

# APPLICATION FOR MEMBERSHIP

**ALL QUESTIONS TO BE ANSWERED IN FULL (Please print)**

Have you been a member of PG Group Medical Scheme previously? Yes ☐ No ☐

[illegible]

Have you been a member of another medical scheme during the past two years? Yes ☐ No ☐

**Please refer to page 04 for previous medical scheme information.**

**PERSONAL PARTICULARS** (PLEASE NOTE: Copy of identity documents must be provided with this application.)

**APPLICANT**

[illegible]

**MARK APPLICABLE BOX WITH AN 'X'**

Single ☐ Married ☐ Divorced ☐ Widow(er) ☐

## CONTACT DETAILS

[illegible][illegible][illegible]

**SPOUSE**

[illegible]

### DEPENDANT 1

[illegible]

## DEPENDANT 2

[illegible]

### DEPENDANT 3

[illegible]

#### DEPENDANT 4

[illegible]

**Please note:** We reserve the right to request additional information if required.

## UNDERWRITING QUESTIONS

Have you or your dependants experienced any of the conditions below for which medical advice, diagnosis, care or treatment was provided during the past 12 months?

PLEASE ANSWER 'YES' OR 'NO' TO EACH QUESTION ('Y' or 'N')

If 'YES', please provide detailed information of medical condition and treatment.

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholesterol or lipids, ischaemic heart disease, heart failure, angina, stroke (CVA) or peripheral vascular disease						
2	Cystic fibrosis						
3	Obstructive lung disease (asthma, emphysema or COAD)						
4	Diabetes (insulin or non-insulin dependent diabetes mellitus)						
5	Hypo- or hyperthyroidism						
6	Arthritis (i.e. osteo, rheumatoid arthritis or gout) - all related musculoskeletal conditions						
7	Osteoporosis						
8	Gastro oesophageal reflux disease (GORD/heartburn) or stomach/duodenal ulcers (please circle)						
9	Immune deficiency status (i.e. HIV/AIDS*, immunoglobulin deficiencies)						
10	Anaemia or abnormalities of clotting mechanism - haemophilia, thrombosis, bleeding disorder						
11	Hormone replacement therapy, endometriosis or ovarian cysts						
12	Depression and/or anxiety disorders, anorexia, attention deficit disorder, Alzheimer's disease						
13	Any nervous or mental complaint (e.g. epilepsy, blackouts, paralysis or headaches)						
14	Glaucoma, cataracts or any other disorders of the eye						
15	Parkinson's disease or multiple sclerosis (please circle)						
16	Hyperplasia of prostate (BPH) or prostatism						
17	Inflammatory bowel disease (Crohn's disease or ulcerative colitis)						
18	Urinary tract infection or calculi (stones)						
19	Back or neck related condition (lumbago, sciatica, injury, spasm, loss of limb, previous surgery)						
20	Are you pregnant? If so, how many weeks?						
21	Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure for the following 12 months?						
22	Are you on any medication at present?						
23	Do you take chronic medication?						
24	Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical scheme claim within the next 12 months?						
25	Skin conditions/disorders (e.g. acne, eczema, psoriasis, etc.)						
26	Ear, nose or throat disorders (e.g. ear discharge, recurrent tonsillitis, hearing/speech impediments)						
27	Infectious diseases (e.g. tuberculosis, shingles, measles, etc.)						
28	Malignant neoplasms (cancer, growths or malignant tumours)						
29	Benign neoplasms (non-malignant tumours/growths)						
30	Specialised dentistry, maxillofacial treatment, dental problems, gum disease						
31	Have you had or are you expecting to have plastic or reconstructive surgery?						
32	Any hereditary or congenital conditions, e.g. Down's syndrome						
33	Connective tissue disorders, e.g. systemic lupus						
34	Do you or your dependants take part in any professional or dangerous sports?						

\* Should you be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership number, you must fax confirmation of your HIV/AIDS status to our HIV/AIDS Department on **086 609 3792/012 675 3848** to ensure registration on the HIV YourLife Programme. Please note that this may result in you receiving a second card from the Scheme pending whether your application will require underwriting as per current legislation.

UNDERWRITING QUESTIONS (continued)

PLEASE PROVIDE DETAILS BELOW IF YOU HAVE ANSWERED 'YES' TO ANY OF THE UNDERWRITING QUESTIONS

Question number	Nature and duration of complaint and full details of treatment being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment?

Failure to disclose any pre-existing conditions could result in benefits being limited, excluded and/or membership being terminated.

BANKING DETAILS OF APPLICANT (For direct payment of monies due to members.)

Name of Account Holder

Bank and Branch Name

Branch Code

Account Number

Account Type

Current

Savings

Transmission

Please Note : No credit card transactions are allowed.

EMPLOYER INFORMATION

Name of Employer

Applicant's Employee No.Applicant Employment Date

D

D

M

M

Y

Y

Applicant's OccupationDate Membership should start

D

D

M

M

Y

Y

Salary

R

Business Telephone No.

Group Number

ONLINE DATA ACCESS

Would you like access to your information on the website? YesNo

Email Address

Preferred Username

ALL INFORMATION HERETOFORE GIVEN IS CERTIFIED CORRECT

Signed on behalf of the Employer

Company Stamp

Name of Signatory

Date

D

D

-

M

M

-

2

0

Y

Y

## PREVIOUS MEDICAL SCHEME INFORMATION

Please detail previous medical scheme membership.

Name of Scheme	Membership Number	Join Date	Termination Date	Name of Employer

Please attach certificates of membership (not membership cards), which are required in order to avoid late joiner penalties, waiting periods and condition-specific exclusions.

## ACKNOWLEDGEMENTS

1. I acknowledge that I am aware of the provisions of the Rules dealing with the submission of fraudulent claims to PG Group Medical Scheme, the commission of fraudulent acts and the non-disclosure of material information to PG Group Medical Scheme. In particular, I am aware that I am not permitted to allow any person other than my registered dependants to use my membership card.
2. I am aware that, if I am accepted for membership, your Rules will be binding on me and that, in the case of a dispute, the registered Rules will be decisive.
3. I hereby authorise and instruct my Employer to deduct from my remuneration and any other sums due to me (any amounts which may be due by me to a pension fund or provident fund, that holds funds for my benefit after I cease employment) in order to pay, and continue to pay, the amounts referred to in the first sentence hereof to PG Group Medical Scheme as and when they fall due. Furthermore, I understand that I will be liable for any legal costs incurred in the recovery of any amount owing to PG Group Medical Scheme.
4. I am aware that proof of identification may be requested at any stage.
5. All sums due by me to PG Group Medical Scheme shall be forthwith due and payable by me to PG Group Medical Scheme on demand.

## DECLARATION

1. The answers given herein are full, complete and true and, if I am accepted as a member of PG Group Medical Scheme, will constitute the basis of my membership.
2. I realise that I must submit evidence of the good health of myself and my dependants, and that benefits may be limited or excluded in respect of any particular ailment, disease, disorder, condition or disability which existed on my admission date.
3. I am bound now, and in the future, if my dependants and myself are accepted as members, to give PG Group Medical Scheme all such information and evidence as PG Group Medical Scheme may from time to time require and to this end authorise the medical practitioner or other provider who has attended to me in the past or who will attend to me in the future, to provide PG Group Medical Scheme with such information as PG Group Medical Scheme may require, hereby waiving the provisions of any law or regulation restricting the giving of such information. I must also submit as and when required by PG Group Medical Scheme, to an examination by PG Group Medical Scheme's medical assessor.
4. I acknowledge that I have been given the opportunity of perusing the Rules of PG Group Medical Scheme prior to signing this application and that, even if I have not availed myself of such offer, I shall be deemed to have read the Rules.
5. Words used in this application shall bear the meaning ascribed to them in the Rules.

## DISCLAIMER

PG Group Medical Scheme reserves the right to list members, who in the opinion of MMI Health's Fraud and Ethics Committee have behaved unethically towards PG Group Medical Scheme, abused their benefits, perpetrated fraud or colluded with others to perpetrate fraud against PG Group Medical Scheme, on the Transunion ITC. This information may be viewed by all medical schemes that participate in the Board of Healthcare Funders Forensic Management Unit.

Signature	<input type="text"/>	Date	<input type="text" value="D"/> <input type="text" value="D"/> - <input type="text" value="M"/> <input type="text" value="M"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
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Signed by me as applicant declaring that I have carefully read this application form and accepting that the fact that I have applied does not necessarily mean that I will be accepted as a member.

**Membership will only be finalised upon receipt of a fully completed application form and supporting documents.**

**Incomplete forms will result in membership activation being delayed.**