APPLICATION

Office Use Only
PROVIDENCE
Date Loaded: _____
Loaded By: _____
Member No.: _____

Administered by: PROVIDENCE Healthcare Risk Managers (Pty) Ltd
7 Lutman Street, Richmond Hill, Port Elizabeth, 6001
P.O. Box 1672, Port Elizabeth, 6000
Customer Care: 0860 08 08 88 or 041 395 4545
E-mail: suremed@providence.co.za
Website: www.suremedhealth.co.za

APPLICATION FORM

suremed health

APPLICATION FOR MEMBERSHIP

P.O. Box 1672
Port Elizabeth
6000

7 Lutman Street
Port Elizabeth
6001

CALL CENTRE: 0860 08 08 88
E-MAIL ADDRESS: suremed@providence.co.za

ADMINISTERED BY PROVIDENCE

Section 1 • ABOUT YOURSELF (Main Applicant)

Title: Initials: Surname:

First Names: (as per ID document)

Date of Birth: Y Y Y Y M M D D

Identity Number / Passport Number: Country of issue:

RSA PASSPORT OTHER

ID type:

Postal Address:

Physical Address:

Telephone Number (Work):

Telephone Number (Home):

Cellular Number:

E-mail:

Please select one option by placing an "X" in the appropriate box

Marital Status

Single Married Widowed Divorced

Gender M F

Monthly household income:
(Proof of both)

Member's income:

Spouse's income:

Please indicate preferred method of communication -

E-mail: SMS: Post:

Name of Employer:

Start date of Employment: Y Y Y Y M M D D

Occupation / Designation:

Clock / Payroll Number:

SECTION 2 • YOUR DEPENDANT'S DETAILS

A. SOUSE DETAILS

Title: Initials: Surname:

First Names: (as per ID document)

Date of Birth: Y Y Y Y M M D D

Marital Status: Single Married Widowed Divorced

Gender: M F

Identity Number / Passport Number: Country of issue:

RSA PASSPORT OTHER

ID type:

Postal Address:

Physical Address:

Telephone Number (Work):

Cellular Number:

Telephone Number (Home):

E-mail:

SECTION 2 • YOUR DEPENDANT'S DETAILS (Continued)

A. DEPENDANT'S DETAILS

NOTE: Acceptance of dependants will be decided in accordance with the Scheme Rules.

D1 Name:
Surname:
Identity Number / Passport Number:
Date of Birth: Y Y Y Y M M D D
Gender: Female Male
Relationship:

D2 Name:
Surname:
Identity Number / Passport Number:
Date of Birth: Y Y Y Y M M D D
Gender: Female Male
Relationship:

D3 Name:
Surname:
Identity Number / Passport Number:
Date of Birth: Y Y Y Y M M D D
Gender: Female Male
Relationship:

D4 Name:
Surname:
Identity Number / Passport Number:
Date of Birth: Y Y Y Y M M D D
Gender: Female Male
Relationship:

D5 Name:
Surname:
Identity Number / Passport Number:
Date of Birth: Y Y Y Y M M D D
Gender: Female Male
Relationship:

D6 Name:
Surname:
Identity Number / Passport Number:
Date of Birth: Y Y Y Y M M D D
Gender: Female Male
Relationship:

SECTION 3 • PREVIOUS MEDICAL SCHEMES OF PRINCIPAL MEMBER / SPOUSE / DEPENDANTS

Please provide full details of previous membership of registered Medical schemes (starting with most recent) and provide proof by attaching your Certificates of Membership. (Your previous scheme membership card will not be accepted)

PRINCIPAL MEMBER

Scheme Name:
Membership Number:
Date from: Y Y Y Y M M D D
Date to: Y Y Y Y M M D D
Certificate Attached: ***COMPULSORY*** Yes No
Years/Months on Medical Aid: Y Y M M

Scheme Name:
Membership Number:
Date from: Y Y Y Y M M D D
Date to: Y Y Y Y M M D D
Certificate Attached: ***COMPULSORY*** Yes No
Years/Months on Medical Aid: Y Y M M

SPOUSE'S / DEPENDANT'S INFORMATION (If different from principal member)

Scheme Name:
Membership Number:
Date from: Y Y Y Y M M D D
Date to: Y Y Y Y M M D D
Certificate Attached: ***COMPULSORY*** Yes No
Years/Months on Medical Aid: Y Y M M

Scheme Name:
Membership Number:
Date from: Y Y Y Y M M D D
Date to: Y Y Y Y M M D D
Certificate Attached: ***COMPULSORY*** Yes No
Years/Months on Medical Aid: Y Y M M

Have you, your spouse or any other dependant's ever been refused cover or offered cover on special terms by a life assurance company or medical scheme?: Yes No

If yes, please give details of the reason:

SECTION 4 • YOUR HEALTH PLAN

Please select your heath plan by placing an "X" in the appropriate box

CHALLENGER ☐ NAVIGATOR ☐

SHUTTLE ☐ EXPLORER ☐

Joining date: Y Y Y Y M M D D

OFFICE USE ONLY

Monthly Contribution

Total Monthly Contribution
(Including late joiner fee and any additional fee)

ADDITIONAL MEMBERSHIP CARD REQUIRED? ☐ YES ☐ NO

FOR FURTHER DETAILS PLEASE REFER TO THE LATEST BENEFIT GUIDE

SECTION 5 • INTERMEDIARY DETAILS

Application Information: New business: ☐ Addition to existing group: ☐ Group size:

Name of group / individual: Joining date:

Intermediary Details:

Brokerage name: CMS number: CMS number expiry date: Y Y Y Y M M D D

FSB License number: Start date: Y Y Y Y M M D D

Broker name: CMS number: CMS number expiry date: Y Y Y Y M M D D

FSB License number: Start date: Y Y Y Y M M D D

Telephone Number: Fax Number:

Cellular Number: E-mail:

Please indicate preferred method of communication - E-mail: ☐ SMS: ☐ Post: ☐

Broker Signature: _____ Date: Y Y Y Y M M D D

SECTION 6 • PERSAL DETAILS (GOVERNMENT EMPLOYEES ONLY) (Copy of payslip required)

Persal Organisation number:

SECTION 7 • BANKING DETAILS FOR COLLECTING CONTRIBUTIONS

These details apply when you pay your total contributions without your employers help.

BANK: **BRANCH NAME AND TOWN:**

TYPE OF ACCOUNT:
Current ☐
Savings ☐
Transmission ☐

NAME OF ACCOUNT HOLDER:

ACCOUNT NUMBER: **BRANCH NUMBER:**

I hereby authorise PROVIDENCE Healthcare Risk Managers (Pty) Ltd. to debit my bank account, wherever it may be conducted for any amount due in respect of monthly contributions or any other amounts due in terms of the rules of the Scheme. I undertake to advise PROVIDENCE at P.O. Box 1672, Port Elizabeth, 6000 of any changes to my present account details.

Please use this account for claim refunds: ☐ YES ☐ NO

Signature of account holder: _____ Signature of main applicant: _____

If you are using someone else's banking account, please ensure that you have signed confirmation/authorisation from the account holder. Please attach a copy of a cancelled cheque or bank statement to confirm account details.

SECTION 8 • BANKING DETAILS FOR CLAIM REFUNDS

This section only applies if your claim refunds should be paid into a different account from which contributions are collected.

BANK: **BRANCH NAME AND TOWN:**

TYPE OF ACCOUNT:
Current ☐
Savings ☐
Transmission ☐

NAME OF ACCOUNT HOLDER:

ACCOUNT NUMBER: **BRANCH NUMBER:**

I the main member authorise any claim refunds to be paid into the bank account details provided above and I acknowledge that once claims have been refunded into this bank account chosen, the Scheme will no longer be liable in anyway for the amounts refunded.

Signature of account holder: _____ Signature of main applicant: _____

Please attach a copy of a cancelled cheque or bank statement to confirm account details.

SECTION 9 • MEDICAL HISTORY

Have you or any of your dependants ever experienced, been treated for (prior to 12 months of application date), or currently suffer from any of the following conditions?

CONDITION CATEGORY (Indicate with an X, if "Y" indicate beneficiary/ies)			SELECT BENEFICIARY/IES M = Member / S = Spouse 1-5 = oldest to youngest child (Indicate with an X)							Medical Diagnosis	Date first diagnosed	Date of last related symtoms, consultation or hospitalisation	Currently on treatment for this condition (Y/N)	Medication used for this condition and date last taken
1. **Cardiovascular (Heart)** e.g. High blood pressure, Raised cholesterol, Heart failure, Angina (chest pain), Heart attack, Heart murmurs, Palpitations, Rheumatic fever, Previous heart surgery	Y	N	M	S	1	2	3	4	5					
2. **Blood** e.g. Haemophilia, Bleeding disorders, Thrombosis (blood clots), Leukaemia, Lymphoma	Y	N	M	S	1	2	3	4	5					
3. **Mental/Emotion** e.g. Depression, Anxiety, Anorexia or other eating disorder, Attention Deficit Hyperactivity Disorder, Schizophrenia, Alzheimer's Disease	Y	N	M	S	1	2	3	4	5					
4. **Nervous System** e.g. Epilepsy, Multiple sclerosis, Paralysis, Parkinson's, Stroke, Migraine	Y	N	M	S	1	2	3	4	5					
5. **Eyes** e.g. Glaucoma, Cataract, Macular degeneration, Visual impairment, Conjunctivitis, Disorders of the cornea	Y	N	M	S	1	2	3	4	5					
6. **Mouth** e.g. Dental problems, Gum disease, Over/underbite, Missing/skew teeth, Planned dental treatment	Y	N	M	S	1	2	3	4	5					
7. **Ear, Nose and Throat** e.g. Allergic rhinitis, Ear infections, Hearing/speech impairment, Tinnitus (Ringing ears)	Y	N	M	S	1	2	3	4	5					
8. **Respiratory** e.g. Asthma, Chronic Obstructive Pulmonary Disease, Cystic fibrosis, Emphysema, Chronic bronchitis, Shortness of breath, Persistent cough, Coughing up blood, Any lung surgery	Y	N	M	S	1	2	3	4	5					
9. **Gastrointestinal** e.g. Peptic ulcer, Heartburn, Irritable bowel, Ulcerative colitis, Hiatus hernia	Y	N	M	S	1	2	3	4	5					
10. **Liver/Pancreatic Disorders** e.g. Hepatitis, Cirrhosis, Liver failure, Gallstones, Pancreatitis	Y	N	M	S	1	2	3	4	5					
11. **Kidney/Urinary/Reproductive system** e.g. Renal failure, Prostate problem, Kidney stone, Recurrent infection, Nephritis, Blood/Protein in urine, Polycystic kidneys	Y	N	M	S	1	2	3	4	5					
12. **Gynaecological** e.g. Ovarian cysts, Endometriosis, Fibroid, Disorder of the cervix, Menstrual disorder	Y	N	M	S	1	2	3	4	5					
13. **Skin problems** e.g. Eczema, Acne, Rosacea, Psoriasis	Y	N	M	S	1	2	3	4	5					
14. **Muscle/Bones** e.g. Osteoporosis, Gout, Arthritis (Osteo or Rheumatoid), Pain, Previous fractures, Myasthenia gravis, Loss of limb, Back problems/Operations, Slipped disk, Backache	Y	N	M	S	1	2	3	4	5					
15. **Connective tissue disorders** e.g. Systemic lupus erythematosis, Scleroderma, Dermatomyositis/Polymyositis, Mixed connective tissue disorder	Y	N	M	S	1	2	3	4	5					
16. **Metabolic/Endocrine** e.g. Diabetes, Thyroid problem, Addison's disease, Growth problems, Pituitary problems, Cushing's syndrome	Y	N	M	S	1	2	3	4	5					
17. **Infections/tumors** e.g. HIV, Cancer, Hepatitis, Tuberculosis, Benign tumors	Y	N	M	S	1	2	3	4	5					
18. **Other** Please specify	Y	N	M	S	1	2	3	4	5					

If you or your spouse / dependant requires chronic medication a Chronic form must be completed as well.

Please complete the following general medical questions (Indicate "Y" or "N" with an X where applicable)

19. **Height** (Metres)	Member (M)		Spouse (S)		1		2		3		4		5	
20. **Weight** (Kilograms)	Member (M)		Spouse (S)		1		2		3		4		5	

QUESTIONS (If "Y" indicate applicable beneficiary/ies)			SELECT BENEFICIARY/IES							DETAILS
21. Do you/your dependants smoke?	Y	N	M	S	1	2	3	4	5	
22. Are you/your dependants pregnant or suspect pregnancy?	Y	N	M	S	1	2	3	4	5	How many weeks?
23. Have you/any of your dependants undergone an operation recently?	Y	N	M	S	1	2	3	4	5	
24. Do you/any of your dependants consume alcohol? Specify details	Y	N	M	S	1	2	3	4	5	Rarely Y N Moderately Y N Frequently Y N
25. Do you/your dependants take part in professional/dangerous sport?	Y	N	M	S	1	2	3	4	5	
26. Do you/your dependants use chronic medication?	Y	N	M	S	1	2	3	4	5	
27. Do you/your dependants have a congenital/hereditary or physical disability?	Y	N	M	S	1	2	3	4	5	
28. Are you/your dependants expecting any surgery/hospitalisation/treatment in the next year?	Y	N	M	S	1	2	3	4	5	
29. Have you/your dependants had surgery or been admitted to hospital in the past year?	Y	N	M	S	1	2	3	4	5	
30. Have you/your dependants in the last 24 months been involved in a motor vehicle accident, been injured on duty or contracted a work related illness?	Y	N	M	S	1	2	3	4	5	
31. Have you/your dependants ever had or are currently suffering from alcohol/drug problems?	Y	N	M	S	1	2	3	4	5	

SECTION 10 • EMPLOYER TO COMPLETE AND SIGN

Paypoint:

Scheme Join Date: Y Y Y Y M M D D

Clock/Payroll Number:

Date of Employment: Y Y Y Y M M D D

Date of Benefit: Y Y Y Y M M D D

Basic Salary: R

Number of Subsidised Dependants:

Spouse:

Child:

Adult Dependants:

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

Employer's Telephone:

Employer's Fax:

Employer's E-mail:

Name of Medical Scheme/Salary Administrator:

Designation:

COMPANY STAMP REQUIRED

Signature: _____

Y Y Y Y M M D D

SECTION 11 • DECLARATION BY MEMBER

Suremed Health

1. **Rules of the Scheme**
I apply for my dependants and myself to join Suremed Health (the Scheme) administered by PROVIDENCE Healthcare Risk Managers and agree that my dependants and I will be bound by the rules of the Scheme.

2. **Disclosure of information**
2.1 Any breach of any warranty or non-disclosure of any information by myself or my dependants relevant to the assessment of this application will render my membership null and void, and all contributions paid by me will be forfeited to the Scheme.
2.2 I will notify the Scheme should any change to my health of health of my dependants occur before the commencement date of my membership. I acknowledge that the failure to do so may render my membership null and void.
2.3 hereby consent to the disclosure by the Scheme of any information supplied to either or both of them (including, without limitation, general, medical and financial information pertaining to my dependants or myself) to any third parties, provided that such parties agree to keep such information confidential at all times.
2.4 I hereby agree that the Scheme will be entitled to disclosure any information pertaining to my dependants or myself, whether of a clinical or financial nature to any entity in the Scheme from time to time, as long as such entity agrees to keep the information confidential at all times and use the information solely for the administration of its programmes.
2.5 I consent to the Scheme addressing any request for information, test or examinations directly to any dependant of mine over the age of 21 (twenty one), with the same legal consequences as if the request had been addressed to me in my capacity as a principal member.
2.6
2.6.1 I authorise the Scheme to obtain from any person, including although not limited to my broker, any necessary information which the Scheme may require, in its sole and absolute discretion concerning
2.6.2 I myself or any dependant of mine, to assess any risk or claim relating to this application or my membership; direct the person concerned to provide the Scheme with such information on request.
2.7 I hereby authorise the Scheme to obtain any medical information or any other information pertaining to my dependants or myself that I may have disclosed to any entity in the Scheme and to utilise such information for underwriting or any risk management purposes.

3. **Pre-authorisation**
3.1 I shall notify the Scheme should I or any of my dependants require hospitalisation for a non-emergency event at least 48 (forty eight) hours before the event. I acknowledge that failure to do so will result in a reduction of the benefits payable by the Scheme for any procedure undertaken.
3.2 No benefit will be payable by the Scheme unless it is satisfied by the validity of a claim and it has received all the information which the Scheme may deem necessary, including, but not limited to, the results of any medical examination and tests which the Scheme may require me or my dependants to undertake.

4. **Monthly Contribution**
It is my sole responsibility as a member to ensure that the monthly premium is received by the Scheme. Short payment or non-payment of any of my premiums will result in suspension of the payment of any of my claims. Should contributions be outstanding for 2 (two) consecutive months, my membership will be cancelled. All subscriptions or contributions shall be paid directly to the Scheme no later than three days after the due date.

5. **The Scheme's right on termination**
On termination of my membership from the Scheme:
5.1 shall repay the Scheme any amount owing by me in respect of my Medical Savings Account TM or owing by me for any other reason;
5.2 understand that should contributions to my Medical Savings Account TM exceed claims paid from this account the excess will be payable to me, although strictly in accordance with the applicable legislation.

6. **Recording of Calls**
6.1 I consent to all conversations between myself and the Scheme or between my dependants and the Scheme being recorded and all information obtained through these conversations forming part of the Scheme's records;
6.2 I further consent to all of these recordings remaining the sole property of the Scheme.

7. **Acting on behalf of dependants**
I undertake to obtain the necessary consents from any dependant of mine to whom these terms and conditions may apply to act on their behalf with regards to any matter concerning their membership of the Scheme and I hereby indemnify the Scheme against any claim which may arise as a result of my failure to do so.

8. **Claims for which a third party is / may be liable**
I have been specifically referred to the Scheme Rules regarding medical/hospital expenses related to treatment resulting from an injury sustained by myself/family dependents for which any other party or institution may be liable and I undertake to be bound by said Rules.

9. **General**
I hereby understand that I must not resign from my current medical scheme until I have received notification of acceptance from the Scheme. Once I have received notification of my acceptance from the Scheme, I will cancel my current medical scheme membership as it is illegal to belong to two medical schemes at the same time.
I warrant that the contents of this application are true and correct and complete.
If there is no waiting period or late-joiner penalty applied to me or any of my dependants, the Scheme may activate my membership with effect from the commencement date reflected on this application form.

I agree to advice the Scheme in writing of any changes in details which may occur between the date of this application from and the activation date of my membership with the Scheme.

Signed at: _____ on Y Y Y Y M M D D
(Town / City)

By: _____
(Main applicant)

SECTION 12

IMPORTANT: We cannot process your application if it is incomplete, incorrect, or if you have not attached the correct documents. Please use this check list to make sure that you are sending us everything we need.

- [ ] Have you completed all the sections relevant to your application?
- [ ] Have you given us the correct contact details?
- [ ] Do we have your banking details so that we can collect your contributions and pay your claim refunds?
- [ ] Have you signed the form? (Unsigned forms will be returned to you for signature)
- [ ] If applicable, has your broker or intermediary completed and signed the relevant section of this form?
- [ ] Have you provided your employer's details?
- [ ] Have you chosen one option only?

Have you given us the following documentation where applicable?:

- [ ] ID documents of principle member as well as dependants.
- [ ] Birth certificate.
- [ ] Proof of taxable income. (e.g. pay slip)
- [ ] Proof of student registration.
- [ ] Legal adoption forms. (If children are adopted)
- [ ] Membership certificate.
- [ ] Marriage certificate.
- [ ] Chronic application form.
- [ ] Affidavit, should any dependant's surname differ from principal member's surname.
- [ ] Copy of cancelled cheque or bank statement for collecting contributions and/or claim refunds.