Medihelp application form 2022

Corporate

Enquiries: 086 0100 678
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 with the Council for Medical Schemes in terms of the Medical Schemes Act 131 of 1998 and is a self-administered non-profit scheme.

Please use this form only in the following cases – in all other cases, please complete Medihelp's Application Form: Corporate (form 4220):

- Membership must be obtained from the date of appointment as per the agreed group underwriting policy and;
- Enrolment must take effect from 1 January and there must be no break in the applicant's coverage at the previous scheme prior to joining Medihelp.

How to complete this form:

- Complete the editable PDF form and add your signature electronically before you email the form to us. If you prefer to complete a print version, please complete the form in print using black ink and email 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, 9 and 11. Read and make sure you understand the conditions for membership in Section 9 before you sign the form. Incomplete information may delay the application process.
- Email the completed and signed form to corpapps@medihelp.co.za.

The next steps after we receive 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 use the Application in Motion (AiM) functionality on our website at https://onlineapplication.medihelp.co.za to track your application and to provide further details if necessary.
- If we offer you membership under the standard terms, your membership will be activated without issuing enrolment conditions. You and/or your adviser will be notified accordingly in writing.
- 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 the AiM functionality.
- 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 compiled for national statistical purposes 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 phone 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 and 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 only if contributions are paid in full or partially by your employer or any other institution.

Name of employer/institution _____

Campus/site _____

Branch code/employer group number _____

Payroll number _____

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

Pay area _____

Appointment

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 (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect or MedElite), please refer to section 5.2; and**
- **If you choose MedMove!, MedVital Elect, MedAdd Elect or MedPrime Elect, please refer to section 5.3.**

Vital plans	Saving plans	Comprehensive plans	
☐ MedMove!	☐ MedAdd	☐ MedPrime	☐ MedElite
☐ MedVital	☐ MedAdd Elect	☐ MedPrime Elect	☐ MedPlus
☐ MedVital Elect	☐ MedSaver	☐ MedElect	

5.2 Utilisation of savings account funds

MedAdd, MedAdd Elect and MedSaver

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 selected qualifying day-to-day medical expenses from my savings account (excluding certain in-hospital expenses such as co-payments). ☐

MedPrime, MedPrime Elect and MedElite

- If you enrol on the MedPrime, MedPrime Elect or MedElite plan, all qualifying day-to-day medical expenses will be paid from your savings account first.

5.3 Declaration by applicants who apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect

I confirm that I am aware of the following:

1. I will be liable for co-payments if I do not use Medihelp's hospital network, designated service providers (DSPs) and formulary medicine.
2. I must register my prescribed minimum benefits (PMB) condition with Medihelp and my PMB chronic medicine must be pre-authorised by Medihelp. Medihelp uses a DSP for PMB chronic medicine and a formulary applies. I will be responsible for a co-payment* on my PMB chronic medicine should I fail to obtain this medicine from the DSP or deviate from the formulary for my 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 condition** which warrants the involuntary use of a non-network hospital. I further note that in a medical emergency, 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 or 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.

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

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 phone 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 compiled for national statistical purposes by the Council for Medical Schemes):

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

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 phone number | | | | | | | | | | |

Email address _____

Relationship to applicant (please select **one** by marking with an X)

Child dependant

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

Other relative

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

If you have marked one of the options at "**Other relative**" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

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 compiled for national statistical purposes by the Council for Medical Schemes):

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

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

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 phone number | | | | | | | | | | |

Email address _____

Relationship to applicant (please select **one** by marking with an X)

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

Other relative
- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

If you have marked one of the options at "**Other relative**" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

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 compiled for national statistical purposes by the Council for Medical Schemes):

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

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 phone number | | | | | | | | | | |

Email address _____

Relationship to applicant (please select **one** by marking with an X)

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

Other relative
- ☐ Grandchild
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister

If you have marked one of the options at "**Other relative**" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

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 compiled for national statistical purposes by the Council for Medical Schemes):

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

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 phone number | | | | | | | | | | |

Email address _____

Relationship to applicant (please select **one** by marking with an X)

Child dependant

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

Other relative

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

If you have marked one of the options at "**Other relative**" and the dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), please indicate the following:

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 compiled for national statistical purposes by the Council for Medical Schemes):

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

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", please provide the following details:

Dependant's residential address _____

_____ Code | | | | |

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

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. Current membership of medical scheme

Are you currently a member of a medical scheme? Yes | No

If so, please provide us with the following

Name of medical scheme*	Membership number	Date joined*	Date ended*

Are these details the same for all dependants applying for cover? Yes | No

* This information is compulsory. If not completed, your application for membership cannot be finalised.

9. 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 employees 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. Should I or any of my dependants be HIV positive or have Aids, it will be my responsibility to inform the Scheme and to enrol on Medihelp's HIV/Aids programme within 21 days from my enrolment date by phoning LifeSense on 0860 50 60 80. If I fail to adhere to this condition, it will be considered as the non-disclosure of information, which may result in the termination of my membership.
10. Should I need to obtain authorisation for chronic medicine, I will phone Medihelp on 086 0100 678 once my membership of Medihelp has been finalised, to obtain an application form for chronic medicine benefits. Alternatively, I 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.
11. 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.
12. 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.
13. I take note that the monthly contribution fees will be due on the date of my enrolment 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.
14. 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:

15. 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.
16. 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.
17. Medihelp's Rules may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and using designated service providers.
18. Medihelp may also restrict interchanges between plans to the beginning of a year, and require a notice period as set out in the Rules.
19. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.

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

20. 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.
21. I am aware that Medihelp may increase its contributions annually at the beginning of the year.

Protection of information:

22. I hereby give permission, and declare that I have obtained the consent of all my dependants, that –

22.1 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;

22.2 My dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;

22.3 Any adviser appointed by me and whose appointment is accepted by Medihelp, 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;

22.4 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

22.5 Medihelp may share my information for statistical analysis and academic research purposes.

23. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
24. 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.
25. 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.
26. 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

10. 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 or 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.

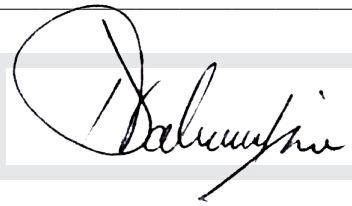
Name of brokerage CLASSIQUE MEDICAL AID CONSULTANTS

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

Name and surname of adviser Deon Valentine

Telephone number Code 021 No. 7978885 Fax 021 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.

11. Third-party access (optional)

NB: Complete this section only if you wish to give permission to a third party (other than your adviser) to handle your Medihelp affairs on your behalf.

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 number | | | | | | | | | | | | | |

Telephone number _____ Cell phone number _____

Email address _____

Signature of applicant | | Signature of third party | |

Date | 2 | 0 | y | y | m | m | d | d | Date | 2 | 0 | y | y | 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.

uppe marketing A30074

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