MEDSHIELD
your kind of care

MEDSHIELD MEMBER APPLICATION

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 sections must be completed.

Please note: Copies of ID/Passport numbers must be provided for the principal member as well as all beneficiaries. Should this be outstanding, your application cannot be processed.

Selection of Benefit Option: ____________________

Membership number: (for office use only): | | | | | | | | | | | |

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: B S C o n s u l t i n g

Healthcare consultant:

Brokerage number: 6 2 3 0 2 1 2 5

Agent name: B r a d l e y S a y e r s

Agent number: 0 8 2 9 5 5 8 9 5 7 email - bradley.say@gmail.com

I, ____________________ hereby understand that it is an offence to submit fraudulent business and have explained the following to the prospective member:

Non-disclosure ☐ General and condition specific waiting periods ☐ Pro-rating of benefits ☐ Late Joiner Penalty ☐

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

BS-Consulting
Broker code - 62302125

Section A Personal Details (attach copy of ID)

Title: Initials:

First Name:

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): C O D E (H): C O D E

Cell No: Fax: C O D E

Tax Number: Basic Monthly Income: R

Persal Number:

Please complete for marketing purposes

Race: Gender: Male Female Marital Status: Single Married Divorced Widowed

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 No. (w): C O D E (H): C O D E

Cell No:

Race: Gender: Male Female Marital Status: Single Married Divorced Widowed

Special dependants (e.g. parents, foster child, niece, nephew, brother, sister, grandchild),
Please complete a MEM02 form. Acceptance of dependants will be in accordance with the Rules of the Scheme.
An affidavit is required for special dependants

Dependants (attach copies of ID or Birth Certificate)

Name of Beneficiary	Surname (If different to Principal Member)	ID Number	Gender (M/F)	Relationship to principal member	Adult over 21 (Yes/No)
1					
2					
3					
4					
5					

Section C Previous Medical Aid History

Where applicable, please provide details and proof of membership of all previous medical schemes cover. (Membership certificates which reflect a termination date must be attached to this application). Failure to provide this information will result in a late joiner penalty fee.

Name of Scheme	Membership Number	Date Joined						Date Terminated					
		Y	Y	M	M	D	D	Y	Y	M	M	D	D
		Y	Y	M	M	D	D	Y	Y	M	M	D	D
		Y	Y	M	M	D	D	Y	Y	M	M	D	D
		Y	Y	M	M	D	D	Y	Y	M	M	D	D
		Y	Y	M	M	D	D	Y	Y	M	M	D	D

Section D Medical History

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

Have you or your dependants sought any advice, been diagnosed with, been treated for or suspect that you may have any of the following conditions within the last **12 months?** If Yes to any of the questions please provide full details, should you require additional space please add an additional page to the application form.

1. Any chronic illnesses? e.g. Cardio and vascular conditions, Obstructive lung disease, Diabetes, insulin or non insulin dependent diabetes mellitus, Thyroid or other glandular or blood disorders, etc. Y N

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

2. Skin, muscle or bone disease? e.g. Any skin rash, acne, eczema or psoriasis, multiple sclerosis, osteo or rheumatoid arthritis,osteoporosis, injury, back / neck or joint problems or replacement, fibromyalgia, prosthetic limbs, lumbago sciatica, spasms, etc. Y N

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

3. Digestive system, stomach, liver, gall bladder or pancreas? e.g. Stomach or duodenal ulcer, GORD/heartburn, hiatus hernia, Crohn's disease, ulcerative colitis, irritable bowel syndrome, rectal bleeding, hepatitis, cirrhosis, liver failure, etc. Y N

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

4. Psychiatric conditions? e.g. Schizophrenia, bipolar mood disorder, substance abuse, eating disorder, depression, panic attacks and / or Anxiety, ADHD or post traumatic stress disorder, etc. Y N

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

5. Complaints of the nervous system or brain? e.g. Epilepsy, stroke, blackouts, migraine, headaches, paralysis, Parkinson's or Alzheimers.

Y	N

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

6. Complaints/disorder of the Ear, nose, throat or eye? e.g. Defective vision, cataracts, glaucoma, eye disorders, blindness, retinitis, disorders of the cornea or wear spectacles or contact lenses, hearing loss, ear discharge, otitis media, allergies or recurrent tonsillitis, etc.

Y	N

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

7. Urinary tract, genital system or gynaecological disorders? e.g. UTI , kidney stones, kidney failure, prostatitis, sexually transmitted disease, HRT, ovarian cysts, fibroids, menstrual disorders or any abnormality of pregnancy or confinement, etc.

Y	N

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

8. Are you or any of your dependants pregnant or suspect that you are pregnant?

Y	N

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

9. Malignant or Benign neoplasms? e.g. cancers, malignant or non-malignant tumours/growths of any kind including removal of malignant or benign moles, etc.

Y	N

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

10. Dentistry? e.g. Specialised dentistry/maxillo-facial treatment (currently undergoing or anticipating any specialised/ orthodontic or maxillofacial treatment), etc.

Y	N

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

11. Any other medical condition not listed in question 1 - 10?

Y	N

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

12. Prescribed Medication

A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.
Please supply details of any prescribed medication that you or any of your dependants are currently taking or expect to take in the future. Your doctor or pharmacist can contact MHRS on 086 010 0608 to telephonically register you for chronic medication.

Question No.	Name of Beneficiary	Condition and Duration of Condition	Name of Attending Doctor	Date of Treatment

13. Surgery and Hospital Admissions

Please supply details of any surgery or HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past 12 months, and/or details of all planned surgical procedure(s) and HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future.

Name of Beneficiary	Surgical Procedure/ Hospital Admission	Date	Reason	Doctor	Current Condition

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 Program on 086 050 6080 for more information on how to join the Programme.

Section E MediPhila only (Select GP from network)

Name of Beneficiary	Name of Doctor	Practice Number							
1									
2									
3									
4									
5									

Section F Bank Details

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account.
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.

***Should the bank details provided for debit order details not be that of the principal member of the scheme a bank statement is required.**

NB: if bank details are in the name of an Oganisation/Company a "Letter of Authority" on company letterhead must accompany this form.

☐ 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 (If Applicable): ____________________
Employee Payroll No.: ____________________
Employment Date: Y Y Y Y M M D D

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the Scheme Rules and option chosen. All sections of the application form have been completed.

COMPANY STAMP

Employer's Email Address: ____________________
Employer Representative's Name: ____________________
Employer Representative's Designation: ____________________

Date: Y Y Y Y M M D D

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 months notice in writing of your intention to cancel your membership.

Member Declaration

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 which will be deemed to be my postal address unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi 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 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: ______________________________

Date: | Y | Y | Y | Y | M | M | D | D |

Consent for Disclosure of Information to 3rd Party

Please complete the below should you require a nominated person to contact/make changes to your Medshield Medical Scheme membership on your behalf (i.e. a family member, attorney, etc.) - Please note that this is not complusory and merely for your convenience, should you so choose.

Title: Initials:

First Name/s:

Surname:

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

Relationship to Member:

Title: Initials:

First Name/s:

Surname:

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

Relationship to Member:

DOCUMENT CHECK LIST

In order to avoid delays in processing your application, please provide the following documents:	PLEASE TICK
ID copies\Birth certificate (of all beneficiaries)	
Student certificate (dependants over 20 years old)	
Proof of previous medical scheme (certificate of membership reflecting an end date)	
MEM02 - Member Record Amendment (for special dependants)	
Persal payslip (for Persal members)	

MEDSHIELD MEDICAL SCHEME

P.O. Box 4346, Randburg, 2125
www.medshield.co.za
newapplication@medshield.co.za
fax: 010 597 4710
Contact Centre: 086 000 2120
Mon - Fri 8:30 - 17:00

BANK DETAILS

Account Holder: Medshield Medical Scheme
Bank: Nedbank
Branch: Rivonia, 196905
Account number: 1969125969

MEDSHIELD medical scheme

FAMILY PRACTITIONER (FP) NOMINATION FORM

Email: membership@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. All sections must be completed in full. The completed form needs to emailed to membership@medshield.co.za

SECTION A — DETAILS OF PRINCIPAL MEMBER

Membership Number:			
Title:		Initials:	
First Name/s:			
Surname:			
ID/Passport Number:			
Date of Birth:			
Email Address:			
Cell Number:			
Additional Cell Number:			

SECTION B — FAMILY PRACTITIONER (FP) NOMINATION

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.

MediCurve: Each Beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

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 a FP was nominated from the FP Network & Day-to-Day benefit is depleted the 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

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
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

Signature of Principal Member: ____________________ Date: ____________

NEW BORN REGISTRATION

Email: membership@medshield.co.za

This form needs to be completed for the registration of your newborn baby.
Please note that a newborn baby is defined as a biological child of the Principal Member or spouse born into the Scheme.
In order for your newborn baby to be registered from date of birth, you must register your newborn on the Scheme within 60 days from date of birth.

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

A COPY OF THE BIRTH CERTIFICATE FOR YOUR NEWBORN BABY MUST ACCOMPANY THIS FORM.

Membership Number:

SECTION A — TO BE COMPLETED BY PRINCIPAL MEMBER

Member ID Number:

Member Name:

Member Surname:

SECTION B — NEWBORN'S DETAILS

Dependant 1

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number:

Relationship to Principal Member:

Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

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

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other

I do not wish to disclose:

Dependant 2

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number:

Relationship to Principal Member:

Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

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

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other

I do not wish to disclose:

SECTION C

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.

MediCurve: Each beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

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 a FP was nominated from the FP Network & Day-to-Day benefit is depleted the 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 EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date:

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

COMPANY STAMP

Tick this box if no Company Stamp is available

By selecting this box you confirm that the Employer has granted approval

Employer's Email Address:	
Employer's Representative's Name:	
Employer's Representative's Designation:	
Date:	

Employer's Representative's Signature: ______________________________

SECTION E MEMBER DECLARATION

I, ____ (Principal Member's full name) the undersigned, declare that: I understand that Medshield will rely upon the facts set out herein for the accurate loading of details. I understand and accept that should any details contained herein prove to be incorrect, or should I fail to inform Medshield of any subsequent change to the details, Medshield will not be held responsible.

Principal Member Signature: ____________________________________ Date: ____________

MEDSHIELD medical scheme

MEMBER RECORD AMENDMENT/DEPENDANT REGISTRATION

Email: membership@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.

This form needs to be 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.

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

SPECIAL DEPENDANTS ARE SUBJECT TO SCHEME APPROVAL.

SECTION A DOCUMENT CHECKLIST

In order to avoid rejection of your application please provide the following documents:	Please Tick
ID copy(ies) for dependants (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 income for dependants 21 and older that's not studying	
Certified affidavits for special dependant: - Certified affidavit from Principal Member stating that dependant resides with member and is financially on him/her. - Certified affidavit from dependant's parents providing reasons and permission for dependant to be added to the Principal Member's membership	
Proof of previous medical scheme for dependant (certificate of membership reflecting an end date)	
Legal custody documents	
Marriage certificate for the registration of spouse	

SECTION B DETAILS OF PRINCIPAL MEMBER (must be completed)

Membership Number:

Initials & Surname:

ID/Passport Number:

Contact Telephone Number:

CHANGE OF ADDRESS/CONTACT DETAILS (In the event that your details have changed, please complete the below)

Postal Address:

Postal Code:

Residential Address:

Please provide at least one email address

Personal Email Address:

Business Email Address:

Telephone Number (W):	
Telephone Number (H):	
Cell Number:	

SECTION C REGISTRATION OF DEPENDANTS

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.

DEPENDANT 1

Life Partner / Spouse	Aged Parent	Sibling	Grandchild	Over Aged Child
Late Registration of Own Child	New Born/Foster or Adopted	Other (please specify):		

Title:		Initials:	
First Name/s:			
Surname:			
Maiden Surname:			
ID/Passport Number:			
Date of Birth:			
Dependant Email Address:			
Dependant Telephone Number (W):			
Dependant Telephone Number (H):			
Dependant Cell Number:			

Gender: (Mark with an X)	M	F	Marital Status:	Single	Married	Divorced	Widowed

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

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

DEPENDANT 2

Life Partner / Spouse	Aged Parent	Sibling	Grandchild	Over Aged Child
Late Registration of Own Child	New Born/Foster or Adopted	Other (please specify):		

Title:		Initials:	
First Name/s:			
Surname:			
Maiden Surname:			
ID/Passport Number:			
Date of Birth:			
Dependant Email Address:			
Dependant Telephone Number (W):			

Dependant Telephone Number (H):								
Dependant Cell Number:								
Gender: (Mark with an X)	M	F	Marital Status:	Single	Married	Divorced	Widowed	

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

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

DEPENDANT 3

Life Partner / Spouse	Aged Parent	Sibling	Grandchild	Over Aged Child
Late Registration of Own Child	New Born/Foster or Adopted	Other (please specify):		

Title:		Initials:					
First Name/s:							
Surname:							
Maiden Surname:							
ID/Passport Number:							
Date of Birth:							
Dependant Email Address:							
Dependant Telephone Number (W):							
Dependant Telephone Number (H):							
Dependant Cell Number:							
Gender: (Mark with an X)	M	F	Marital Status:	Single	Married	Divorced	Widowed

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

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

If student dependant is over the age of 20, student proof in the form of a stamped or signed letter, on a letterhead from the accredited institution for tertiary education for the current year must accompany this form.

In the event that you are requesting the Scheme to add a special dependant (e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions – mark the appropriate block with an "x"

Acceptance of special dependants will be in accordance with the Rules of the Scheme.

1. Does the dependant receive a monthly income?	Y	N
Name of Employer:		
Pension (old age, military, disability):		
Pension (other including annuity):		

If yes, complete the following:

Monthly Salary:	R
	R
	R
Total Salary:	R

2. Is the dependant entirely reliant on you for maintenance and support? Y N

Name of Employer: ______________________________

3. Does the dependant live with you? Y N

Give reasons and attach certified affidavit: ______________________________

SECTION D PREVIOUS MEDICAL AID HISTORY

Where applicable, please provide details and proof of all previous registered South African medical schemes, which your dependants (for whom you are applying for) belonged to (proof in the form of membership certificates reflecting the join and end dates, must be attached to this application form). This information is used to determine whether waiting periods and or late joiner penalties are applicable.

Where late joiner penalties 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.

Select relevant box with a tick:

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

SECTION E

FAMILY PRACTITIONER (FP) NOMINATION - MediPhila, MediCurve, MediValue Compact and MediPlus Compact

If you have selected MediPhila, MediCurve 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.

MediCurve: Each beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

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 a FP was nominated from the FP Network & Day-to-Day benefit is depleted the 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 F — MEDICAL HISTORY (yes or no)

To be completed for each dependant that you are applying for in respect of himself/herself. All questions must be answered with a "Yes" or "No".

All conditions, symptoms and or disorders have to be declared, no matter how insignificant they may seem. Incomplete, inaccurate information or information that is withheld may result in the termination of your membership effective from date of registration.

If additional space is required, please complete a separate sheet of paper and attach it to the application.

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

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

Any additional information:

2. Does any of your dependants for whom you are applying for take chronic medication or are you expecting them to take medication on an ongoing basis? Y | N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.
Your doctor or pharmacist can contact Chronic Medicine Management on 086 000 2120 to telephonically register you for chronic medication.
Any additional information:

3. Has any of your dependants, for whom you are applying for 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	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

Any additional information:

4. Is any of your dependants, for whom you are applying for 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	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

Any additional information:

5. Is 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	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

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 G — EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date:

Benefit Date:

COMPANY STAMP

Tick this box if no Company Stamp is available

By selecting this box you confirm that the Employer has granted approval

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's Representative's Name:

Employer's Representative's Designation:

Date:

Employer's Representative's Signature: ______________________________

SECTION H — CONSENT (Consent for Medshield Medical Scheme to process personal information)

The Scheme understands that your personal information and that of your dependants is important to you. Medshield undertakes to keep this information confidential and shall take all reasonable steps to comply with the provisions of legislation protecting your personal information.
We require your consent to obtain, process and disseminate your personal information so we can provide you with the services stipulated in our contractual agreement, as detailed for your chosen benefit option and in compliance with the Medical Schemes Act 131/1998. These services include but is not limited to:

a. Treatment Authorisations;
b. Claims Assessment;
c. Claims Payment;
d. Communication;
e. Disease Management; and
f. Wellness Initiatives.

While your consent is voluntary, it is a requirement for the administration of your Medshield membership. **If you object to the processing of your personal information, the Scheme will not be able to activate and service your membership.**

I, the Principal Member, ____ (Name & Surname),

ID number ____, do hereby:

Please read the items of consent below carefully. All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

- ☐ Give permission, with the consent of my dependants, that Medshield Medical Scheme may collect, process, store and share our personal information, including health information with the Scheme's contracted service providers to perform their functions for the administration and/ or managed care of my membership which include the assessment and processing of my application, eligibility, underwriting, risk assessment, assessment and payment of claims, the provision of managed healthcare services, assessments of non-disclosures, validation and allocation of benefits, reporting to statutory bodies, fraud prevention and detection, member surveys and communication, collection and refund of contributions, members portions and savings and credit reporting.
- ☐ Authorise Medshield Medical Scheme to obtain from any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my or any of my dependants' health, whether such information relates to the past or future, to disclose such information to the Scheme and it's contracted third parties and agree that this request shall remain in force after my / their death, as well as prior thereto.
- ☐ Confirm that I am duly authorised to apply for membership and to act for those for whom I am applying for under the age of 18 in any matter relating to this application and the administration of our Medshield membership.
- ☐ I hereby acknowledge and declare that as the Principal Member of the Scheme, to the extent that it may be required by law, that I have received the necessary consent from my dependant(s) over the age of 18 to act on their behalf in any matter relating to this application and the administration of our Medshield Membership and to access and view their healthcare claims.
- ☐ Consent that all conversations between me, or any of my dependant(s), and the Scheme or its contracted service providers may be recorded.
- ☐ Acknowledge that my and my dependants' personal information, shall be retained as part of the records of the Scheme for as long as it is required by the Scheme for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of the applicable law. Medshield Medical Scheme are required to collect and keep personal information in terms of the allowable statutory limits.
- ☐ Confirm that if I (Principal Member) am part of a group membership by virtue of employment, I grant permission to Medshield Medical Scheme to share information relating to my membership with my employer. This will be limited to information that is relevant to my application, collection of contributions and information that is required for the ongoing servicing of my membership, but will not include any health information unless I have given Medshield permission to do so.
- ☐ Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Planner, if any, who is an accredited Medical Aid Broker of my choice.
- ☐ Consent to receive Scheme communication as it pertains to my membership and any information from the Scheme which could enhance my benefits, health and the management of my health.
- ☐ I have the right to request my personal information and that of my dependant(s), which is in the possession of Medshield Medical Scheme, provided that I furnish adequate identification and written consent from my dependant(s) over the age of 18.
- ☐ I have the right to request Medshield Medical Scheme where necessary, to correct, or delete my, or any of my dependant(s), personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.
- ☐ I shall inform the Scheme of any changes relating to my or any of my dependant(s) personal information within 30 days of the change, as required by the Scheme rules, as it may impact the administration of my membership and communication from the Scheme.
- ☐ I agree that should I have a complaint relating to the processing of my and my dependant(s) personal information, I will refer it to the Scheme to resolve. If I am not satisfied with the outcome of the complaint, I may refer the complaint to the Information Regulator.

Principal Member Signature: ________________________________ Date: ____________

SECTION I — MEMBER DECLARATION

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

Please read the declarations below carefully.

1. ☐ I the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree that my dependants and I shall abide by its Rules as amended from time to time which are available on Medshield's website www.medshield.co.za

2. ☐ I understand that the Scheme's brochures are a summarised version and do not supersede the rules of the Scheme.

3. ☐ I acknowledge that I have familiarised myself with the benefits covered on my benefit option of choice and that I may only change my benefit option during year-end for an effective date of 01 January.

4. ☐ I am aware of the fact that on joining the Scheme during the course of a calendar year, the maximum benefits to which I may be entitled shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular calendar year

5. ☐ I certify that all the information given is true and correct, whether completed by me or on my behalf, 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, effective from date of registration. In such event, the Scheme will have the right to offset applicable costs against contributions paid and refund the difference, if any.

6. ☐ I understand that should a period greater than three (3-month) lapse since contributions were paid to Medshield, that my membership will not be reinstated and that I have to re-apply subject to full underwriting.

7. ☐ I undertake to give notice to the Scheme to terminate my membership in accordance with the Rules of the Scheme.

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.

If applicable:

9. ☐ 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.

If applicable:

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

11. ☐ Notwithstanding point 9 and 10, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

If applicable:

12. ☐ 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.

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

14. ☐ I acknowledge and agree that it's my responsibility to advise the Scheme in writing of any change in banking details. The Scheme will not be liable should an incorrect account be credited under any circumstances

15. ☐ 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.

16. ☐ 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.

17. ☐ I agree to inform the Scheme of any deterioration or change in my state of health or in that of my dependant(s) before the commencement date of membership, or the date of acceptance of this application form by the Scheme, or the date of receipt of the first subscription, whichever date is the latest shall entitle Medshield to reconsider the application and propose new terms of admission.

18. ☐ It is illegal to be a member of more than one medical scheme at the same time. I acknowledge that it is my responsibility to resign from my existing medical scheme and agree that neither me, nor any of my dependants, will be registered on both Medshield and another medical scheme simultaneously.

19. ☐ 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: ______________________________ Date: ____________

Principal Member Signature: ______________________________

NB: Medshield Medical Scheme requires that your application form be 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.

Medshield is an Authorised Financial Services Provider (FSP 51381)