



Medihelp application form 2024 Corporate

Enquiries: 086 0100 678
Email: corpapps@medihelp.co.za
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 if Medihelp has an agreement with your employer. In all other cases, please complete Medihelp's Application Form: Corporate (form 4220).

How to complete this form

- Complete the editable PDF form and add your signature electronically before you email it to us. Printed forms must be completed in print using black ink. Please make sure to email or post all pages of the form to Medihelp.
- Please complete all sections in full and sign the application form, also Sections 5, 7, and 9. Please read the conditions for membership in Section 9 carefully before you sign the form and make sure that you have completed all the details. 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

- Medihelp will contact you should any details be omitted or if any additional information is required. 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.
- Your membership will be activated without issuing enrolment conditions in accordance to the agreed group underwriting policy.
- You will be notified when your application has been finalised.

1. When would you like your cover to start? 2 0 y y m m d d

Please note that no person may be enrolled as a member of Medihelp while such person is a member of another medical scheme. Refer to paragraph 12 of Section 9 of this application form.

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Married in community of property/ customary marriage	Married out of community of property	Single/ not married	Engaged/ cohabitant/ life partner	Divorced	Widow/ widower	Other (specify)	

Date of birth Date of marriage

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

Cell phone number*

Personal email address*

* This information is compulsory and is required to communicate important information to you about your rights, benefits, and duties as a member. If not completed, your application for membership cannot be finalised.

Telephone number (W) Telephone number (H)

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 applies to you:

Visually impaired Yes No Hearing impaired Yes No

3. Your contact information

Is your postal and residential address the same? Yes No

Residential address

House/unit number and building name _____ House/building number and street name _____

 Suburb _____ City _____
 Province _____ Postal code

Postal address

House/unit number and building/organisation name _____ PO Box/house/building number and street name _____

 Suburb _____ City _____
 Province _____ Postal code

This information is compulsory. If not completed, your application for membership cannot be finalised. Refer to paragraph 8 of Section 9 of this application.

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 Appointment Permanent Temporary
 Pay area _____

Office stamp of employer

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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, MedElect or MedPrime Elect please refer to Section 5.3.

Basic plans <input type="checkbox"/> MedMove! <input type="checkbox"/> MedVital <input type="checkbox"/> MedVital Elect	Saving plans <input type="checkbox"/> MedAdd <input type="checkbox"/> MedAdd Elect <input type="checkbox"/> MedSaver	Comprehensive plans <input type="checkbox"/> MedPrime <input type="checkbox"/> MedPrime Elect <input type="checkbox"/> MedElect <input type="checkbox"/> MedElite <input type="checkbox"/> MedPlus
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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.

• Do you prefer that Medihelp should pay all in-hospital co-payments from your savings account? Yes No

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. Select a plan that will suit your needs by marking your choice with an “X” (continued)**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:

- I will be liable for co-payments if I do not use Medihelp's network facilities, designated service providers (DSPs), and formulary medicine.
- I must register my prescribed minimum benefits (PMB) conditions with Medihelp and my PMB chronic medicine must be pre-authorized 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 get this medicine from the DSP or deviate from the formulary for my plan.
- My treating specialists should form part of Medihelp's DSP specialist network to prevent co-payments on PMB treatments.
- I must use Medihelp's network facilities for all planned hospital admissions. If there is no network facility available near my place of residence, I will need to travel to the nearest network facility to obtain medical services. If I use a non-network facility 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 facility. I further note that in a medical emergency, authorisation for admission to a network facility should be obtained on the first workday after the admission if I am unable to get 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	<input style="width: 95%; height: 30px;" type="text"/>	Date	<input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="d"/> <input type="text" value="d"/>
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6. Your dependants whom you want to register

You may register the following persons as dependants:

- Spouse/partner
- Own children of the applicant and spouse/partner
- Stepchildren of the applicant and spouse/partner
- Adopted children or in the process of adoption/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner

If any of the following persons are dependent on the applicant for family care and support, they may be registered as dependants:

- Father/mother/brother/sister of the applicant
- Grandchildren of the applicant

PLEASE NOTE

- Grandchildren of the applicant pay the same contribution as that of an adult dependant, unless legally adopted.
- 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.

The following persons may not be registered as dependants of the applicant:

- Stepbrothers and stepsisters
- Step-grandchildren
- Stepparents
- Grandchildren of the applicant's partner
- In-laws
- Godchildren
- Cousins

We require the following supporting documents to ensure your quick enrolment:*

Dependants	Document required
<ul style="list-style-type: none"> Adopted children or children in the process of adoption/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner. 	<ul style="list-style-type: none"> Legal documentation confirming that the child was adopted or in the process of adoption/placed in foster care/temporary safe care of the applicant. 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.
<ul style="list-style-type: none"> Child (if surname differs from the applicant's surname). 	<ul style="list-style-type: none"> Unabridged birth certificate confirming the birth parents of the child.

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

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

Surname	<input style="width: 95%;" type="text"/>	Title	<input type="text" value="Mr"/> <input type="text" value="Mrs"/> <input type="text" value="Ms"/> <input type="text" value="Other (specify)"/>	
First names in full	<input style="width: 95%;" type="text"/>			
Known as	<input style="width: 95%;" type="text"/>			
ID/passport number	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	Gender	<input type="text" value="Male"/>	<input type="text" value="Female"/>
Date of birth	<input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="d"/> <input type="text" value="d"/>	Cell phone number	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	
Email address	<input style="width: 95%;" type="text"/>			

6. Your dependants whom you want to register (continued)

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

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired Yes No Hearing impaired Yes No

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”, provide your dependant’s residential address.

House/unit number and building name _____ House/building number and street name _____
Suburb _____ City _____
Province _____ Postal 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 _____

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired Yes No Hearing impaired Yes No

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

Child dependant Own child Child born in terms of a surrogate motherhood agreement **Other relative** Grandchild Brother
 Adopted child Stepchild Mother Sister
 Foster child Child in temporary safe care Father

If you have marked one of the options at “Other relative” and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), 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”, provide your dependant’s residential address.

House/unit number and building name _____ House/building number and street name _____
Suburb _____ City _____
Province _____ Postal code [][][][]

6. Your dependants whom you want to register (continued)

Dependant 4 (continued)

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
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If "No", provide your dependant's residential address.

House/unit number and building name _____ House/building number and street name _____

 Suburb _____ City _____
 Province _____ Postal 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 _____
 Name of account holder _____

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 used 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
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If so, please provide us with the following

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

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

Are these details the same for all dependants applying for cover?

Yes	No
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9. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information

Medihelp confirms that:

- 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.
- 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.
- 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.

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

Medihelp confirms that: (continued)

4. The Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy.
5. Should you use a Medihelp-contracted brokerage's services then relevant membership information will be made available to the appointed brokerage 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. I will also study my benefit guide and familiarise myself with the coverage offered by the benefit 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 financial adviser or any other third party completed this application 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 calling 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 get authorisation for chronic medicine, I will call Medihelp on 086 0100 678 once my membership of Medihelp has been finalised, to get 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 for 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.
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 whom I appoint and whose appointment Medihelp accepts 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

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

Protection of information (continued)

- 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 (POPIA), No. 4 of 2013.
- 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.
- 27. If you believe that Medihelp has used your personal information contrary to its Privacy Policy, you have the right, under the Protection of Personal Information Act, to lodge a complaint with the Information Regulator. However, we encourage you to first follow our internal complaints process to resolve the matter. If, thereafter, you believe that we have not resolved the matter adequately, you can contact the Information Regulator at: The Information Regulator (South Africa), JD House, 27 Siemens Street, Braamfontein 2017, Telephone number: 010 023 5207, Email: PAIAComplaints@inforegulator.org.za or POPIAComplaints@inforegulator.org.za.
- 28. If you believe that Medihelp has not handled your enquiry satisfactorily, please first follow our internal complaints process to resolve the matter. If thereafter, you believe that we have not resolved the matter adequately, you can contact the Council for Medical Schemes (CMS), as Medihelp is a registered medical scheme and regulated by the CMS. The CMS' contact details are as follows:
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, Customer Care Centre: 0861 123 267, Email: complaints@medicalschemes.co.za, Website: www.medicalschemes.co.za.

Signature of applicant	Date
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Should you be applying on behalf of another person as guardian, curator or authorised representative, please complete the following:

In your capacity as	Guardian	Curator	Power of attorney (legal appointment)
ID/passport number	Title Mr Mrs Ms Other (specify)		

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator/power of attorney, must accompany this application. If you are signing as the applicant's parent, a copy of your passport/ID document and the applicant's birth certificate must accompany this application.

First name	Surname
Telephone number (W)	Cell phone number

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
Name and surname of adviser	SHAMIEM AHMED	
Telephone number	0 2 1 7 9 7 8 8 8 5	Fax 021 7978856
Email address	enquiries@classmed.co.za	

Signature of adviser	Date
	2 0 y y m m d d

Lead reference number	For office use only
	M H

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