METROPOLITAN

# Application for Medical Aid Membership

## (Indoor and Sales Staff)

NAME

DEPARTMENT/REGION/BRANCH

EMPLOYEE NUMBER

DEBIT NUMBER / COST CENTRE

# METROPOLITAN MEDICAL SCHEME

## MEMBERSHIP

Membership to the Medical Scheme is a condition of employment and compulsory for all permanent employees, unless membership as a dependant on your spouse/partner's medical aid can be proven.

The Scheme offers two options i.e.:

**The Classic option:** provides cover in terms of hospitalisation and chronic medication as well as an out of hospital benefit per family.

**The Premier option:** provides comprehensive cover.

Personal Financial Advisors who are appointed on a permanent basis, can only select the Classic option with the provision to upgrade to the Premier option on the first available option change as laid down by the Rules of the Medical Scheme. In such cases, the employer contribution subsidy will still be limited to the Classic option.

Membership is guaranteed but a waiting period might be applied.The waiting period will be waived if a membership certificate from the previous scheme is submitted indicating continuous membership for a period of two years and longer. An employee who has never belonged to a medical scheme, is subject to medical selection and a three-month waiting period on basic benefits will be applied from the scheme's entry date. Premiums will be collected from the employee and the employer during the waiting period, but the employee will be liable for any claims submitted during this waiting period.

In the event of an employee failing to meet the health standards specified by the rules of the scheme and as determined by the Scheme's Medical Officer, it is accepted that certain benefits of such scheme may be restricted during the first 12 months of membership without it constituting a substantive alteration to the employee's condition of employment. The 12-month restriction might also be applied to the spouse/partner depending on his/her state of health at acceptance of the benefits

Membership of the medical scheme will automatically be terminated upon the termination of this employment contract for whatever reason, provided that such membership may continue in respect of retired employees, subject to the terms and conditions set out by the medical scheme.

If you wish to register any dependants (other than minors i.e. children younger than 21 years), they will be subject to medical selection. Spouse/Partners and children younger than 21 years will be regarded as normal dependants. Children that is older than 21 years and are full-time students will be regarded as normal dependants until they reach the age of 25 years. Other dependants such as older children and parents will be regarded as adult dependants. Only parents that are earning an income that is less than the current state pension and who is living with the member will be regarded as a dependant. The necessary proof according to the rules must be provided.

## CONTRIBUTIONS

The contribution is based on the pensionable salary and are raised monthly in arrears. The contribution is determined according to the job grade for indoor staff and the job status for Sales Staff.

**Indoor Staff (JG 1-9) and Area & Regional managers**
Employee contribute 1/3 of the premium
Employer contribute 2/3 of the premium (included in total monthly package)

**All other indoor & Sales staff**
Employee contribute 40% of premium
Employer contribute 60% of premium

Please note that no Employer contribution is made if the CPM of the Personal Financial Advisor is less than the amount as stipulated by the Employer (currently R4 500).

## APPLICATION FOR MEMBERSHIP

***Options - Please tick***

| | |
|---|---|
| I hereby apply for membership of the Metropolitan Medical Scheme and will complete the attached application form in full for assessment by the company's medical underwriters. | |
| I do not wish to apply for membership of the Metropolitan Staff Medical Scheme as I am already a dependant on my spouse/partner's medical aid (Please provide proof in the form of a membership certificate from your existing registered medical scheme | |

Employees applying for membership of the medical scheme have the option to choose between the following two options:

***Options - Please tick***

| | |
|---|---|
| Classic option: Hospital cover chronic medication and out of hospital benefits. | |
| Premier option: Comprehensive cover (not available to Personal Financial Advisors at commencement of service, but can upgrade at first available option as laid down by the rules of the scheme) | |

.....  .....

Employee's Signature  Date

***Please note that in all instances the rules of the scheme will prevail.***

METROPOLITAN MEDICAL SCHEME

# Application for membership

## PARTICULARS OF APPLICANT

Title: Mr/Mrs/Miss

Surname:

First names:

Postal address:

Postal code:

Tel. code & no.: Cell:

Fax code & no.: Email:

Date of birth: (dd/mm/yyyy) Marital status: *Married/Single/Divorced/Widow(er)*

Sex: Male: Female: Language:

ID number: Member

**Dependants:**

| | Full names and surname | Relationship to Applicant | Sex | ID Numbers |
|---|---|---|---|---|
| Spouse/ Partner | | | | |
| Dependants | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Use a second form if space is insufficient.**

## MEMBERSHIP PARTICULARS

Were you a member or a dependant of a registered medical scheme during the past two years? Yes No

**If "Yes", A CERTIFICATE OF MEMBERSHIP, indicating your date of resignation from that scheme, must be attached before registration on the Metropolitan Medical Scheme will be finalised. Please note that in terms of the Medical Schemes Act, it is unlawful to be registered on two schemes simultaneously.**

(i) (a) Name of current medical aid scheme:

(b) Membership number:

(c) Period of membership: to (dd/mm/yyyy)

(ii) (a) Name of previous medical aid scheme:

(b) Membership number:

(c) Period of membership: to (dd/mm/yyyy)

(iii) (a) Was membership subject to any restrictions: Yes No

(b) If "YES" state particulars:



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## 1. MEDICAL PARTICULARS

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

**N.B.** There is no obligation to disclose your and/or your dependants' HIV/AIDS status on this form.

Have you or your dependants ever suffered from or had symptoms of any of the following?

**Answer the questions Yes or No. If "yes" give full details in the Schedule on Page 5:**

| | | MEMBER | SPOUSE/ PARTNER | DEPEND-ANTS |
|---|---|---|---|---|
| (a) | Any nervous or mental complaint, e.g. epilepsy, migraine, black-outs, anxiety states, etc? | | | |
| (b) | Any respiratory disease, e.g. asthma, bronchitis, persistent cough, tuberculosis, etc? | | | |
| (c) | Any disease of the heart or circulatory system, e.g. heart attack, rheumatic fever, coronary artery disease, high blood pressure, stroke, palpitations, chestpain, etc? | | | |
| (d) | Any disease of the digestive system, gall bladder or liver e.g. stomach ulcer, indigestion, hiatus hernia, gall-stones, etc? | | | |
| (e) | Any disease of the kidneys, bladder, reproductive organs, or gynaecological related symptoms or conditions, or sexually transmitted diseases, including Hepatitis B, gonorrhoea, gential herpes or syphillis? | | | |
| (f) | Any ear, nose or throat disorder (e.g. recurrent tonsillitis, cataracts, chronic sinusitis)? | | | |
| (g) | Any disorder of muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout)? | | | |
| (h) | Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder? | | | |
| (i) | Any lumps, growths (benign or malignant), types of cancers (including Hodgkins and leukaemia)? | | | |
| (j) | Any tropical diseases (e.g. bilharzia, malaria, cholera)? | | | |
| (k) | Any other illness, disorder, disease, operation, disability or accident which required medical, radiological, surgical, pathological or dental investigations during the past 12 months? | | | |
| (l) | Have or are you or any of your dependants receiving any surgical, medical, major dental (including implants), chiropractic, optical or gynaecological treatment, procedures, advice or tests? | | | |
| (m) | Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? | | | |
| (n) | Has your weight or the weight of your dependants changed by more than 5kg over the last 12 months? | | | |
| (o) | Do you or any of your dependants experience any other ailment or disease at present? | | | |
| (p) | Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this questionnaire relating to past or present diseases, accidents, operations, or other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months? | | | |
| (q) | Are you or any of your dependants expecting to undergo any medical procedure, operation, confinement or receive any major dental treatment during the next 12 months? | | | |
| (r) | Are you or your dependants currently pregnant? | | | |

If you answered "YES" to any of the questions on Page 4, please complete details in the next section in full.

| Treating doctor's name | Treating Doctor's Tel. no. | Person treated | Date | Nature of illness |
|---|---|---|---|---|
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**MEDICATION USAGE**

Do you or any of your dependants use medication on a regular basis? Yes ☐ No ☐ If "yes", please provide details.

| Beneficiary | Illness | Period medication used (dd/mm/yyyy) |
|---|---|---|
| | | From |
| | | To |
| | | From |
| | | To |
| | | From |
| | | To |
| | | From |
| | | To |
| | | From |
| | | To |
| | | From |
| | | To |

Please note that in order to qualify for the Scheme's chronic medication benefit, a separate application form must be completed. Details of this process are reflected in the member guide that you will receive together with your membership card.

## 2. OPTIONS

**The Scheme offers two options - i.e:**

(i) **Classic Option:** provides cover in terms of hospitalisation and chronic medication as well as a limited out of hospital benefit.

(ii) **Premier Option:** provides comprehensive cover

**Personal Financial Advisors who are appointed on a permanent basis, can only select the Classic option with the provision to upgrade to the Premier option on the first available option change as laid down by the Rules of the Medical Scheme. In such cases, the employer contribution subsidy will still be limited to the Classic option.**

**Which option do you select?**

## 3. BANK DETAILS

Please provide us with banking details that will be used for the reimbursement of paid claims.

Name of account holder

Name of bank:

Name of branch: Branch code:

Bank account no:

Type of account: Savings ☐ Current ☐ Transmission ☐

## 4. DECLARATION

I, the undersigned, declare and warrant that the information contained herein is true and correct in every respect and I understand that all benefits that may be granted under the medical scheme of Metropolitan may be forfeited if any answer is proved to be untrue or incomplete.

I further authorise Metropolitan Medical Scheme or its administrators or health risk managers, when deemed necessary, to obtain information on my behalf from any service provider for purposes of, but not limited to, authentication of claims submitted to the Scheme for payment, verification of pre-existing conditions and obtaining medical reports in cases of protracted illness.

Signed at this day of 20

SIGNATURE OF APPLICANT SIGNATURE OF SPOUSE/PARTNER

**FOR OFFICE USE**

Membership no:

Employee no:

Department / Regional Office

Salary category: A B C

Entry date: (dd/mm/yyyy)

Option: C P

Checklist:

- ☐ Copy of member ID
- ☐ Copy of spouse/partner ID
- ☐ Copy of dependant's birth certificate
- ☐ Partner contract
- ☐ Membership certificates

**NOTES:**