# Medihelp application form 2021

## Corporate

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

**Thank you for choosing to join Medihelp medical scheme. Medihelp is registered in terms of the Medical Schemes Act 131 of 1998 and is a self-administered non-profit scheme, registered with the Council for Medical Schemes.**

**How to complete this form:**

- We recommend that you use our online application form on our website at www.medihelp.co.za under "Join/Apply online". You can also use our editable PDF form and add your signature electronically before you email the form to us, but if you prefer to complete a print version, please complete the form in print using black ink and email, fax or post all pages of the form to Medihelp.
- Please complete all sections in full and sign the application form, also where your signature is required at sections 5, 7, 10 and 12. Read and make sure you understand the conditions for membership in section 10 before you sign the form. Incomplete information may delay the application process.
- Email the completed and signed form to corpapps@medihelp.co.za or fax the form to 012 336 9534.

**The next steps after we receive your application:**

- Use the Application in Motion (AiM) functionality on our website at https://onlineapplication.medihelp.co.za to track your application.
- We will contact you should we require any details that were omitted on the application form or if we require any additional information to determine the conditions of your membership. You can also use the AiM functionality to see whether you need to provide further details.
- If we offer you membership under the standard terms, your membership will be activated without issuing enrolment conditions. We will notify you and/or your adviser by letter.
- If we offer you membership under any non-standard terms (waiting periods and/or late-joiner penalties apply), we will notify you and/or your adviser by letter and stipulate the conditions that will be applicable to your membership. If you accept these terms, you must sign the letter and return it to us, after which we will activate your membership. The enrolment conditions can also be accepted on AiM.
- We will send a welcome letter, SMS or email to you and/or your adviser to let you know when your application has been completed.

### 1. When would you like your cover to start?

2 0 y y m m d d

### 2. Your information (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

Please indicate your race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

### 3. Your contact information

Residential address _____ Tel No. (W) Code _____ No. _____

_____ Tel No. (H) Code _____ No. _____

_____ Code _____ Cell number _____

Is your postal address the same as your residential address? Yes | No Email address _____

We will use this email address to keep you up to date with important information on your journey to good health.

Postal address _____

_____ Code _____

May Medihelp use your/your dependants' personal details to get your opinion on 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 your employer/the institution responsible for paying your contributions

**NB:** Complete this section only if your contributions are paid in full or partially by your employer or any other institution.

Name of employer/institution _____ Campus/site _____

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. Select a plan that will suit your needs by marking your choice with an "X"

### 5.1 Plans

**Note:**

- If you choose a plan with a savings option (Prime 2, Prime 2 Network, Unify, Prime 3, Prime 3 Network and Elite), please refer to section 5.3; and
- If you choose any of the network plans (including Necesse), please refer to section 5.4.

| | | | |
|---|---|---|---|
| ☐ 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 \| Network | ☐ 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 plan, "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 contribution category.**

**Acceptable proof of income**

**Important:**

- If you cannot provide acceptable proof of income, your contribution will be calculated according to the highest income category.
- Medihelp may require additional proof other than the below.
- 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 payments (deposits/transactions) refer to your income.

| | |
|---|---|
| **Income from investments:**<br>This income must be declared by all individuals, if applicable, and includes interest, dividends and rental income.<br>• Letter from an auditor/accountant/income tax adviser<br>• Latest tax assessment – ITA34<br>• IT3(a) and the past **three** months' bank statements<br>• Rental income – rental agreement and past three months' bank statements | **Income from full-time employment:**<br>Gross monthly income includes all forms of remuneration, such as basic salary, overtime, commission, bonuses, allowances, fringe benefits and one-off payments.<br>• Past **three** months' official payslips<br>• Latest tax assessment – ITA34<br>• IRP5 of the previous tax year<br>• Past **three** months' commission and bank statements indicating commission deposits<br>• An official appointment letter by an employer, not older than three months, which indicates the member's gross monthly income |
| **Pensioners: (Pension, annuity)**<br>• Latest tax assessment – ITA34<br>• Past three months' pension payment advices. If you have fewer than three months' proof, please also supply the past three months' bank statements | **Self-employed:** (Income from vocation/profession, total income from business, irregular income)<br>• Latest tax assessment – ITA34<br>• Letter from an auditor/accountant/income tax adviser<br>• Past **three** months' commission and bank statements |
| **Unemployed:**<br>Individuals who receive no income from a vocation/profession/business, who are unemployed or receive an allowance<br>• UIF payments<br>• Past **three** months' bank statements | **Employer groups:**<br>• Any proof of income applicable to individuals as indicated above |
| **Full-time students:**<br>• A notice or letter of confirmation on an official letterhead from the institution where you are registered as a full-time student<br>• New students who register for the first time: A letter of acceptance for the specific study year<br>**Full-time students who are 26 years or older or have dependants:**<br>• Proof of studies as well as the past three months' bank statements | **Income from trusts:**<br>• Latest tax assessment – ITA34<br>• The past three months' bank statements indicating trust payments |

### 5.3 Utilisation of savings account funds

**Prime 2, Prime 2 Network and Unify**

Please indicate your preference. If you do not select an option, Medihelp will pay all qualifying medical expenses from your savings account:

- Pay all qualifying day-to-day and hospital related medical expenses from my savings account. ☐
- Pay only selective qualifying day-to-day medical expenses from my savings account (excluding certain in-hospital expenses such as co-payments). ☐

**Prime 3, Prime 3 Network and Elite**

- If you enrol on the Prime 3, Prime 3 Network or Elite plan, all qualifying day-to-day medical expenses will be paid from your savings account first.

## 5. Select a plan that will suit your needs (continued)

**5.4 Declaration by applicants who apply for enrolment on a network plan (Prime 1 Network, Prime 2 Network, Prime 3 Network and 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 benefit (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 plan.
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*, unless the treatment required is in respect of an emergency medical situation** which warrants the involuntary use of a non-network hospital. I further note that in an emergency medical situation, authorisation for the hospital admission should be obtained on the first workday after the admission if I am unable to obtain the authorisation on the day of admission.

*** Please refer to your plan's guide/brochure for all applicable co-payments.**

**** Please refer to your plan's guide/brochure for the definition of an emergency medical condition.**

Signature of applicant _____ Date 2 0 y y m m d d

## 6. Your dependants that you wish to register

**You may register the following dependants:**

- 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 contribution 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.

**Spouse/partner (complete only if applying for registration as a dependant)**

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

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 (please select **one** by marking with an X) Spouse ☐ Partner ☐

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

## 6. Your dependants that you wish to register (continued)

**Dependant 2**

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

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 (please select one by marking with an X)

**Child dependant**

- Own child
- Adopted child
- Foster child
- Child in temporary safe care
- Child born in terms of a surrogate motherhood agreement
- Stepchild

**Other relative**

- Grandchild
- Mother
- Father
- Brother
- Sister

If you wish to register a dependant other than a child dependant or if the dependant is 21 years and older, is the dependant:

Married? Yes | No Financially dependent on you? Yes | No

Does the dependant earn an income? Yes | No If so, how much does the dependant earn per month? R _____

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

Black | Coloured | Indian/Asian | White | Other

**Dependant 3**

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

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 (please select one by marking with an X)

**Child dependant**

- Own child
- Adopted child
- Foster child
- Child in temporary safe care
- Child born in terms of a surrogate motherhood agreement
- Stepchild

**Other relative**

- Grandchild
- Mother
- Father
- Brother
- Sister

If you wish to register a dependant other than a child dependant or if the dependant is 21 years and older, is the dependant:

Married? Yes | No Financially dependent on you? Yes | No

Does the dependant earn an income? Yes | No If so, how much does the dependant earn per month? R _____

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

Black | Coloured | Indian/Asian | White | Other

## 6. Your dependants that you wish to register (continued)

**Dependant 4**

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

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 (please select one by marking with an X)

**Child dependant**

- ☐ Own child
- ☐ Adopted child
- ☐ Foster child
- ☐ Child in temporary safe care
- ☐ Child born in terms of a surrogate motherhood agreement
- ☐ Stepchild

**Other relative**

- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

If you wish to register a dependant other than a child dependant or if the dependant is 21 years and older, is the dependant:

Married? Yes | No Financially dependent on you? Yes | No

Does the dependant earn an income? Yes | No If so, how much does the dependant earn per month? R | | | | | | | |

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

**Dependant 5**

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

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 (please select one by marking with an X)

**Child dependant**

- ☐ Own child
- ☐ Adopted child
- ☐ Foster child
- ☐ Child in temporary safe care
- ☐ Child born in terms of a surrogate motherhood agreement
- ☐ Stepchild

**Other relative**

- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

If you wish to register a dependant other than a child dependant or if the dependant is 21 years and older, is the dependant:

Married? Yes | No Financially dependent on you? Yes | No

Does the dependant earn an income? Yes | No If so, how much does the dependant earn per month? R | | | | | | | |

Please indicate your dependant's race only if you wish to do so (the information is for national statistical purposes compiled by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

## 7. Banking details for debit order deductions and credit refunds and recovery of contributions

Bank _____

Branch _____

Branch code | | | | | | | | | | |

Type of account _____

Name of account holder _____

Account number _____

This account will be used both for the recovery of contributions and for refunding credit amounts. In case of a trust, a copy of the trust deed must be submitted and the responsible trustee must sign.

* If your employer pays your monthly subscription in full, the banking details supplied will only be utilised for credit refunds

Signature of account holder for credit refunds and recovery of contributions

## 8. Previous/current membership of medical schemes

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

Yes | No

Who was the principal member of the previous scheme? Name and surname _____

8.2 **Please provide details of ALL the medical schemes where you and your dependants 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 dependants' membership of the particular scheme is still active.
- Ensure that the dates of your/your dependants' membership at the different schemes do not overlap.
- Information regarding previous and current membership must be indicated separately for you and your dependants.
- The Medical Schemes Act makes provision for a late-joiner penalty (LJP) to be imposed on an applicant who is 35 years or older at the time of joining a scheme and has not enjoyed previous coverage with a medical aid. The penalty, which is added to the member's monthly contribution, is calculated as a percentage of the member's contribution based on the total number of years without creditable coverage since the age of 35 years, as shown below:

**LJP intervals and penalty percentages**

| | |
|---|---|
| 1 – 4 years | 5% |
| 5 –14 years | 25% |
| 15 – 24 years | 50% |
| 25 years + | 75% |

of the contribution of the beneficiary (excluding savings contribution)

| Name of medical scheme* | Name and surname* | Membership number | Date joined* | Date ended* |
|---|---|---|---|---|
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* This information is compulsory. If not completed, your application for membership cannot be finalised.

## 8. Previous/current membership of medical schemes (continued)

8.3 Did your or your dependants' previous medical scheme apply a late-joiner penalty?

| Yes | No |
|---|---|

If "Yes", please provide the following details:

| Name of applicant/dependant | Late-joiner penalty | | | |
|---|---|---|---|---|
| | 5% | 25% | 50% | 75% |
| | 5% | 25% | 50% | 75% |
| | 5% | 25% | 50% | 75% |

8.4 Did your or your dependants' previous medical scheme apply any condition-specific waiting periods 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 | 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 |

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

## 9. Medical history

- Please ensure that you have completed **section 8** of this application form in full.
- Only complete **section 9.1** if you **and** your dependants mentioned in this application form, have been members of a medical scheme registered in South Africa, for a continuous period of more than 24 months and the lapse between medical schemes is less than 90 days.
- Complete **section 9.2** in full if you or any of your dependants mentioned in this application form, have not been members of a medical scheme registered in South Africa, for a continuous period of more than 24 months or the lapse between medical schemes exceed 90 days.

**NB: Medihelp will review all** requests for hospital admission or chronic medicine authorisation made by members during their first year of membership before we authorise benefits. If we find that you did not complete your application form in full, withheld information or provided inaccurate details, we may terminate your membership.

**Doctors consulted in the past 12 months**
If your family has consulted a doctor in the past 12 months, please provide us with the details:

Name and surname _____
Tel No. (W) _____ How long has he/she been your doctor (in years)? ☐☐

Name and surname _____
Tel No. (W) _____ How long has he/she been your doctor (in years)? ☐☐

Name and surname _____
Tel No. (W) _____ How long has he/she been your doctor (in years)? ☐☐

### 9.1 Applicants who are moving from another medical scheme to Medihelp

1. Have you or any of your dependants been admitted to hospital within the last 12 months prior to submitting this application? Yes / No
2. Are you or any of your dependants currently taking regular, ongoing medicine and/or receiving treatment for a medical condition or symptom? Yes / No
3. Are you or any of your dependants planning or expecting to be hospitalised (including for a pregnancy) or to receive medical or surgical treatment and/or undergo examinations during the next 12 months? Yes / No

## 9. Medical history (continued)

### 9.2 Medical questionnaire

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details as all applications for pre-authorisation are reviewed which may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

**1. Cancer, tumours and abnormal growths**

Cancer of any organ, cancerous tumours, non-cancerous tumours, blood-related cancers, lymphoma, leukaemia, skin lesions, breast disease, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal Pap smear result, abnormal PSA (prostate-specific antigen) result, any other abnormal cancer screening or diagnostic test result.

**Mark with an "X"**

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
|---|---|---|---|---|
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**2. Blood conditions**

Deep vein thrombosis, pulmonary embolism, blood clots, anaemia, ITP and platelet deficiencies, polycythaemia vera, haemophilia, blood clotting diseases, leukaemia, lymphoma, any other bleeding disorders.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
|---|---|---|---|---|
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**3. Metabolic and endocrine conditions**

Diabetes, thyroid disease, Addison disease, Cushing syndrome, obesity, metabolic syndrome, parathyroid disease, Paget disease, osteoporosis, osteopenia, growth deficiency, Conn syndrome, any other metabolic or endocrine condition.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**9.2 Medical questionnaire (continued)**

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details as all applications for pre-authorisation are reviewed which may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

**4. Mental health**

Depression, bipolar disorder, anxiety disorder, post-traumatic stress disorder, obsessive-compulsive disorder, schizophrenia, personality disorders, insomnia, sleeping disorders (e.g. narcolepsy), eating disorders, Alzheimer disease, dementia, autism, attention deficit-hyperactivity disorder (ADHD), drug or alcohol dependency or abuse, rehabilitation for drug or alcohol dependency or abuse, suicide attempt, counselling, any other psychological condition.

**Mark with an "X"**

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
|---|---|---|---|---|
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**5. Brain and nerve conditions**

Stroke, bleeding on the brain, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, Parkinson disease, Guillain-Barré syndrome, migraine, chronic headache, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability, any other brain or nerve condition.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in ful | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
|---|---|---|---|---|
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**6. Eye and eyelid conditions**

Cataracts, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, cornea transplant, eye surgery, blurry vision, glassescontact lenses, partial or full blindness, any other eye or eyelid condition.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**7. Ear, nose and throat conditions**

Chronic otitis media, chronic otitis externa, chronic ear infection, deafness, hearing problems, hearing aid, cochlear implant, chronic tonsillitis, chronic adenoiditis, dizziness, vertigo, tinnitus, sinus problems, nasal surgery, dental or orthodontic treatment, dental surgery, any other ear, nose or throat condition.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
|---|---|---|---|---|
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**9.2 Medical questionnaire (continued)**

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details as all applications for pre-authorisation are reviewed which may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

**8. Heart and circulation conditions**

High blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins, any other condition affecting the heart or blood vessels.

**Mark with an "X"**

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
|---|---|---|---|---|
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**9. Breathing and respiratory conditions**

Asthma, bronchitis, chronic obstructive pulmonary disease, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia, pulmonary embolism, any other breathing or respiratory condition.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
|---|---|---|---|---|
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**10. Abdominal and digestive conditions**

Hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder conditions, gall stones, reflux, heartburn, hiatus hernia, oesophageal disease, atrophic gastritis, ulcers, abdominal hernia, inguinal hernia, malabsorption, Crohn disease, ulcerative colitis, diverticulitis, any other abdominal or digestive condition.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**11. Skin conditions**

Chronic wounds, eczema, psoriasis, acne, sunspots, skin cancer, melanoma, any other condition affecting the skin.

| Yes | No |
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| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**9.2 Medical questionnaire (continued)**

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details as all applications for pre-authorisation are reviewed which may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

**12. Back, bone and muscle conditions**

Arthritis, rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, lupus, gout, hip problems, knee problems, clubfoot, bunions, back pain, neck pain, Sjögren syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, any other condition affecting the back, bones or muscles.

**Mark with an "X"**

| Yes | No |
|---|---|
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| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**13. Gynaecological and obstetric conditions**

Abnormal Pap smear result, abnormal menstrual bleeding, endometriosis, polycystic ovarian syndrome, infertility, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, any other gynaecological or obstetric condition.

| Yes | No |
|---|---|
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| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**14. Pregnancy**

Are you or any of your dependants pregnant or undergoing testing for pregnancy?

| Yes | No |
|---|---|
| | |

| Name of patient | Specify any known complications, if applicable | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**15. Kidney and urinary conditions**

Kidney or renal failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, any other kidney or bladder problems.

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**9.2 Medical questionnaire (continued)**

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details as all applications for pre-authorisation are reviewed which may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

**16. Male urinary and genital conditions**

Prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urine retention, any other male urinary or genital condition.

**Mark with an "X"**

| Yes | No |
|---|---|
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| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**17. Chronic illnesses**

Are you or any of your dependants currently taking regular, ongoing medicine, and/or are you receiving treatment for a medical condition or symptom not mentioned in the medical questionnaire?

| Yes | No |
|---|---|
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| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**18. HIV/Aids**

Are you or any of your dependants mentioned on this application HIV positive or have you been diagnosed with Aids?*

| Yes | No |
|---|---|
| | |

Please note that if you do not make a selection, Medihelp will regard your answer as "No".

* If you or any of your dependants prefer not to disclose your HIV status on this application form, you will remain responsible to inform the Scheme and to register on the Medihelp HIV/Aids programme within 21 days from your enrolment date by phoning LifeSense on 0860 50 60 80.

It is important to disclose this information to prevent the possible termination of your membership. When we receive your application to register on the HIV/Aids programme, we will determine whether underwriting conditions must be applied and, if this is the case, issue an amended proof of membership document to you.

| Name of patient | Specify illness/condition/ disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**19. Planned treatment**

Are you and/or your dependants planning to have any examination, treatment and/or procedure done in the next 12 months?

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**9.2 Medical questionnaire (continued)**

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details as all applications for pre-authorisation are reviewed which may result in the possible termination of your membership.
- Kindly note that the conditions listed below are only examples and that it is not a full list of all possible conditions, symptoms or disorders.
- 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 dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

**20. Any other conditions not mentioned**

Has any person indicated in this application 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)?

**Mark with an "X"**

| Yes | No |
|---|---|
| | |

| Name of patient | Specify illness/ condition/disorder in full | Date of diagnosis | Last date of follow-up consultation, tests or treatment | Indicate type of treatment, therapy and the **name** of the medicine used during the past 12 months |
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**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 logging on to the secured website for members, the Member Zone.**

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

**Medihelp confirms that:**

1. your and your registered dependants' 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 or marketing initiatives undertaken by Medihelp;
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 plan 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 dependants 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 dependants, 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 the provisions of the Medical Schemes Act and Medihelp's registered Rules.**
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 60 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 dependants nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.

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

11. I take note that the monthly contribution 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 contributions 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 contributions: my identity number, my tax certificate information, as well as my dependants' dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account, if applicable, 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 dependants 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 dependants 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 plans 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 benefits may be suspended should I not pay my contributions or debt in full, that my membership may be terminated should any amount still be outstanding 30 days after the date of suspension, and that my account will be handed over for collection.

19. I am aware that Medihelp may increase its contributions 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 dependants, that –

20.1 Medihelp may enquire about my health status or that of my dependants 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 dependants may enquire about my personal and medical information and that of any of my dependants 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 dependants 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 dependants' 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 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 dependants 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 dependants 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 dependants, that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependants' consumer credit record, including and not limited to information about my/my dependants' 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

## 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 CLASSIQUE MEDICAL AID CONSULTANTS

Brokerage code A 0 3 2 8 Adviser code 0 8 8 4

Name and surname of adviser

Tel No. Code 021 No. 7978885 Fax No. Code 021 No. 7978856

Email address enquiries@classmed.co.za

Signature of adviser

Date 2 0 y y m m d d

For office use only

Lead reference number M H

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

## 12. Permission for third-party access to enquiries, document requests and changing of details

Please complete this section only if you wish to grant permission to a third party not registered on your membership to have access to your Medihelp details.

I, the applicant, hereby give permission, and declare that I have obtained the consent of all my dependants, that the person stated below may:

☐ have access to my personal and medical information and that of any of my registered dependants at Medihelp's disposal, make enquiries about such information and request documentation.

☐ instruct Medihelp to register or deregister dependants, change my plan, terminate my membership and change my banking details on my behalf.

I grant the person stated below full power of authority to perform the tasks as expressly stated in this paragraph from the date as indicated, as I would have done if I were personally present.

Neither Medihelp nor its affiliates, agents, consultants or employees will be liable for any damages whatsoever, including, without limitations, any direct, indirect, special, incidental, consequential, or punitive damages, either in terms of a contract, act, delict or otherwise, that relate to any information provided to this third party or any amendments made by this third party as a result of this instruction given by me to Medihelp.

This permission will be valid until I recall it in writing. Details of the third party are as follows:

Initials and surname _____ Title | Mr | Mrs | Ms | Other (specify) |

Relation to applicant _____ ID/passport No. | | | | | | | | | | | | | |

Tel No. _____ Cell No. _____

Email address _____

Signature of applicant _____ Signature of third party _____

Date | 2 | 0 | j | j | m | m | d | d | Date | 2 | 0 | j | j | m | m | d | d |

**NB: Kindly submit a certified copy (not older than three months) of the applicant's ID/passport as well as that of the third party mentioned above, together with this form for security reasons.**