MEDSHIELD medical scheme

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

MEDSHIELD MEMBER APPLICATION

Email: newapplication@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary. All section must be completed.

Selection of Benefit Option: _____

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Date membership to commence: Y Y Y Y M M D D

Applicant's signature: _____ Date: Y Y Y Y M M D D

Consultant Declaration

Brokerage name: Classique Medical Aid Consultants

Broker code: 6 2 3 7 1 2 5 1

DOCUMENT CHECKLIST

In order to avoid rejection of your application please provide the following documents:	PLEASE TICK
ID document copy(ies) for all beneficiaries (e.g. ID / birth certificate/passport)	
Student certificate (child dependant age 21-27 that is studying or turning 21 in the next 3 months)	
Proof of previous medical scheme (certificate of membership reflecting an end date)	
Mem02 - Member Record Amendment (for Special Dependants: e.g. parents, foster child, niece, nephew, brother,sister, grandchild)	
Stamped bank statement, stamped confirmation letter from the bank, copy of cancelled cheque, signed letter of authority for 3rd Parties	
ID document copy(ies) of the nominated Third Party(ies) Consent (To whom we may provide specified information)	

I, Deon Valentine hereby understand that it is an offense to submit fraudulent business and I have explained Non-disclosure, General and condition specific waiting periods, Late Joiner Penalty, PMB and proration of benefits to the applicant.

I further declare that I have attached all documents as per the document check list above to this application form, and that the application form is submitted to the Scheme within 14 days of the member declaration sign date.

Consultant's signature: _____ Date: Y Y Y Y M M D D

SECTION A — Personal Details (attach copy of ID)

Title: Initials:

First Name(s):

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Postal Address:

Postal Code:

Residential Address:

Postal Code:

E-mail Address:

Telephone No. (W): (H): C O D E

Cell: Fax: C O D E

Tax Number: Basic Monthly Income:

Persal Number:

Please complete for marketing purposes:

Gender: Male Female

Marital Status: Single Married Divorced Widowed

Please complete for statistical purposes. If you do not wish to disclose your race, please mark the relevant box with an X.

Race: I do not wish to disclose:

SECTION B — Dependants you wish to register (attach copy of ID)

Spouse or Partner: Spouse Life Partner Divorced Spouse

Title: Initials:

First Name(s):

Surname:

Previous Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Country of Residence:

Email Address:

Telephone (Work): Cell:

Gender: Male Female

Marital Status: Single Married Divorced Widowed

Please complete for statistical purposes. If you do not wish to disclose your race, please mark the relevant box with an X.

Race: I do not wish to disclose:

Please complete a MEM02 form for special dependants (e.g. parents, foster child, niece, nephew, sibling, grandchild).
Acceptance of dependants will be in accordance with the Rules of the Scheme. Affidavits are required for Special Dependants.

Dependants (attach copies of ID or birth ce rtificate)

Name of Beneficiary	Surname (if different to Principal Member)	ID Number	Gender (M/F)	Relationship to Principal Member	Adult over 21	
1					Y	N
2					Y	N
3					Y	N
4					Y	N
5					Y	N
6					Y	N

SECTION C Family Practitioner (FP) Nomination – MediPhila, MediValue Compact and MediPlus Compact

If you have selected MediPhila, or one of the Compact options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP).
If you do not nominate a FP as per the criteria listed per option below, your application form will not be processed by the Scheme.

MediPhila
Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediValue Compact and MediPlus Compact
Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime
Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary.
Where an FP was nominated from the FP network & day to day is depleted member will qualify for an additional 2 visits per FAMILY from OAL.

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

BENEFICIARY	BENEFICIARY NAME	NOMINATED FAMILY PRACTITIONER NAME	PRACTICE NUMBER / TELEPHONE
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION D Previous Medical Aid History

Where applicable, please provide details and proof of membership for all previous registered South African medical schemes you and your dependants belonged to (membership certificates, which reflects the termination date, must be attached to this application). Failure to provide this information may result in underwriting being applied as per point 11 on the member declaration (page 6). Where a Late Joiner Penalty has already been imposed and evidence of credible cover is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the following month. No backdate will be allowed unless evidence of previous submission is provided to the Scheme.

Name of Scheme	Membership Number	Date Joined	Date Terminated

SECTION E Medical History (yes or no)

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.
Refer to member declaration, page 6, point 2.

1. Have you or any of your dependants sought advice, been diagnosed or treated for any condition within the past 12 months? Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

any additional information:

2. Do you, or any of your dependants take chronic medication or are you expecting to take medication on an ongoing basis? Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED. Your doctor or pharmacist can contact Chronic Medicine Management on 086 110 0220 to telephonically register you for chronic medication.
any additional information:

3. Have you or any of your dependants been admitted to hospital or undergone any procedure (other than routine medical or dental treatment) in the past 12 months? Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

any additional information:

4. 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 - including pregnancy? Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

any additional information:

5. 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? Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

any additional information:

Immune Deficiency Status (Confidential Disclosure)

If you, or any of your dependants, have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Programme on 086 050 6080 to register on the HIV/AIDS Disease Management Programme. Failure to do so within 21 days of joining the Scheme will be considered as non-disclosure of information and may result in termination of your membership.

SECTION F Bank Details

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account.
A stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank in the name of the Principal Member is required.
Should contributions be paid by a 3rd party, a stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank together with a signed letter of authorisation from the account holder must accompany this form. For Organisations a signed letter of authorisation needs to be on a company letterhead.
NB: If contributions are not deducted by PERSAL or your employer, payment via debit order is the preferred method for the collection of contribution payment.

☐ Use this account for contribution collections and claims refunds

☐ Use this account for contribution only

Bank Name: _____

Branch Name: _____

Bank Branch Code: _____

Type of Account: Current | Transmission | Savings

Name of Account Holder: _____

Bank Account Number: _____

Date: Y Y Y Y M M D D

Signature of Account Holder: _____

☐ Use this account for claims refunds only

Bank Name: _____

Branch Name: _____

Bank Branch Code: _____

Type of Account: Current | Transmission | Savings

Name of Account Holder: _____

Bank Account Number: _____

Date: Y Y Y Y M M D D

Signature of Account Holder: _____

SECTION G Employer Information (only for Paypoints)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date: Y Y Y Y M M D D

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section G have been completed:

Employer's Email Address:

Employer Representative's Name:

Employer Representative's Designation:

Employer Representative Signature: _____

Date: Y Y Y Y M M D D

SECTION H Important Conditions of Membership

1. **Disclaimer**
   Brochures are a summarised version and do not supersede the registered Rules of the Scheme. All benefits are paid in accordance with the registered Rules of the Scheme.

2. **Are all benefits available once I am a member?**
   Benefits are based on a 12-month period (January to December), depending on which month you join the Scheme, your benefits will be pro-rated accordingly, i.e. should you join in March, you have 10 months' benefits available. If a benefit for the year is R1 800 you will have R1 800/12 x 10 = R1500. Waiting periods are applied to some conditions, e.g. pregnancy.

3. **Do I have to wait before I can claim for benefits?**
   Yes, on pre-existing conditions, e.g. a condition prior to joining the Scheme. You will receive written notification if waiting periods are imposed.

4. **Will contributions increase after I become a member?**
   Yes. All medical schemes increase contributions from time to time when the cost of medical, dental, hospital or other health services increase or when benefits are improved.

5. **What happens when I exceed my annual benefit limits?**
   You will be liable for the payment of any excess amount directly to the service provider.

6. **Can I resign from the Scheme at any time?**
   The Scheme requires 1 calendar month notice in writing of your intention to cancel your membership.

SECTION I Member Declaration

All boxes must be ticked with an X as confirmation that you have read, understood and agree with the terms as stated.

1. ☐ I the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree to abide by its Rules and Regulations in accordance with the provisions of the Medical Schemes Act (Act 131 of 1998) as amended. I have been informed that the Scheme Rules will be made available on request and that I am responsible to read and be bound by them.

2. ☐ I certify that all the information given is true and correct and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void and that all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me, or any person on my or my dependant's behalf, under such contracts.

3. ☐ I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

4. ☐ As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

5. ☐ Notwithstanding point 3 and 4, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

6. ☐ As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

7. ☐ I hereby authorise the Scheme, or any of its nominated representatives, to confirm my bank details.

8. ☐ Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

9. ☐ I hereby authorise and request any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my / the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my / their death, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of any nature, which may be made against them as a result of, or arising out of, the disclosure of any test results or medical information.

10. ☐ The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi or by any agreed electronic means unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi or by any agreed electronic means shall be deemed to have been received by me on the 7th day after the date of posting.

11. ☐ I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

    - a 3 (three) month general waiting period in respect of all benefits;
    - a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
    - a late joiner contribution penalty.

12. ☐ Should my state of health change significantly from the date of signing this application to the date of acceptance, I will notify the Scheme in writing.

13. ☐ I hereby confirm that neither myself or any of my dependants are active beneficiaries on another medical scheme.

14. ☐ I hereby give permission, with the consent of my depedants that Medshield Medical Scheme may collect, process, store and share our personal information with the Scheme's managed care partners for the purpose of rendering medical services to me and my dependants.

15. ☐ I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: _____

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form is submitted to the Scheme within 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

Date: Y Y Y Y M M D D

SECTION J — Third Party Consent (To whom we may give specified information)

This form is to be used as a LOA (Letter of Authority) ☐ **This form is to be used as a POA** (Power of Attorney) ☐

1. About the information we provide to the Third Party

This Consent form will give Third Parties access to the Membership number, Date of birth, ID/Passport number, Postal/Email address, Physical address, Benefit option type, Limits (waiting period), Membership certificate, Tax certificate, Banking details, Contribution payment, Chronic condition(s), Claims transaction history.

2. Primary Party (Family/other adult representative)

Please note that consent may be provided to a primary party who you may wish to have access to your information.

Relationship to Principal Member:

Title: Initials:

First Name(s):

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

E-mail Address:

Telephone No. (W): (H): C O D E

Cell: Fax: C O D E

Gender:

3. Secondary Party (Family/other adult representative)

Please note that consent may be provided to a secondary party who you may wish to have access to your information.

Relationship to Principal Member:

Title: Initials:

First Name(s):

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

E-mail Address:

Telephone No. (W): (H): C O D E

Cell: Fax: C O D E

Gender:

4. Your Legal Declaration

1. This document authorises Medshield Medical Scheme to disclose and/or distribute the above information to the third party(s) indicated herein.
2. I agree that Medshield Medical Scheme accepts no liability whatsoever for any loss, including direct, indirect and consequential loss, that may arise from any disclosure contemplated herein.
3. I acknowledge that the third party who receives the specific information from Medshield Medical Scheme also indemnifies Medshield Medical Scheme from any claims that may be made by the third parties/members against Medshield Medical Scheme, resulting from the wrongful use or disclosure of the information by such third party.
4. I acknowledge that Medshield Medical Scheme subcontract some services to third parties and, as a result, I indemnify any subcontracted service provider of any liability relating to privacy where the sharing of information relates to the provision of healthcare services in terms of the Medical Schemes Act.
5. I agree that once consent is provided, all data within the selected category will be provided to the selected third party.
6. This consent will be in force until expressly withdrawn by me, even if to change to a different practitioner or employer intermediary.
7. This authority will stay enforced up until cancellation by the Principal member.
8. This consent will become null and void in the event of the death of a member or person providing consent and a new consent form should be completed by the executor appointed.
9. If you change your employment, please note to change your Employer contact if it was selected and other third party changes.

Signed at: _____ Date: Y Y Y Y M M D D

Signature of Person Giving Consent: _____

Name of Person Giving Consent: | | | | | | | | | | | | | | | | | | | | | | | | | |