Please email completed applications to enquiries@classmed.co.za

Medihelp application form 2025

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
- Submitting your application online on Medihelp's website allows for immediate confirmation of receipt and faster processing. Please visit our webiste at https://onlineapplication.medihelp.co.za
- Complete all sections in full using black ink and sign sections 5, 7 and 9. Please read the conditions for membership in section 9 carefully before you sign the form. Incomplete information may delay the application process.
- Email the completed and signed form to corpapps@medihelp.co.za.

Next steps after we receive your application
- Medihelp will contact you if we need any additional information. You can also use the Application in Motion (AiM) functionality on our website at https://onlineapplication.medihelp.co.za to track your application and provide further details, if necessary.
- If we offer you membership with standard terms, your membership will be activated without issuing enrolment conditions. We will notify you and/or your adviser in writing.
- If we offer you membership with any non-standard terms (with waiting periods and/or late-joiner penalties), we will notify you and/or your adviser in writing, and stipulate the conditions that will apply to your membership. To accept these terms, you can go to AiM and accept the enrolment conditions to activate your membership.
- We will notify you when we have finalised your application.
- Once you receive communication with a link to register on the Member Zone, you can download your digital membership card.

1. When would you like your cover to start?

2	0	y	y	m	m	d	d

Please note that the enrolment date will be the first day of the month after the application is finalised or the future date requested. No person may be enrolled as a member of Medihelp while they are a member of another medical scheme. Please refer to paragraph 12 of section 9 of this application form.

2. Your information (person who requests membership)

If you use your passport number, please attach a copy of your passport.

ID/passport number | | | | | | | | | | | | | |

Title: Mr | Mrs | Ms | Other (specify)

Date of birth: y y y y m m d d

Surname ______________________ Initials ______________________

First names ______________________ Gender: Male | Female

Preferred name ______________________

Marital status: Married | Unmarried

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 used for national statistical purposes by the Council for Medical Schemes.

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

3. Your contact information

Please note: We communicate with our members exclusively through electronic channels.

Residential address*

House/unit number ______________________ Complex/building name ______________________

Street name ______________________

Suburb ______________________ City ______________________

Province ______________________ Postal code ______________________

3. Your contact information (continued)

Cell phone number* [ ]

Personal email address* ______

*All contact information is compulsory, as we need it to communicate important information about your rights, benefits, and duties as a member. Without this information, we will not be able to finalise your application for membership.

Telephone (W) [ ] [ ] Telephone (H) [ ] [ ]

To enable us to communicate effectively with you, we would like to know if the following applies to you:

Visually impaired [Yes] [No] Hearing impaired [Yes] [No]

4. Details of your employer/the institution responsible for paying your contribution

NB: Complete only if your contribution is paid, either in full or in part, by your employer or any other institution.

Name of employer/institution ______

Campus/site ______

Branch code/employer group number ______

Office stamp of employer

Payroll number ______

Appointment date y y y y m m d d

Appointment type [Permanent] [Temporary]

Pay area ______

5. Mark your plan choice with an "X"

5.1 Plans

Note

- If you choose a plan with a savings account (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect, or MedElite), please read section 5.2; and
- If you choose MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect, or MedElect, please read section 5.3.

Basic 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.

- Do you want Medihelp to 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.

5.3 Declaration if you apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect, or MedElect

I confirm that I am aware of the following:

1. **Co-payments:** I will be liable for co-payments if I do not use Medihelp's network facilities, designated service providers (DSPs), and formulary medicine.
2. **Chronic medicine:** I must register my prescribed minimum benefit (PMB) conditions with Medihelp, and my PMB chronic medicine must be pre-authorised by Medihelp. Medihelp uses a DSP for PMB chronic medicine and a formulary (medicine list) applies. If I do not get my PMB chronic medicine from the DSP or if I deviate from the formulary for my plan, I will be responsible for a co-payment* on my PMB chronic medicine.
3. **Network doctors:** To avoid co-payments on PMB treatments, any specialists consulted must form part of Medihelp's DSP specialist network.
4. **Network facilities:** 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 have to travel to the nearest network facility for medical services. If I use a non-network facility instead, I will be liable for a co-payment*, unless the treatment required is for a medical emergency* that warrants the involuntary use of a non-network facility. I further note that in a medical emergency, authorisation for admission to the 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 the Member guide 2025 for all applicable co-payments and the definition of a medical emergency. Visit the Medihelp website at www.medihelp.co.za, click on Plans, then Compare plans, and download the 2025 plan comparison.

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

6. Dependants 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 children in the process of being adopted/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 they have been legally adopted as children.
- Foster children and children in temporary safe care may be registered as dependants only up to the age of 21, in accordance with legislation.
- If a dependant is not a South African citizen, a copy of their passport must be submitted with the completed application.
- When registering a partner as a dependant, you confirm that you are in a domestic partnership, and undertake to inform Medihelp within 30 days if your relationship status changes.

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
- Grandparents
- Nieces and nephews

To avoid delays in your enrolment process, please attach the following supporting documents:*

Dependant	Document required
• Adopted children or children in the process of being adopted/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner	• Legal documentation confirming that the child has been adopted or is in the process of being adopted/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
• Child (if surname differs from the applicant's surname)	• Unabridged birth certificate confirming the birth parents of the child

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

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

Dependant 1

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

First names in full ____________________

Preferred name ____________________

If a passport number is used, please attach a copy of the passport.

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d | Cell phone number * | | | | | | | | | | |

Personal email address * ____________________

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this 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 used for national statistical purposes by the Council for Medical Schemes.

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

6. Dependants you want to register (continued)

Dependant 2

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

First names in full ____________

Preferred name ____________

ID/passport number ____________ Gender | Male | Female

Date of birth | y | y | y | y | m | m | d | d | Cell phone number * ____________

Personal email address * ____________

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this 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; Adopted child; Stepchild; Foster child; Child in temporary safe care

Other relative: Grandchild; Brother; Mother; Sister; Father

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black; Coloured; Indian/Asian; White; Other

Dependant 3

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

First names in full ____________

Preferred name ____________

ID/passport number ____________ Gender | Male | Female

Date of birth | y | y | y | y | m | m | d | d | Cell phone number * ____________

Personal email address * ____________

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this 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; Adopted child; Stepchild; Foster child; Child in temporary safe care

Other relative: Grandchild; Brother; Mother; Sister; Father

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

Black; Coloured; Indian/Asian; White; Other

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7. Banking details for deducting contributions and refunding credit amounts

Bank

Branch

Branch code

Type of account

Initials and surname of accountholder

Account number

This account will be used to deduct contributions by debit order and refund credit amounts. In the 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 contribution in full, the banking details supplied will only be used for credit refunds.

Complete this section if a third party pays the contribution on behalf of the applicant.

This information is compulsory, as this is a requirement for South African Revenue Services (SARS) purposes.

I, the undersigned, hereby agree to pay the monthly medical scheme contribution on behalf of the member. I also authorise Medihelp Medical Scheme to deduct the contribution from my bank account.

If a third party will be paying the contribution on behalf of the member, please attach the following supporting documents, not older than three months:

- Accountholder's identity document/passport/driver's license
- Accountholder's bank statement/confirmation of bank account

ID/passport number

Title

Mr	Mrs	Ms	Other (specify)

Surname

Initials

First name

Nature of payer (for example, individual, company, trust, etc.)

Physical address

Registered company name

Company registration number

Income tax number

Cell phone number

Relationship to member

Email address

Signature of applicant

Signature of accountholder

8. Previous and/or current membership of medical schemes

Are you currently a member of a medical scheme? If so, please provide us with the following: Yes No

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

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

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

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

Medihelp confirms the following:

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. All employees and contracted parties who have access to your data for these purposes have signed a confidentiality agreement 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.
5. If you use a Medihelp-contracted brokerage's services, then relevant membership information will be made available to the appointed brokerage in order to provide a service to you, and any authorised person at the brokerage may instruct Medihelp to change any of your personal information except 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 the Rules of Medihelp 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 cover offered by the plan that I choose.
7. I will abide by the Rules of Medihelp, as amended from time to time and available at www.medihelp.co.za on the self-service platform for members, and 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 me and my dependants, even if this application was completed by my financial adviser or any other third party on my behalf. I will notify Medihelp in writing if there are any changes in my health status or that of my dependants after my application for membership has been submitted, but before my membership start date. I confirm that the residential address stated in section 3 is the address that I choose for the purpose of serving any legal documentation. I will notify Medihelp in writing of any future changes to my personal details and/or banking details. I understand that failure to do so may result in my membership being terminated in accordance with the Medical Schemes Act 131 of 1998 and the registered Rules of Medihelp.
9. If I or any of my dependants are HIV positive or have Aids, it is 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 non-disclosure of information, which may result in the termination of my membership.
10. If 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 signing in to the self-service platform 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, after which 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 first day of enrolment and thereafter on the first day of each 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, if I terminate my membership of Medihelp.
14. I note that a third party paying the contribution on my behalf is not part of the contract with Medihelp and will not receive communication regarding changes in the monthly payable contribution. I undertake to inform the third party of any changes in my contribution and accept that I remain responsible for the payment thereof.

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

Your responsibilities as a member of Medihelp (continued)

15. 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

16. 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 if no waiting period and/or late-joiner penalty is imposed.
17. 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.
18. The Rules of Medihelp may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and using designated service providers.
19. Medihelp may also restrict interchanges between plans to the beginning of a year, and require a notice period as set out in the Rules.
20. Medihelp may refuse to pay a claim that is submitted after the period prescribed in the Rules.
21. I am further aware that my benefits may be suspended if I fail to pay my contributions or debt in full, that my membership may be terminated if any amount remains outstanding 30 days after the date of suspension, and that my account will be handed over for collection.
22. I am aware that Medihelp may increase its contribution annually at the beginning of the year. I also authorise Medihelp to adjust the contribution if necessary due to a change in my membership and deduct the amended amount or any outstanding contribution amounts, from me or the third-party payer/employer/institution I indicated as the authorised payer of my contribution.

Protection of information

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

23.1 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 plan;

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

23.3 Any adviser 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;

23.4 Medihelp may disclose my and my dependants' medical and personal information to healthcare providers for the purpose of delivering medical services to me and my dependants, and to pay for such services; and

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

24. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
25. 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.
26. 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.
27. 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.
28. 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, but 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 Stiemens Street, Braamfontein 2017, telephone number: 010 023 5207,
email: POPIAComplaints@inforegulator.org.za.
29. 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's 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.

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

Protection of information (continued)

If you are signing as the applicant's parent and your child is younger than 18, please attach a copy of your passport/ID document and the applicant's birth certificate.

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

If you are signing as the applicant's parent and your child is 18 years and older, please attach the following:

A copy of your passport/ID document as well as the document confirming your appointment as guardian/curator/power of attorney.

If you are applying on behalf of another person as parent, guardian, curator, or power of attorney, please complete the following:

In your capacity as: Parent ☐ Guardian ☐ Curator ☐ Power of attorney (legal appointment) ☐

ID/passport number ______________ Title: Mr / Mrs / Ms / Other (specify)

First name ______________ Surname ______________

Telephone number (W) ______________ 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 it is not provided, your application for membership cannot be finalised.

Relationship to applicant ______________

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 their 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: 4 1 2 8

Name and surname of adviser: SHAMIEM AHMED

Telephone number: 0 2 1 7 9 7 8 8 8 5

Email address: enquiries@classmed.co.za

Signature of adviser [signature] Date 2 0 y y m m d d

Lead reference number ______________

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

MHNN005 SEPTEMBER 2024

medihelp
Medical Aid in Action