MEMBER AND DEPENDANT APPLICATION FORM

NEW APPLICATION ☐

Name of company _____

Date of commencement ☐☐ ☐☐ ☐☐
D D M M Y Y

NEW DEPENDANT ☐

Name of individual _____

Membership number: ☐☐☐☐☐☐☐☐☐

Option (please tick the appropriate box)

☐ **Pinnacle**

☐ **Dynamix**

☐ **Symmetry**

☐ **Mumed**

☐ **Axis**

☐ **NetworX** (please complete schedule below)

NetworX Option: Members are required to nominate a General Practitioner (per beneficiary) from the list of approved network service providers.

Beneficiary name	Name of nominated GP	Address of nominated GP	GP practice number	GP telephone number

CHECKLIST

Mumed / NetworX Applications – Copy of latest salary slip or three months bank statement or IRP 5 or IT 34 ☐

Membership certificate / s from previous medical aid / s ☐

Adult dependant 21 years and over – Proof of registration / Affidavit of dependency ☐

Copy of Identity Documents / copy of passport to accompany form ☐

Proof of adopted / Foster / Child status – legal documents ☐

PLEASE ATTACH CERTIFICATES OF MEMBERSHIP FROM THE PREVIOUS, MEDICAL SCHEME / S TO THIS APPLICATION

FOR OFFICE USE ONLY

Member number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Company code ☐☐☐☐☐☐

Persal number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Code ☐☐☐☐☐☐

Race (for statistical use only)

Language

Subs table

Universal House, 15 Tambach Road, Sunninghill Park, Sandton
PO Box 1411 Rivonia 2128
Tel: 011 208 1000 Fax: 011 208 1028
E-mail: admin@universal.co.za Website: www.compcarewellness.co.za

Administrated by Universal Healthcare Administrators (Pty) Ltd

SECTION 1 - EMPLOYER DETAILS

Name of employer

Contact person

Postal address | Postal code

Email address

Telephone details Tel: Code ( ) | Fax: Code ( ) | Cell:

SECTION 2 - PRINCIPAL MEMBER DETAILS

Surname

First name / s

Title | Marital status | Nationality | Present age

Date of birth | Identity number

Tax number

Postal address | Postal code

Physical address

Email address | Correspondence via E – Mail YES NO

Telephone details (B) Code ( ) | (H) Code ( )

Facsimile details (B) Code ( ) | Cell:

Occupation | Date employed

Gross monthly earnings (all income including salary, commission, fringe benefits, interest, dividends etc) R

(Please note that if no proof of income is attached, members will be billed on the maximum income category)

SECTION 3 - SPOUSE / PARTNER DETAILS

Surname

First name / s

Title | Marital status | Nationality | Present age

Date of birth | Identity number

Tax number

Telephone details (B) Code ( ) | (H) Code ( )

Facsimile details (B) Code ( ) | Cell:

Occupation | Date employed

Gross monthly earnings (all income including salary, commission, fringe benefits, interest, dividends etc) R

(Please note that if no proof of income is attached, members will be billed on the maximum income category)

SECTION 4 - DEPENDANT DETAILS (INCLUDING SPOUSE / PARTNER)

No	Gender	First name / s & surname	Identity number	Relationship	Living-in	Income p.m.
						R

PLEASE NOTE: For any dependant / s other than your direct family, provide affidavits / legal documents.

SECTION 5A - MEDICAL DETAILS

Please complete all questions in full as non-disclosure of material information could prejudice future claims made by you and / or any of your dependants.

	Principal member	Spouse / Partner	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Height (cm)							
Weight (kg)							
Smoker / Non smoker							

Please give the name of your General Practitioner and / or specialist, you or any of your dependants have consulted recently.

Name of General Practitioner / Specialist	Telephone number	Number of years consulted
	Code ( )	
	Code ( )	
	Code ( )	
	Code ( )	

SECTION 5B - MEDICAL HISTORY QUESTIONNAIRE

It is most important that the questions on the following page be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit. Please advise whether you or any of your dependants suffer from, or have suffered from, or received treatment / consultation for any of the following conditions. Please ensure that you **underline** the appropriate condition, tick and complete the appropriate block / s.

			YES	NO	Name of member / dependant
1.	**Heart & Vascular System**	High blood pressure; high cholesterol; angina; heart attack; angiogram; previous coronary artery bypass; rheumatic fever; heart murmurs; valve problems / replacement; arrhythmias – insertion of pacemakers; heart failure; stroke; varicose veins; DVTs (deep vein thrombosis); pulmonary emboli.			
2.	**Lungs**	Asthma; emphysema; chronic bronchitis; TB; chronic infections - bronchitis & pneumonia.			
3.	**Digestive System, Gallbladder; Liver**	Dyspeptic disease (heartburn; hiatus hernia; peptic ulcers; reflux); irritable bowel syndrome (spastic colon; inflammatory bowel disease e.g. CHRON'S & ulcerative colitis; chronic diarrhoea / constipation); gallstones & jaundice; hepatitis; pancreatitis; haemorrhoids; incontinence; bowel prolapse.			
4.	**Nervous System**	Persistent headaches; epilepsy; paralysis; degenerative diseases – Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).			
5.	**Bone; Muscle & Joints**	Arthritis; rheumatism; gout; back, knee or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease; osteoporosis; previous amputations / artificial limbs; birth defects; joint replacements.			
6.	**Urinary Tract**	Infections; stones; albumin / blood in urine; urinary incontinence; prolapsed bladder.			
7.	**Gynaecological System**	Menopause; female hormone replacement; irregular menses; infertility; breast tumours (benign / malignant); ovarian tumours; cysts; prolapsed uterus / rectum / bladder; miscarriage; caesarean section.			
8.	**Male Genital System**	Prostate problems (hypertrophy / cancer or infections); infertility; hernias – groin; scrotal swellings; testicular tumours; abnormalities of the penis.			
9.	**Gland / Hormonal**	Over / under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.			
10.	**Blood**	Anaemia; bleeding disorders (haemophilia); leukaemia; Hodgkin's disease.			
11.	**Ear, Nose & Throat**	Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness – hearing aids.			
12.	**Eyes**	Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus); allergies – pterygiums; anticipated / previous laser surgery; artificial eyes.			
13.	**Emotional (psychological, psychosomatic problems)**	Depression; bipolar disorder; anxiety; stress; previous treatment for post traumatic stress syndrome; eating disorders – bulimia & anorexia; mental retardation; alcoholism; drug abuse.			
14.	**Infections / Tropical Diseases**	Sexually transmitted diseases; genital warts; HIV / AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzias; cholera; typhoid.			
15.	**Skin Disorders**	Acne; eczema; psoriases; lesions (keloid hypertrophic scars); skin rashes; shingles; Kaposi sarcoma – tumours.			

			YES	NO	Name of member / dependant
16.	**Connective Tissue Disorders**	Systemic lupus erythromatosis; scleroderma.			
17.	**Teeth & Gums**	Impacted molars (wisdoms); previous / current orthodontic treatment; braces; crowns; recurrent infections - gums.			
18.	**Cancer**	Cysts; growths; tumours of any kind.			
19.	**Allergies**	Are you or any of your dependants allergic to any specific type of medication (e.g. penicillin, aspirin, sulphas, morphine, NSAIDS); pollen dust; animals; specific food types (e.g. nuts).			
20.	**Immuno-Suppressive Treatment**	Have you or any of your dependants ever had or expecting to undergo an organ treatment transplant? Have you or any of your dependants ever suffered from any condition requiring Immunosuppressive treatment?			
21.	Have you or any of your dependants ever received any form of physiotherapy, occupational therapy or chiropractic treatment?				
22.	Are you or any of your dependants pregnant? If **yes** - how many weeks? Please give expected date of delivery.				
23.	Have you or any of your dependants had any previous or pending claims for which any other party may be liable e.g. MVA (Motor Vehicle Accident) claims? If **yes,** please give details.				
24.	Are you or any of your dependants expecting to undergo any medical treatment, e.g. hospitalisation, operation, specialised dentistry etc, within the next twelve months?				
25.	Do you or any of your dependants have a chronic condition requiring ongoing medication? If **yes,** please give the name and dosage of all the medication you or any of your dependants are currently taking.				
26.	Have you or any of your dependants ever received any medical attention of any nature, e.g., hospitalisation, operation, specialised dentistry etc, not mentioned above?				
27.	Have you or any of your dependants ever appeared before a medical board in view of early retirement and declared medically unfit?				

If any of the questions above have been answered **yes,** please supply details below. If there is not enough space, please attach an additional page.

No	Member / Dep	Full details of the disorder, consulting Doctor, type of medication & dosage used	Date of treatment	Degree of recovery

SECTION 6 - PREVIOUS MEMBERSHIP

Please attach certificates of membership (from previous Medical Scheme / s) to this application. If no certificate / s is attached, interchangeability could be forfeited.

Name of previous Medical Scheme / s	Membership number	Date joined	Date terminated

SECTION 7 - ELECTRONIC TRANSFER INFORMATION

PERSONAL BANKING DETAILS
Electronic transfer of payments to you and collection of members portion's (co-payment's) where applicable.
CREDIT CARD ACCOUNTS NOT ACCEPTED

	PAYMENTS (Claims refunds)	**COLLECTIONS (Members portions)**
Name of account holder		
Account holders ID no		
Name of bank		
Branch		
IBT number	- -	- -
Account number		
Type of account	Current ☐ Savings ☐ Transmission ☐	Current ☐ Savings ☐ Transmission ☐

DISCLAIMER: It is the member's responsibility to advise the administrator in writing of any change in banking details. Neither the scheme nor its administrators will be held liable should an incorrect account be credited under any circumstances.

I / We hereby authorise the Scheme to debit my / our bank account, the amount necessary for amounts owed by the member to the scheme to the maximum value of R500 or as arranged with the scheme.

Authorised Signature / s	Date	Authorised Signature / s	Date
Member's Signature (if different from the authorised signature)	Date	Member's Signature (if different from the authorised signature)	Date

SECTION 8 - METHOD OF PAYMENT OF CONTRIBUTION

Please select method of payment (please tick) Debit order ☐ Employer deduction ☐ Direct payment via cheque / EFT ☐

If paying by debit order, please fill in the following:
I / We hereby authorise the scheme to debit my / our banking account (wherever it may be), the amount necessary for any contributions and changes in relation to this agreement, incorporating the contribution rate changes.

Name of account holder			
Name of bank			
Branch		Branch code	
Account number		Type of account - please tick: Current ☐ Savings ☐ Transmission ☐	
Authorised signatory			

SECTION 9 - MEMBER ACKNOWLEDGEMENT AND DECLARATION

1. I, the undersigned hereby apply for membership of CompCare Wellness Medical Scheme and agree that all answers and information contained in this application completed by me or by any other person / s will be the basis of the proposed agreement.
2. I warrant that the contents of this application are true, correct and complete. No cover will be granted unless CompCare Wellness Medical Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
3. I agree to abide by and undertake to familiarise myself with the rules of the scheme as amended from time and grant my employer the right to deduct from my remuneration any amounts (including members portion's) outstanding by myself to CompCare Wellness Medical Scheme, including interest thereon. I further grant my employer the right to pay such monies over the scheme.
4. I understand that the scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998).
5. I agree to notify the scheme within 30 days in the event that any alternation in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk.
6. The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:
   - 6.1. For the purpose of considering application / s for membership, as well as any claims for benefits, CompCare Wellness Medical Scheme and any medical personnel authorised by CompCare Wellness Medical Scheme has the right to obtain or forward any medically relevant information including the HIV / AIDS status, which it may deem necessary from or to any medical practitioner or institution or nominee that possesses or needs such information, and that party may disclose such information to CompCare Wellness Medical Scheme and any party duly authorised by CompCare Wellness Medical Scheme.
   - 6.2. The information may be requested and supplied at any time, including after the death of the member or dependants, and will include accounts from service providers, indicating diagnoses, and medical or clinical reports when indicated. Such information will, however, be treated as confidential at all times by the party to whom it is supplied.
   - 6.3. By agreeing to sign the application form / s the applicant / member and dependants thereby waives his / her right to privacy in terms of the abovementioned clauses.
7. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the scheme.
8. Neither the applicant nor any of his / her dependant / s will / are be beneficiaries of another registered medical scheme, on the date of registration with CompCare Wellness Medical Scheme.
9. I hereby indemnify and hold harmless the scheme and administrator against any and / or claims that may result due to the use of preferred providers.
10. I hereby acknowledge that I must give 3 (three) months written notice when I voluntarily resign from the Medical Scheme.
11. I hereby give the scheme permission to communicate to me by SMS ☐ Email ☐

I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the scheme from liability and subject my membership cancellation. I warrant that I am authorised to sign on behalf of my dependant / s. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

SIGNATURE OF APPLICANT _____ **DATE** _____

SECTION 10 - EMPLOYER

This application form has been scrutinised, and we are not aware of any facts other than those stated which should be made known to the scheme. We certify that the applicant is on our permanent staff and confirm the salary details are correct.

Contribution amount R | Date

Employer's name

Employer's signature | Capacity

SECTION 11 - MEDICAL SCHEME CONFIDENTIALITY DECLARATION

CompCare Wellness Medical Scheme confirms that:

1. All personal details and medical information shall be kept confidential.
2. Personal and medical information will not be sold for commercial purposes or used for related scheme business.
3. CompCare Wellness Medical Scheme has taken adequate security measures to protect the confidentiality of the said information.
4. Limited controlled access is granted to employees and third parties, for the medical scheme to fulfil its obligations towards its beneficiaries.
5. Personal and medical information will be used for processing this application, reimbursement of claims, determining member entitlement to benefits and risk management practice.
6. CompCare Wellness Medical Scheme confirms that it has entered into confidentiality agreements with all contracted third parties who have access to beneficiary information for the purposes of data transfer management, scheme administration and managed care arrangements.

SECTION 12 - BROKER DECLARATION AND DETAILS

WHERE A BROKER HAS BEEN USED, THE BROKER MUST COMPLETE THE FOLLOWING BROKER DECLARATION SECTION:

1. I hereby confirm that I have been appointed by the member applicant, and acknowledge that the member applicant may terminate my services at any time.
2. I confirm that I am fully accredited in terms of relevant legislation, on date of my signature, of this document.
3. Financial Services Board: Accreditation number | Council for Medical Schemes: Accreditation number
4. I confirm that I have provided the member applicant with my full name, physical and postal address and telephone number.
5. The commission payable upon completion of the transaction by the: Member applicant R | Scheme R
6. I confirm that I have a valid contract with the scheme.
7. I confirm that the information provided by me, to the member applicant and the scheme is true and correct to the best of my knowledge.
8. I confirm that where I have completed this application from on behalf of the applicant member, the applicant member is familiar with the information requested and responses provided.
9. The advice and assistance provided to the applicant member was impartial and in his / her best interests.
10. In the event of a material misrepresentation being made by me or engagement in unlawful conduct I undertake to refund all monies paid by the applicant member and / or the scheme in consequence of such misrepresentation or conduct.
11. I confirm that the member applicant has personally signed the form.

DISCLAIMER: The scheme shall not be held responsible for any misrepresentation made by any of its agents / representatives / consultants.

SECTION 13 - BROKER DETAILS

Brokerage name | Broker code

Broker's name

Broker's cell | Brokers Tel: Code ( )

SIGNATURE OF BROKER

SECTION 14 - BROKER CONSULTANT

Broker consultant name | BC code

SIGNATURE OF BROKER CONSULTANT | DATE