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

Individual application form 2021

P.O. Box 1101, Florida Glen, 1708 Call 0860 002 108
Fax (011) 671 5380 Email newapplications@bonitas.co.za

Medical aid start date: D D M M Y Y

Would you like pre-underwriting? YES NO

Instructions: We cannot process your application if it is incomplete, incorrect or if you have not attached the correct supporting documents. Please refer to the registered rules ("the Rules") of Bonitas Medical Fund ("the Scheme" / "Bonitas") which can be accessed at www.bonitas.co.za.

CLASSIQUE MEDICAL AID CONSULTANTS
Deon Valentine
BONITAS - 21038

Please attach the following documents to this form:
- Government employees must attach a copy of their latest salary advice
- A copy of your identity document or passport
- Copies of your previous medical aid membership certificates
- Proof of registration at a tertiary institution for child dependants between 21 and 24 years of age who are currently studying full-time

Please note: If you select BonCap you will need to complete the income verification form.

Section 1: Choosing your option (Please select one option only.)

BonComprehensive	BonClassic	BonComplete	BonSave	BonFit Select	BonStart Plus
BonStart	Standard	Standard Select	Primary	Primary Select	Hospital Standard
BonEssential	BonEssential Select	BonCap			

BonCap contributions are income based. Please select the income band that applies to your gross monthly income. You will need to attach proof of your income.

R0 to R8 980 | R8 981 to R14 590 | R14 591 to R19 930 | R19 931+

Please note: If you select the BonStart or BonStart Plus option, you agree that you have access to a mobile smartphone, data or Wi-Fi connection and therefore have internet access to make use of a virtual consultation, as and when needed.

Please sign here to accept:

Section 2: Details of main member

Please complete this section. You must submit the completed application form to your HR Department if your medical aid is through your employer.

Title: Surname:

First names:

Identity number: Tax number:

Name of employer:

Employee/Persal number: Employment date:

Marital status: Gender: M F

Ethnic group: Black | Coloured | Indian | White | Asian | Other

Cellphone: Telephone:

Email:

Postal address:

Code:

Section 3: Details of dependants

Please enter the details of any dependants you want to be covered on your option. Please attach copies of all dependants' identity numbers or passport numbers. You must also attach copies of marriage certificates, birth certificates, adoption papers or foster care court orders where applicable.

Dependant 1 Adult | Child Relationship to main member:

Title: Surname:

First names:

Identity number: Date of birth:

Marital status: Tax number:

Gender: M F

Cellphone: Telephone:

Email:

Dependant 2 Adult Child Relationship to main member:

Title: Surname:

First names:

Identity number: Date of birth:

Marital status: Tax number:

Gender: M F

Cellphone: Telephone:

Email:

Dependant 3 Adult Child Relationship to main member:

Title: Surname:

First names:

Identity number: Date of birth:

Marital status: Tax number:

Gender: M F

Cellphone: Telephone:

Email:

Dependant 4 Adult Child Relationship to main member:

Title: Surname:

First names:

Identity number: Date of birth:

Marital status: Tax number:

Gender: M F

Cellphone: Telephone:

Email:

Section 4: Broker details (To be completed by the broker or agent - if applicable)

Name of brokerage: CLASSIQUE MEDICAL AID CONSULTANTS Broker code: 21038

Name of broker/agent: Deon Valentine

Section 5: Employer information

If your medical aid is through your employer, this section must be completed by your employer and have your employer's stamp on it.

Name of company representative:

Title of company representative:

Bonitas paypoint code:

Employer stamp

We, the employer, confirm that the applicant is employed by us and began employment on the employment date stated in **Section 2**. Contributions will be deducted according to the Scheme Rules and option chosen.

Signature of employer representative: Date:

Section 6: GP nomination

If you choose the Standard Select, Primary Select or BonCap option you must nominate two GPs from the relevant Bonitas GP network for each beneficiary. You can access the GP network list when you log in to www.bonitas.co.za.

	Name and surname	First doctor's name	Practice number	Second doctor's name	Practice number
Main member:					
Dependant 1:					
Dependant 2:					
Dependant 3:					
Dependant 4:					

Section 7: Medical questionnaire

All medical questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Please note that you need to answer these questions accurately and completely. Failure to make full disclosure could result in the Scheme either failing to process your application, or cancelling your membership from the date of inception or negatively impact your claims.

Important: Has any person indicated on this application form ever suffered from, or received treatment/consulted a doctor at any time for any of the following medical conditions, illnesses or disorders? (Disorder includes affection or condition of illness.)

1. Have you or any of your dependants sought advice or been diagnosed or treated for any medical or surgical conditions in the past 12 months? (Example: back injury, kidney dialysis, pneumonia) **YES** ☐ **NO** ☐
2. Do you, or any of your dependants take any chronic medication at this stage or are expecting to take medicine on an ongoing basis in the near future? (Example: chronic medicine for diabetes, hypertension, asthma) **YES** ☐ **NO** ☐
3. Are you or any of your dependants planning or reasonably expecting to be hospitalised or to have a procedure or treatment in the next 12 months? (Example: pregnancy, gastroscopy, MRI scans, chemotherapy) **YES** ☐ **NO** ☐

Name and surname	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

4. Are there any other conditions or symptoms not mentioned above for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months that you would like to disclose? **YES** ☐ **NO** ☐

Name and surname	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

Please note that this medical questionnaire does not constitute an application to register or authorise chronic medicine/PMB services/planned procedures/treatment for benefits.

Section 8: Previous/current membership of medical scheme(s)

If any registered member is over the age of 35, it's important to provide us with all previous medical scheme information to avoid possible Late Joiner Penalty fees that may cause an increase of between 5% to 75% on monthly contributions. Please provide details of all the medical schemes where you and your dependants are currently, or have previously been enrolled.

Name and surname	Name of medical scheme	Membership number	Date of last treatment	Date joined	Date ended

Are you changing your medical scheme due to a change in employment? **YES** ☐ **NO** ☐

Have any condition-specific waiting periods been imposed by your previous medical scheme? **YES** ☐ **NO** ☐

Section 9: Banking details

Use this account for contribution collection		**Use this account for refunds only**	
Bank name:		Bank name:	
Branch code:		Branch code:	
Branch name:		Branch name:	
Name of account holder:		Name of account holder:	
Account number:		Account number:	
Account type:		Account type:	

Upon me being accepted as a member of Bonitas, I instruct Bonitas to collect my monthly contributions by debit order using the information that I stipulated above. I understand that contribution collections and transfers cannot be done to and from credit card accounts. I irrevocably authorise Bonitas to adjust any incorrect transactions and/or correct any electronic transfer or fund errors without prior notice. I, further, instruct Bonitas to deposit claims and savings refunds into my account using the account information that I stipulated above.

Account holder's signature: _____

If the account holder's details differ from the main member, we require a letter from the account holder instructing and authorising Bonitas to collect monthly contributions from the account holder's bank account. We will also require a copy of the account holder's identity document and a bank statement or a letter from the bank confirming the account holder's account details.

Section 10: Protection of your personal information

1. The Scheme will keep your and your dependants' personal information confidential and will process your and your dependants' personal information in a manner that is compliant will all applicable protection of personal information legislation as enacted from time to time.
   Your personal information refers to personal information about you, and your dependants. It includes information about your and your dependants' gender, pregnancy, age, physical and mental health and wellbeing, medical history, financial and educational status and your identifying numbers, symbols, e-mail addresses, physical addresses and telephone and other contact numbers and addresses. Processing (of personal information) means the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information.
   You understand and acknowledge that when you include your dependents on this application, the Scheme and its administrator, Medscheme Holdings (Pty) Ltd, will process their personal information for the activation of their membership of the Scheme, the administration of their health plan and to pursue their and the Scheme's legitimate interests. By submitting your dependents' personal information to the Scheme, you confirm and warrant that your dependants consent to, and have duly authorised you to share their personal information with the Scheme and its administrator for the purposes set out herein, and that you can provide the Scheme with written proof of such consent and authority on request.
2. We, have all the required data security measures in place to protect your and your dependants' personal information. This includes but is not limited to, access control measures to restrict the disclosure of personal information only to authorised individuals and confidentiality and protection-of-personal information agreements with service providers and staff members.
3. You consent that to the extent that the Scheme or its administrator requires your or your dependants' medical or health information for the purposes of managed healthcare, assessing and processing any claims or any other reason related to your and your dependants' membership of the Scheme Fund, any healthcare service provider which has such information about you and your dependants may provide same to the Scheme or its administrator for such purposes.
4. You consent thereto that the Scheme and its administrator may process your and your dependants' personal information for the following purposes:
   - Underwriting
   - Assessing and processing claims of you and your dependants and the administration of your medical scheme benefits and matters related to your membership of Bonitas;
   - The provision of managed care services to you and your dependants on your selected benefit option;
   - The provision of the personal information to any contracted third party who requires this information to provide a healthcare service to you and your dependants on your selected benefit option;
   - Fraud prevention and detection;
   - Statistical analysis and risk profiling;
   - Audit and record-keeping;
   - Compliance with legal and regulatory requirements;
   - Verifying your identity and the correctness of any other information provided to the Scheme and its administrator in applying for membership;
   - The provision of any membership services to you and your dependants;
   - Certain marketing and related activities which may be applicable from time to time, subject to such rights as you may have in law;
   - Recovery of any amounts that the Scheme paid on your or your dependants' behalf from any third party liable therefore, such as the Road Accident Fund.
5. We may share your information with the service providers for the purpose of processing it and rendering services to you, subject to such appropriate confidentiality requirement.
6. You have the right to know what personal information the Scheme holds about you. If you wish to receive this information please contact us. We will take all reasonable steps to confirm your identity before providing details of your personal information. You may access the personal information we hold of you and your dependants and request us to correct any errors.
   You agree that the Scheme and its administrator may keep your and your dependants' personal information until you request that it be deleted or destroyed. You have the right to request the Scheme to update, correct or delete your or your dependants' personal information, unless the law requires us to keep it. Where we cannot delete your or your dependants' personal information, we will take all practical steps to de-personalise it.
   You have the right to object to the processing of your personal information and have a choice whether or not to accept these terms and conditions. However, it is important to note that the Scheme and its administrator require your consent and acceptance to activate and service your Scheme membership. If you do not accept these terms and

conditions, we cannot activate and service your Scheme membership.

If you are giving consent on behalf of a dependant, you confirm that you are a competent person and/or that you have authority to give their consent for them. Competent person means anyone who is legally competent to consent to any action or decision being taken for in respect of any matter concerning a member or dependant (for example a parent or legal guardian).

Section 11: Acknowledgement and declaration

1. I, the undersigned, apply to be admitted as a member of Bonitas Medical Fund. If accepted, I agree to follow the Rules of the Scheme. I know that the Rules are available and accessible at www.bonitas.co.za and that it will be provided to me upon my request to the Scheme.
2. I declare that the information contained in this application form is true and correct. I further declare and warrant that my dependants have consented to, and have granted me permission to disclose personal information about them to the Scheme and that I am in a position to provide written proof of their consent and authority as such to the Scheme upon request.
3. I declare that any false information in this application form or the non-disclosure of any material information will result in my and my dependants', membership being declared null and void.
4. I accept that Bonitas has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure of material information, any misrepresentation made by me or any fraudulent behaviour by me or any of my dependants. If any of my or my dependants' circumstances change after the date of signing this application or the acceptance of my membership, I undertake to promptly notify the Scheme of the changes. I understand that failure to do so may lead to the termination, or amendment of the terms and conditions, of my membership. I further understand and acknowledge that the Scheme is entitled to reclaim any amounts it may have erroneously paid to any healthcare service provider on behalf of me or my dependants, from me.
5. I herewith instruct and consent to my employer deducting and paying over any amounts that may become owing or due on my and my dependants' behalf to the Scheme from time to time. I also herewith authorise and consent thereto that any persons, bodies or institutions that may hold retirement funds for my benefit, may deduct therefrom and pay to the Scheme all amounts that may become due and owing to the Scheme.
6. I understand and acknowledge that should a period greater than 3 (Three) months lapse since any of my contributions were paid to the Scheme, then should the Scheme suspend or cancel my membership, my membership will not be automatically reinstated should I pay the arrear contributions. I further understand and acknowledge that I may have to reapply for membership in such case and that full underwriting may be applied to my new membership application.
7. I agree that should the Scheme incur any legal costs or expenses to recover any contributions or any other amount due and owing by me to the Scheme for any reason, I shall be responsible for such costs and expenses on an attorney-and-client scale. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any other amount due and owing to the Scheme.
8. I understand and acknowledge that it is my responsibility to ensure that my monthly contributions are received by the Scheme. I also understand and acknowledge that if any contributions are unpaid, it may result in my and my dependants' membership with the Scheme being terminated until all arrear contributions have been settled. I also understand and acknowledge that should my membership be suspended or terminated, I will not be entitled to any benefits arising from my membership whatsoever.
9. I undertake to inform the Scheme of any changes to my or my dependants' health or personal status within 30 (Thirty) days of the change, as required by the Rules.
10. I consent to and authorise my and my dependants' healthcare service providers to disclose any personal, health, medical and/or account information and documentation relating to any ailment, disease, disorder, condition or disability, whether current or historical, to the Scheme, its administrator, its contracted managed healthcare organisations and/or and any of its other contracted service providers and partners, and to grant them access thereto upon request, provided that the information and documentation is treated as confidential. I declare and warrant that my dependants have consented to their personal, health, medical and/or account information being disclosed by their healthcare service providers to the Scheme, its administrator and its contracted service providers and partners and access provided to them as such, and that I am in a position to provide written proof of their consent as such to the Scheme upon request.
11. I agree that should I be accepted as a member of the Scheme, I and my dependants shall provide the Scheme with all information, including the above-mentioned personal, health, medical and/or financial information, that the Scheme may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Rules.
12. I further agree and understand that I and my dependants may be required to attend an examination by the Scheme's medical assessors from time to time.
13. I declare and warrant that I and my dependants are not registered as members and/or dependants of another registered medical scheme.
14. I understand and acknowledge that the following underwriting conditions may be applicable to my membership as prescribed by the Medical Schemes Act No. 131 of 1998:
    - A 3 (Three) -month general waiting period in respect of all benefits;
    - A 12 (Twelve) -month exclusion in respect of a pre-existing condition;
    - A late-joiner contribution penalty.
15. I understand and acknowledge that the underwriting conditions will affect my rights and my dependants' authorise rights to the benefits afforded in terms of our selected benefit option, if applied.
16. I consent to and authorise the Scheme to take all reasonable steps to verify information provided by me in this application form and agree to submit proof of my and my dependants' identification to the Scheme on demand.
17. I consent and agree to my telephone conversations with the Scheme's call centre being recorded and forming part of the Scheme's records. I also agree that such records will remain the sole property of the Scheme and will be made available to me on request.
18. I declare that the information provided in this application form true, correct and accurate and if accepted will form the basis of my agreement with the Scheme, read together with the Medical Schemes Act and the Rules of Bonitas. I however acknowledge that the contractual rights and obligations may be further varied through my ongoing interaction with Bonitas from time to time.
19. I acknowledge that I have read and understand the contents of this application form and where necessary, have been explained to me.
20. I hereby confirm that as the main member of the Scheme, my dependants have consented to and have granted me permission to access and view their healthcare claims made on my membership and deal with all matters relating to the claims on my membership, and that I am in a position to provide written proof of their consent as such to the Scheme upon request.
21. I hereby consent to and authorise the Scheme to share my and my dependants' personal, health and/or medical information with the Scheme's administrator, contracted managed healthcare organisations and/or or any relevant government authorities for administrative and statistical purposes, provided such information is treated as confidential at all times.
22. I understand that it is my responsibility to provide the Scheme with notice of my intention to terminate my membership, as per the Scheme's Rules, in writing by completing the relevant Termination of Membership form.
23. I agree that my and my dependants' personal, health and medical data may be shared with third parties for the purpose of membership trend analysis (e.g. employer) and for any other such purposes as may be related to our membership of the Fund, on an anonymous basis. I have read and understand these statements and my consent and permission and the consent and permission of my dependants, are given voluntarily and that I am in a position to provide written proof of my dependants' consent and permission as such to the Scheme upon request. My signature below confirms our consent and permission.

Signature of main member: _____ Date: _____