

Application for Membership

Instructions

1. Please complete every section below in full. If not applicable, please write N/A in the appropriate field.
2. The Medical Schemes Act requires that a copy of the Principal Member and all Dependants' identity documents must be attached.
3. Any incomplete or illegible information will result in further enquiries, which could delay your application for membership.
4. Membership is subject to the conditions, exclusions or limitations of benefits in accordance with the Medical Schemes Act and/or Scheme Rules.
5. Since the Scheme's contract is with the Principal Member, the application form is to be completed by and signed on behalf of all the Dependants, by the Principal Member.
6. A certificate(s) of membership, confirming previous medical scheme coverage, must be attached. This is obtainable from previous medical scheme(s).
7. Applicants may not make use of medical services, to be paid for by the Scheme, until such time as WRITTEN CONFIRMATION OF MEMBERSHIP has been received.

Section 1: Option Choice

Important note: The Principal Member may make an option change only as from 1 January of each year

Essence Option

Origin Option

Equilibrium Option

Silver Option

Gold Option

Platinum Option

I request the Scheme to register me and my dependants from - -

Section 2: Principal Member Personal Details (attach copy of ID / Passport)

Title	<input type="text"/>	Initials	<input type="text"/>	First name	<input type="text"/>
Surname	<input type="text"/>				
ID number	<input type="text"/>			Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Race	African/Black (A) <input type="checkbox"/>	Coloured (C) <input type="checkbox"/>	White (W) <input type="checkbox"/>	Indian/Asian (I) <input type="checkbox"/>	Unknown (U) <input type="checkbox"/>
Passport number	<input type="text"/>			Marital status	<input type="text"/>
Residential address	<input type="text"/>				Postal code <input type="text"/>
Postal address (if different)	<input type="text"/>				Postal code <input type="text"/>
Courier address (if different from residential address)	<input type="text"/>				Postal code <input type="text"/>
Telephone - home (code - number)	<input type="text"/>			Cellphone number	<input type="text"/>
Telephone - work (code - number)	<input type="text"/>			Fax - work (code - number)	<input type="text"/>
E-mail address	<input type="text"/>				
Language preference	English <input type="checkbox"/>	Afrikaans <input type="checkbox"/>			

Section 2.1: Spouse / Partner Personal Details (attach copy of ID / Passport if applying for membership)

Title	<input type="text"/>	Initials	<input type="text"/>	First name	<input type="text"/>	
Surname	<input type="text"/>					
Previous surname	<input type="text"/>					
ID number	<input type="text"/>			Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Race	African/Black (A) <input type="checkbox"/>	Coloured (C) <input type="checkbox"/>	White (W) <input type="checkbox"/>	Indian/Asian (I) <input type="checkbox"/>	Unknown (U) <input type="checkbox"/>	
Passport number	<input type="text"/>		Country of origin	<input type="text"/>		
Country of residence	<input type="text"/>					
Relationship to Principal Member	<input type="text"/>					

Section 2.2: Dependants Personal Details (attach copies of ID / Passport or Birth Certificate)

	First name	Surname, if different from Principal Member	ID No./Passport No.	Race	Gender (M/F)	Relationship to Principal Member
1.				A C W I U		
2.				A C W I U		
3.				A C W I U		
4.				A C W I U		

*An Applicant may be requested by the Scheme to confirm relationship to Principal Member.

Section 3: Financial Advisor / Broker

Name	A l e x i a G r a h a m				
Broker Code	3 2 9 0 0 0 0 0 0	Accreditation Number	3 6 0 8 8		
Telephone number (code - number)	<input type="text"/>				
Email Address	i n f o @ j e n u s h e a l t h . c o . z a				

I, _____ (Principal Member), declare that, I am aware of the appointment of the abovementioned Financial Adviser/Broker and that;

1. I give my broker access to my and my dependant(s) membership information with the Scheme in order to be of service to me;
2. This appointment was made voluntarily by me and can be cancelled at any time;
3. This appointment will entitle me to receive certain services from my Financial Advisor/Broker and that this was explained to my satisfaction.

Account Holder Signature

Date - - 2 0

Financial Advisor Signature

A. Graham

Date - - 2 0

Section 4: Banking Details for Payment of Contributions

Bank account holder	KeyHealth Medical Scheme	
Name of financial institution	ABSA	
Account number	6 000 000 12	
Account type	Cheque	
Branch code	632005	
Reference	Kindly use your membership number as reference Please fax proof of payment to 0860 111 390	

Section 5: Method of Contribution Payments

Method of payment Debit order Internet transfer

*Please note that no credit card banking details will be accepted

Section 5.1: Contribution Collection and Claims Reimbursements

Please indicate the choice of monthly debit order deduction date: 02 07 26 Last day of month

<input type="checkbox"/> Use this account for contribution collections and claims reimbursements <input type="checkbox"/> Use this account for contribution collections only	<input type="checkbox"/> Use this account for claims reimbursements only
Name of account holder _____	Name of account holder _____
Name of financial institution _____	Name of financial institution _____
Bank Branch code <input type="text"/>	Bank Branch code <input type="text"/>
Type of Account <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/> Savings <input type="checkbox"/>	Type of Account <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/> Savings <input type="checkbox"/>
Bank account number <input type="text"/>	Bank account number <input type="text"/>
*Please note that no credit card banking details will be accepted	*Please note that no credit card banking details will be accepted
Account Holder Signature <input type="text"/>	Account Holder Signature <input type="text"/>
Date <input type="text"/> - <input type="text"/> - 2 0 <input type="text"/>	Date <input type="text"/> - <input type="text"/> - 2 0 <input type="text"/>

Assignment

I hereby acknowledge that the party hereby authorise to effect the drawing(s) against my account may not cede or assign any of its rights to any third party without my consent and that I may not delegate any of my obligations in terms of this contract/authority to any third party without prior written consent of the authorised party.

Note: Attach a copy of a cancelled cheque/ a recent bank statement/an official bank letter for bank identification purposes. (Current accounts only.)

Account Holder Signature Date - - 2 0

If a company account is to be debited:

- I warrant that the Principal Member, referred to in this application, is an employee of the organisation.
- KeyHealth may bill the employer for the amount due for this member in the same manner as for other members that the organisation employs.

Name

Position in company

Authorised signatory Date - - 2 0

Section 6: Employer Information - To be completed by employer

Company Name

Existing group number Employee number

Business telephone number (code - number) Date of employment - -

Principal Member's occupation

SIGNATURE AND STAMP OF EMPLOYER

DESIGNATION

Date - - 2 0

Section 7: Previous Medical Scheme Information

Attach certificate of previous medical scheme(s), if applicable. Should additional space be required, copy this section and attach it to this application. Please list previous medical scheme details below for Spouse / Partner separately, if different from the Principal Member.

Name of member	Name of scheme	Member number	Date joined	Date terminated / or current

1. Are you changing your medical scheme due to a change in your employment, if yes please provide proof of change of employment. (Closed Schemes members only) Yes No
2. Have you, your Spouse / Partner or any of your Dependants ever had a waiting period, pre-existing condition, exclusion or a late joiner penalty? If Yes, please attach previous membership certificate(s) (if available). Yes No

Section 7.1: Medical Details Questionnaire

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.

All questions must be answered with either 'Yes' or 'No'. If the answer to any question is 'Yes', please provide full details. If more space is required, please include additional pages.

7.1.1 Have you or any of your dependants suffered from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, headaches, Systemic Lupus Erythematosus (SLE) depression, anxiety, epilepsy, and/ or thyroid disorders)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

7.1.2 Have you or any of your dependants suffered from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/ or a spastic colon)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

7.1.3 Have you or any of your dependants suffered from muscle, bone, joints, skin or nerve illnesses or disorders (e.g. back and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, motor neuron disease, osteoporosis, dermatitis)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

7.1.4 Have you or any of your dependants suffered from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts, irregular menstrual cycle / abnormal (irrespective of severity) menstrual bleeding)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

7.1.5 Have you or any of your dependants suffered from eye, ear, nose, mouth (teeth or gums) or throat disorders (e.g. glaucoma, cataracts, sinusitis, visual disorders, deafness, rhinitis, orthodontics)? If yes, provide details. Yes No

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor

Section 7.1: Medical Details Questionnaire - Continued

7.1.6 Have you or any of your dependants suffered from any blood disorders, cancer (either benign or malignant)?
If yes, provide details.

					Yes	No
Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor	

7.1.7 Are you or any of your dependants pregnant?
If yes, provide details.

					Yes	No
Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor	

7.1.8 Were you or any of your dependants hospitalised or had surgery in the past (including, but not limited to pacemaker, VP Shunt, joint replacements)? If yes, provide details.

					Yes	No
Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor	

7.1.9 Are you or any of your dependants planning any hospitalisation or surgery within the next 12 months?
If yes, provide details.

					Yes	No
Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor	

7.1.10 Is there any other condition or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim (including planned procedures, paraplegia, quadriplegia and birth defects)? If yes, provide details.

					Yes	No
Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment	Attending doctor	

7.1.11 Have you or any of your dependants experienced any symptoms, how insignificant it might seem, that have not yet been treated or diagnosed?
If yes, provide details.

					Yes	No

Section 7.2: GP Nomination - Essence Option Only

Members on the Essence Option are required to nominate a General Practitioner (GP) in respect of the treatment of chronic conditions. Please note that a GP nomination is required for each beneficiary.

	First name of Beneficiary	Surname, if different from Principal Member	GP Name	Practice Name	Practice number
1.					
2.					
3.					
4.					
5.					
6.					

Section 7.3: HIV/Aids

Failure to disclose a pre-existing condition as stipulated, could limit and/or exclude certain benefits or result in termination of membership.
If you and/or any of your Dependants are living with HIV/Aids and would prefer not to disclose your and/or their HIV-status on this form due to confidentiality, you may wait until you have received your membership number; please then dial **0860 50 60 80** in order to notify the Scheme that you and/or any of your Dependants are living with HIV/Aids. This information must be disclosed to KeyHealth within 7 days of your official entry onto KeyHealth.

Section 8: Declarations

Section 8.1: Medical Scheme Declaration

KeyHealth Medical Scheme confirms that:

- 8.1.1 A member's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential;
- 8.1.2 Member information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes;
- 8.1.3 The Medical Scheme has data security measures in place including anti-virus security, prevention of unauthorized access to members detail, eliminating unauthorized e-mails, web-mails and access controls for signing on to the computer system;
- 8.1.4 The Medical Scheme has granted access, to certain persons within the organisation and its contracted third parties, to a beneficiary's personal and health information. This is for the facilitation of normal business processes;
- 8.1.5 All KeyHealth employees and its contracted third parties is bound by internal confidentiality agreements;
- 8.1.6 The Medical Scheme and its contracted third parties will use the medical health/diagnosis/procedure information for the following purposes: processing the application for membership; re-imburement of claims, determining member entitlement to benefits, and risk management practices. Risk management practices include: hospital risk management, disease risk management and medicine risk management;
- 8.1.7 The Medical Scheme has ensured that confidentiality agreements have been entered into with all contracted third parties who have access to beneficiary information for the purposes of data transfer and management, Scheme administration and managed care arrangements;
- 8.1.8 In the event of a breach in confidentiality, the Medical Scheme assumes responsibility and the breach will be managed according to the Scheme's internal protocols.

Section 8.2: Financial Declaration

- 8.2.1 I hereby instruct and authorise the Scheme to draw against my bank indicated in this application form (or any other bank or branch to which I may transfer my account) the amount necessary for payment of my monthly contribution due in respect of the abovementioned membership on the selected deduction date as indicated in Section 3.1 each and every month and continuing until termination of our agreement or until cancelled by me in writing. All such withdrawals from my bank account by the Scheme shall be treated as though they had been signed by me personally.
- 8.2.2 I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher.
- 8.2.3 I agree to pay any bank charges relating to this debit order instruction.
- 8.2.4 This authority may be cancelled by me giving you thirty days notice in writing, but I understand that I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my bank (whichever it is or will be).

Section 8.3: Declaration by Principal Member

PLEASE NOTE

- 8.3.1. Acceptance of this application is at the discretion of the Scheme and shall be subjected to such conditions as the Scheme may determine in its rules from time to time.
- 8.3.2. The Scheme reserves the right to call for such additional information on the income, where applicable, and health of the applicant and/or Dependants.
- 8.3.3. With specific reference to and acknowledgement of the detail contained in the Medical Details section, failure to disclose pertinent information or to supply false information could lead to the termination of membership or such other measures as the Scheme may determine in its sole discretion, and the applicant's attention is specifically drawn to Article 66 of the Medical Scheme Act, Act No. 131 of 1998.

8.3.4.1. I declare that

- 8.3.4.1.1. the contents of this application, and any other documents which may be required in support thereof, are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and should there be any change in state of health or illness suffered by myself or any of my registered dependants from the date of signing this application form and the date of inception on the Scheme, notification of such change will be provided to the Scheme in writing with full details of such condition/ailment;
- 8.3.4.1.2. none of the applicants are registered with another medical scheme.

8.3.4.2. further accept that

- 8.3.4.2.1. my statements and answers in this application form shall form the basis of the proposed membership;
- 8.3.4.2.2. if I omit any pertinent information or make any false statement in my application, the Scheme may decline the application, or if membership has already been granted, terminate my or my dependants' membership, or impose such appropriate sanctions as it may determine in its sole discretion;
- 8.3.4.2.3. I will be responsible for all monthly contributions for the applicants and for any other amounts legally due to the Scheme, which may be incurred by them, and that such amounts may be recovered from me retrospectively;
- 8.3.4.2.4. I will be responsible for informing the Scheme of any changes to any of my dependants and their income, where applicable, within 30 days and for obtaining confirmation of those changes, in writing, from the Scheme.
- 8.3.4.2.5. All conversations between myself and the Scheme or its contracted parties may be recorded.
- 8.3.4.2.6. The terms and conditions issued in respect of this application are valid for 30 days from the signature date.

8.3.4.3. authorise

- 8.3.4.3.1. the Scheme to obtain and disclose any medical information it may require in order to consider and process this application for membership, and, during my period of membership, to obtain as it may require, disclose and utilise any information concerning my own and my dependants medical history;
- 8.3.4.3.2. where applicable, my employer to pay to the Scheme any portion of the monthly contribution due by me, by deduction from my salary, and any amount in arrears by way of double deduction from my salary, until fully recovered;
- 8.3.4.3.3. the Scheme to register me and my dependants' membership.

Section 8.3: Declaration by Principal Member - Continued

8.3.4.4. state that

8.3.4.4.1. I am familiar with the conditions and benefits of the option selected, notwithstanding representation by any other party;

8.3.4.4.2. I undertake to abide by the latest Rules of the Scheme as amended from time to time.

8.3.4.4.3. I am of sound mind, memory and understanding.

8.3.4.4.4. I understand that the Scheme may impose general and/or conditions specific waiting periods, as provided for in the Medical Schemes Act 131 of 1998;

8.3.4.4.5. I fully understand the implications of moving from one scheme to another;

8.3.4.4.6. Admission to the Scheme is not subject to the services of a broker being employed;

8.3.4.4.7. I understand the role of my broker (if applicable).

This authorisation will remain valid until cancelled in terms of the Rules of the Scheme.

Signature of
Principal Member

Print Name and Surname
of Principal Member

Date

 - - 2 0 

Be Smart. Keep it Simple.