APPLICATION FOR MEMBERSHIP

MEDIMED MEDICAL SCHEME
CALL CENTRE 041-395 4474
E-MAIL ADDRESS medimed@providence.co.za

P.O. Box 1672
Port Elizabeth
6001

7 Lutman Road
Richmond Hill
Port Elizabeth
6000

ADMINISTERED BY PROVIDENCE HEALTH CARE RISK MANAGERS

SECTION 1 | PERSONAL DETAILS

Title | Initials | Surname

First Names

Date of Birth (Y Y Y Y M M D D)

Identity Number

Postal Address (code)

Physical Address (code)

ID Type RSA Passport Other

Passport Country

Date of Employment (Y Y Y Y M M D D)

Telephone Number (Work) (code)

Occupation/Designation

Telephone Number (Home) (code)

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

Gender M F

Cellular Number

Marital Status Single Widowed Married Divorced

E-mail Address

SECTION 2 | YOUR OPTION

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

MEDISAVE MAX

MEDISAVE STANDARD

MEDISAVE ESSENTIAL*

ALPHA

*PLEASE COMPLETE A SEPARATE DOCTOR SELECTION FORM AND SUBMIT PHOTOGRAPHS FOR EACH REGISTERED DEPENDANT

FOR FURTHER DETAILS PLEASE CONSULT THE LATEST MEDIMED BENEFIT GUIDE

ADDITIONAL MEMBERSHIP CARD REQUIRED? Yes No

SECTION 3 | PREVIOUS MEDICAL SCHEMES OF PRINCIPAL MEMBER

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

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 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 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 Yes No
Years/Months on Medical Aid (Y Y M M)

SECTION 4 | YOUR DEPENDANTS' DETAILS

B. SPOUSE DETAILS

Title | Initials | Surname

First Names

Date of Birth Y Y Y Y M M D D

Identity Number

Marital Status Single Married Widowed

Gender M F

Postal Address

c o d e

Physical Address

c o d e

Telephone (Work)

c o d e

Cellular Number

Telephone (Home)

c o d e

E-mail

B. OTHER DEPENDANTS

NOTE: A separate form must be completed for each of the following dependants: Common Law Partner / Adopted Child / Foster Child.
Acceptance of dependants will be decided in accordance with the Scheme Rules.

D1
Name
Surname
ID Number
Date of Birth Y Y Y Y M M D D
Gender Female Male
Relationship

D2
Name
Surname
ID Number
Date of Birth Y Y Y Y M M D D
Gender Female Male
Relationship

D3
Name
Surname
ID Number
Date of Birth Y Y Y Y M M D D
Gender Female Male
Relationship

D4
Name
Surname
ID Number
Date of Birth Y Y Y Y M M D D
Gender Female Male
Relationship

D5
Name
Surname
ID Number
Date of Birth Y Y Y Y M M D D
Gender Female Male
Relationship

D6
Name
Surname
ID Number
Date of Birth Y Y Y Y M M D D
Gender Female Male
Relationship

SECTION 5 | MEMBER BANKING DETAILS

APPLICATION FOR ELECTRONIC TRANSFER OF FUNDS

I hereby instruct MEDIMED Medical Scheme to electronically collect contributions or to deposit refunds into my bank account. I understand that credit card accounts may not be used for these transactions. I also irrevocably authorise MEDIMED Medical Scheme to reverse any erroneous transaction and/or to rectify any incorrect electronic transfer of funds without prior notice.

Signature (Member) _____ **Date** Y Y Y Y M M D D

PLEASE TICK (MORE THAN ONE OPTION CAN BE SELECTED):

☐ USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS (PENSIONERS OR PRIVATE MEMBERS)

☐ USE THIS ACCOUNT FOR CLAIM REFUNDS

BANK DATE STAMP REQUIRED

BANK NAME

BRANCH NAME

ACCOUNT HOLDER NAME

BANK ACCOUNT NUMBER

BRANCH CODE - - -

ACCOUNT TYPE CURRENT ☐ CHEQUE ☐ SAVINGS ☐ TRANSMISSION ☐

NOTE : For a cheque account, please attach an original cancelled cheque

SECTION 6 | MEDICAL HISTORY (SEE QUESTIONNAIRE)

DECLARATION

By signing below I hereby give permission for, warrant, acknowledge and/or agree to the following:

- That the information in this application, whether in my own handwriting or not, is complete and accurate.
- To undergo a medical examination, at my own expense, should this be required.
- To submit proof of good health for me and my dependants and that the Scheme benefits may be limited or excluded in respect of any particular admission to MEDIMED, or MEDIMED may decline to accept me or any of my dependants in accordance with the Scheme Rules.
- That I am required at all times, if accepted as a member, to give MEDIMED all such information and evidence as MEDIMED may require. To this end I hereby authorise the medical practitioner, or any provider who has attended to me and/or my dependants in the past or the future, to provide MEDIMED with such information. I hereby waive the provision of any law or regulation restricting access to such information.
- My doctor, or the doctor of a patient who is a dependant of mine, may provide personal and/or clinical information on this application form.
- Any information concerning this application will remain confidential at all times.

Signature (Member) _____ **Date** Y Y Y Y M M D D

MEDICAL HISTORY

Height

Weight K G

Do you Smoke Yes No

Are you Pregnant Yes No

If yes, How many weeks

How often do you consume alcohol ? Please mark

Never Yes No

Occasionally (2-4 times a month or less) Yes No

Moderately (2-3 times a week) Yes No

Frequently (More than 4 times a week) Yes No

Has your weight changed by more than 5kg in the last year? Yes No

Do you use Chronic Medication? Yes No

Are you aware of any medical condition(s) which could require medical treatment or surgery? Yes No

If Yes, please supply details on Page 5.

Identity Number | | | | | | | | | | | | | |

CONDITION INFORMATION

Have you or any of your dependants ever experienced or been treated for, or are currently suffering from any of the following conditions?

If Yes, Please tick the appropriate block or specify the conditions, and complete page 5

1. Cardiovascular and or Blood disorders

☐ Chest Pain (Angina) ☐ Valve defect ☐ Rheumatic heart disease ☐ Heart attack
☐ Murmurs ☐ Hypertension (Blood pressure) ☐ Arrhythmia ☐ Hypercholestrolaemia
☐ Anemia ☐ Leukemia
Other, Specify

2. Respiratory problems (Lungs or breathing)

☐ Difficulty in breathing ☐ Shortness of breath ☐ Persistent cough ☐ Asthma
☐ Croup ☐ Tuberculosis ☐ Bronchitis ☐ Pneumonia
☐ Coughing up blood
Other, Specify

3. Ear, Nose & Throat

☐ Hearing/speech impairment ☐ Ear Infections ☐ Sinus problems ☐ Allergic rhinitis
Other, Specify

4. Kidney / Urinary System

☐ Blood in urine ☐ Kidney infections ☐ Prostate conditions ☐ Kidney failure
☐ Kidney stones ☐ Congenital urinary conditions ☐ Recurrent urinary tract infections
Other, Specify

5. Gynaecological

☐ Ovarian cysts ☐ Endometriosis ☐ Abnormal pap smears ☐ Fibroid
☐ Enlarged uterus ☐ Menstrual disorders ☐ Pregnant at present
Other, Specify

6. Glandular/ Endocrine

☐ Diabetes Mellitus ☐ Addison's disease ☐ Cushing's syndrome ☐ Growth disorders
☐ Disorders of the pituitary gland ☐ Hypo/hyperactive thyroid gland
Other, Specify

7. Neurological (Nervous system)

☐ Paralysis ☐ Stroke ☐ Epilepsy ☐ Migraine
☐ Brain or spinal cord disorder ☐ Multiple sclerosis
Other, Specify

8. Gastrointestinal

☐ Malena Stools (Bleeding) ☐ Ulcers ☐ Jaundice ☐ Change in bowel habits
☐ Pancreatic disorders ☐ Colitis ☐ Gall Stones/Cholecystitis ☐ Pancreatic disorders
☐ Irritable bowel syndrome
Other, Specify

9. Musculoskeletal

☐ Joint or spine condition, including Rheumatoid/Osteo-arthritis ☐ Neck or Back problems
☐ Recurrent back pain ☐ Ankylosing Spondylitis ☐ Osteoporosis
Other,Specify

10. LumpsorGrowths

☐ Benign tumours ☐ Malignant tumours ☐ Lymph cancer
☐ Melanoma
Other, Specify

11. Emotional / Psychological

☐ Anxiety ☐ Depression ☐ Schizophrenia ☐ Attention deficit disorder
☐ Anorexia ☐ Anorexia or any other eating disorders ☐ Alzheimers disease ☐ Bi-polar disorders
Other, Specify

12. Eyes

☐ Glaucoma ☐ Blindness ☐ Impaired vision ☐ Retinitis
☐ Conjuntivitis ☐ Macular degeneration ☐ Cataract
Other, Specify

Have you ever had, or are you currently undergoing or anticipating any specialised dentist treatment? (e.g. Orthodontic treatment or impacted wisdom teeth) Yes No

Do you have any congenital, hereditary or physical disability? Yes No

Do you participate in any hazardous sports or pursuits e.g. mountain climbing, paragliding? Yes No

Are you aware of any other conditions which may not have been specified on this form? Yes No

If you answered "yes" to any of the previous questions on page 4, please provide full details by completing this schedule

Question Number	Beneficiary	Diagnosis and Date of Onset	Condition resolved Yes or No?	Name of current medication	Further treatment expected	Date of last treatment or symptoms	Prognosis	Name and contact number of treating GP, dentist or specialist

SECTION 7 | 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 MEDIMED Rules. **All sections of the application form have been completed and signed.**

Employer's Telephone (c o d e)

Employer's Fax (c o d e)

Employer's E-mail

Name of Medical Scheme/Salary Administrator

Designation

COMPANY STAMP REQUIRED

Signature: _____

(Y Y Y Y M M D D)

SECTION 8 | DECLARATION BY MEMBER

IMPORTANT Failure to disclose all relevant information accurately may adversely affect the benefits available to you and your dependants.

- I hereby apply to MEDIMED Medical Scheme (MEDIMED) for membership for myself and my listed dependants, and agree to abide by the Rules of the Scheme.
- I understand that false information could result in my application for membership being rejected or my membership being cancelled. Should this occur, I agree to refund to MEDIMED all relevant payments which MEDIMED made on my behalf.
- I accept any penalties that may be applied in accordance with the Medical Schemes Act of 1998. I understand that these penalties include a 3 month general waiting period, a 12 month waiting period for pre-existing conditions and, if applicable, a late-joiner penalty fee.
- Contributions due to MEDIMED by me or my dependants will be paid MONTHLY. Failure to do so will result in my membership being suspended or terminated as per the MEDIMED Scheme Rules.
- I authorise any doctor, person, party or institution who may have any information about my health or the health of any of my dependants to disclose information required to MEDIMED and I agree that this authority shall remain in force after my death.
- I understand that MEDIMED may provide written notification, to my postal address, of changes to its Rules. Any notice sent to my postal address, shall be considered received by me on the 7th day after the date of posting.
- I agree that in the event that I, or my Employer, appoints an accredited broker to provide intermediary services, the Scheme shall be entitled to pay over to the broker the agreed fee for such services.

I confirm that the following documentation is attached to the application form:

- **copy of my ID document and my dependants ID documents/Birth Certificates;**
- **certificates of previous membership of registered medical schemes; and**
- **proof of income (salary advice)**
- **Marriage Certificate**

I acknowledge and understand that MEDIMED is entitled access to my medical scheme history in terms of the Medical Schemes Act.	Yes / No
I agree that PROVIDENCE, as the appointed administrator of MEDIMED, is permitted access to this information in order to render services to MEDIMED.	Yes / No

If "Yes" or "No" is not selected above, it will be assumed that I have granted this permission to MEDIMED to access this information.

Signed _____ (Member's signature) on this _____ day of _____ 20____

MEDISAVE ESSENTIAL

DOCTOR SELECTION FORM

DOCTOR GROUP CHOICE OF FAMILY:

PORT ELIZABETH **ECIPA** ☐ **PEGP** ☐

UITENHAGE **UDIPA** ☐ **WINTERHOEK** ☐

Principal Member

Medical Aid Number

Employer

Name of Selected Practioner

MEDISAVE ESSENTIAL UDIPA / WINTERHOEK ONLY

Dentist

Optometrist

DEPENDANTS		**Name Of Selected Practitioner**		
			MEDISAVE ESSENTIAL UDIPA / WINTERHOEK ONLY	
Surname	**First Names**	**Doctor**	**Dentist**	**Optometrist**

PLEASE NOTE:

1. Members selecting a provider from the **ECIPA** list of providers select a General Practitioner from the list provided and can visit any Dentist on the list or Optometrist from the **PPN** list.
2. Members selecting a provider from the **PEGP** list of providers select a General Practitioner from the list provided and can visit any Optometrist from the **PPN** list and any Dentist.
3. Members selecting a provider from the **UDIPA** or **WINTERHOEK** list of providers must select a General Practitioner, Optometrist and Dentist from the list provided.
4. Families can only change from a Port Elizabeth Doctor Group to an Uitenhage Doctor Group once a year (to become effective 1 January of each year).

Should you require any additional information or assistance please do not hesitate to contact our customer care departments as follow:

ECIPA and PEGP (041) 395 4474 • **UDIPA and WINTERHOEK** (041) 991 0455

Signature _____ Date Y Y Y Y M M D D

Administered by PROVIDENCE Healthcare Risk Managers (Pty) Ltd. Reg. No.1993/006699/07 Version 5 (November 2009)
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