dependant's copy of ID	☐	☐
• Main member's copy of ID	☐	☐
• Birth certificate of child (where ID is not available)	☐	☐
• Clinic card for new born baby (within 30 days of birth to avoid waiting period)	☐	☐
• Documentary proof if dependant is adopted/foster child/student/disability status/adult dependant	☐	☐
• Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting period)	☐	☐
• Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable)	☐	☐
• Membership certificate from previous medical aid (where applicable)	☐	☐
• Proof of latest income salary advance / 3 months bank statements	☐	☐

Broker Stamp

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss	Initials	First name	
Surname		Identity no.	
Name of employer		Employer code	
Email			
Tel. no. (h)	(w)	(Cell)	
Residential address			
		Postal code	
Postal address			
		Postal code	

Race (please tick) African ☐ Coloured ☐ Indian/Asian ☐ White ☐

Preferred method of communication (please tick) Email ☐ SMS ☐ Post ☐

SECTION B: PARTICULARS OF DEPENDANTS

	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Name and Surname of dependant					
ID number (compulsory)					
Relationship to member (spouse, partner, daughter etc.)					
Sex (M/F)					
Race (African, Coloured, Indian/Asian, White)					
Address, if different from member					
Cell no.					
Date of admission to Hosmed					

Date of marriage where dependant is spouse	

Is or was the dependant previously registered with a medical scheme?	Yes	No	(If yes, please complete the following):	
Name of previous medical aid(s) for past 2 years				
Membership no.				
Period of membership	From		To	

KINDLY ATTACH CERTIFICATE/S OF MEMBERSHIP
Full details over last two years must be given

Give details of illnesses, treatments or conditions for which the dependant was excluded from benefits by the above named medical aid scheme
(If space is insufficient attach separate schedule)

Kindly complete health questionnaire on reverse side hereof in full detail. PLEASE NOTE: Failure to complete or submit all information required will delay processing of membership of dependant. Failure to disclose medical information or the provision of incorrect information can result in the immediate cancellation of your membership.

Member initials _____

SECTION C: EMPLOYER DETAILS

Company			
Region		Date of employment	
Date of addition effected by Employer			

NB: Please complete debit order form for unsubsidised dependants

Signature of member

Name

Designation

Company Stamp

Date

SECTION D: DEPENDANT MEDICAL HISTORY

Do your dependants have, or ever had the following? If "yes" state full details below (complete all questions). If insufficient space please attach schedule.

				Name
1. Any disorder of the heart e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	No	Yes		
2. High blood pressure, chronic headache or disease of the blood vessels including cholesterol or circulatory disorder?	No	Yes		
3. Any respiratory or lung trouble,e.g. asthma, bronchitis, persistent cough, tuberculosis?	No	Yes		
4. Any disorder of the digestive system, gall bladder or liver, e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?	No	Yes		
5. Disease or disorder of the kidneys, bladder or reproductive organs, e.g. albumin in urine, stones, prostatitis or infertility?	No	Yes		
6. Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety state or depression, alcoholism or narcotism?	No	Yes		
7. Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, tonsilitis and sinus problems?	No	Yes		
8. Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?	No	Yes		
9. Diabetes, acne or skin problems, sugar in urine, thyroid or other glandular or blood disorders?	No	Yes		
10. Cancer, growth or tumour of any kind?	No	Yes		
11. Any tropical disease, e.g. Bilharzia?	No	Yes		
12. Any other illness, disorder, operation, disability or injuries from any accident?	No	Yes		
13a. Any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement, e.g. Caesarian section or miscarriage? If "Yes", state full details including dates.	No	Yes		
13b. Are you now pregnant? If "Yes", how many months? _____ If "Yes" is this a multiple birth?	No	Yes		
14. Any special dental treatment, e.g. crowns, bridges, orthodontic, etc?	No	Yes		
15. Any illness or physical defect likely to necessitate medical or dental treatment, e.g. headaches, lumps, orthodontic work etc.?	No	Yes		
16. Do you expect any medical or dental treatment within the next three months?	No	Yes		
17. Do you or your dependants have a medical condition not disclosed?	No	Yes		
18. Detail all medication used by applicant and dependants during the last 2 years, as well as all Pathology and Radiology tests.				
19. Please state full name and contact details of usual medical practitioner				

SECTION E: UNDERTAKING BY MAIN MEMBER

- Please ensure relevant documentation is attached to the Update Form to avoid any delay in processing.
- I declare that the information given is true and correct and I am aware that any false statement will render my membership of the Scheme null and void.
- I accept that my dependants may be subjected to a general waiting period as per Scheme rules.
- I accept that I will be liable for the additional contribution for the dependants added on this form.
- Where applicable: Member Savings Account allocations will be pro-rated depending on when joining the option.
- The Scheme has the sole right to collect negative balances owed to the Scheme by the member, even when member has terminated from the Scheme.

Member name

Member Signature

Date