Medimed
Managing your healthcare security

Registration Number 1506
PO Box 1672 | Port Elizabeth | 6000
7 Lutman Street | Richmond Hill | Port Elizabeth | 6001
info@medimed.co.za | www.medimed.co.za
086 177 7660 | 086 177 7660

APPLICATION FOR MEMBERSHIP

Checklist:

- ☐ 1. ID documents of principle member as well as dependents
- ☐ 2. Birth certificates for children
- ☐ 3. Proof of taxable income (eg pay slip)
- ☐ 4. Proof of student registration
- ☐ 5. Legal adoption forms (if children adopted)
- ☐ 6. Membership certificates of previous Medical Schemes.
- ☐ 7. Marriage certificate
- ☐ 8. Affidavit, should any dependant's surname differ from principal member's surname
- ☐ 9. Copy of cancelled cheque or bank statement for collecting contributions and/or claim refunds

SECTION 1: YOUR OPTION

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

☐ **MEDISAVE MAX** ☐ **MEDISAVE ESSENTIAL***

☐ **MEDISAVE STANDARD** ☐ **ALPHA**

FOR FURTHER DETAILS PLEASE CONSULT THE LATEST MEDIMED BENEFIT GUIDE

ADDITIONAL MEMBERSHIP CARD REQUIRED? ☐ YES ☐ NO

Join Date Y Y Y Y M M D D

*Please complete Section 9 (this is for the Essential option selection)

SECTION 2: PERSONAL DETAILS

Title | Initials | First Names | Surname

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | Tax Number

Country of Issue

Gender: ☐ M ☐ F

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

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Traditional Marriage

Language Preference: ☐ English ☐ Afrikaans ☐ Xhosa ☐ Other: *Specify*

Ethnic Group: ☐ Asian ☐ Black ☐ Coloured ☐ White

Telephone Number (Home) (code) | Telephone Number (Work) (code) | Cellphone Number

E-mail Address

Physical Address

Street Number / Street Name
Suburb
City
Province / State
Code

Postal Address ☐ Same as Physical

Street Number / Street Name
Suburb
City
Province / State
Code

ID/Passport Number:

Primary Member Consent Section

You give permission to make information available to the third party/family member specified below.

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

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

☐ All consent ☐ Updating details ☐ Financial info ☐ Clinical info ☐ None

Relationship

Print Name and Surname of Member:

Signature:

Date: Y Y Y Y M M D D

SECTION 3: INCOME & EMPLOYER SECTION

Private Member ☐ *If ticked Private Member, please complete SECTION 3A and *marked fields in SECTION 3B*

SECTION 3A: PRIVATE MEMBER TO COMPLETE

The rules of the Scheme refer to "income" as: The total gross monthly earning from all sources. If a spouse or partner is registered as a dependent on the Scheme, then "income" is the higher of member or spouse/partner's income.

Important notice: Declaring income lower than your actual income is fraud. This will result in the immediate cancellation of your membership and you will not be able to join the Scheme again.

Monthly earnings in the highest income category? YES ☐ NO ☐ *If yes, not required to submit supporting documentation.*

If your income is lower than the highest bracket, we will require the following documentation:

- A copy of your latest IT 34 (Mandatory)
- Latest payslip with IRPS or
- Letter from your company or employer confirming your monthly income
- And 3 months bank statements

SECTION 3B: EMPLOYER TO COMPLETE AND SIGN

Employer

Paypoint | Tax Number* | Basic Salary* R

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

Number of Subsidised Dependants: Spouse ☐ Children ☐ Adult Dependents ☐

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 Number c o d e

Employer's E-mail Address

Name of Medical Scheme/ Salary Administrator

Designation

COMPANY STAMP REQUIRED

Signature:

Date: Y Y Y Y M M D D

SECTION 4: INTERMEDIARY DETAILS *(To be completed by Broker – if applicable)*

Application Information: ☐ New Business ☐ Addition to Existing Group

Group Size:

Name of Group / Individual:

Joining Date: Y Y Y Y M M D D

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

ID/Passport Number:

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 (code)

Fax Number (code)

Cellphone Number

Please indicate prefered method of communication: ☐ E-mail ☐ SMS

Broker Signature:

Date: (Y Y Y Y M M D D)

SECTION 5: PREVIOUS MEDICAL SCHEMES

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

Scheme Name | Date from (Y Y Y Y M M D D) | Certificate Attached ☐ YES ☐ NO

Membership Number | Date to (Y Y Y Y M M D D) | Years / Months on Medical scheme (Y Y M M)

Scheme Name | Date from (Y Y Y Y M M D D) | Certificate Attached ☐ YES ☐ NO

Membership Number | Date to (Y Y Y Y M M D D) | Years / Months on Medical scheme (Y Y M M)

Scheme Name | Date from (Y Y Y Y M M D D) | Certificate Attached ☐ YES ☐ NO

Membership Number | Date to (Y Y Y Y M M D D) | Years / Months on Medical scheme (Y Y M M)

SECTION 6: YOUR DEPENDANT'S DETAILS

A. SPOUSE'S DETAILS

Title | Initials | First Names | Surname

Identity Number/ Passport Number

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

Gender: ☐ M ☐ F

Telephone Number (Home) (code)

Telephone Number (Work) (code)

Cellphone Number

E-mail Address

Physical Address

Street Number / Street Name

Suburb

City

Province / State

Code

Postal Address ☐ Same as Physical

Street Number / Street Name

Suburb

City

Province / State

Code

Spouse's Consent Section: *You give permission to make information available to the third party/family member specified below.*

Title | Initials | First Names | Surname

Identity / Passport Number

Contact Number

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

☐ All consent ☐ Updating details ☐ Financial info ☐ Clinical info ☐ None

Relationship

Signature:

Date: (Y Y Y Y M M D D)

ID/Passport Number:

B. OTHER DEPENDANTS

Note: Additional documentation is required when adding a Common Law Partner / Adopted Child / Foster Child.
Please refer to Checklist on page 1. Acceptance of dependants will be decided in accordance with the Scheme Rules
If the dependant is 18 and older kindly complete the consent section.

D1

First Names | Surname | Relationship

Date of Birth (Y Y Y Y M M D D) **Gender:** M F

Identity Number/ Passport Number

Cellphone Number

Physical Address
Street Number / Street Name
Suburb
City
Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: R

Adult Dependant Consent Section:
You give permission to make information available to the third party/family member specified below.

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: (Y Y Y Y M M D D)

D2

First Names | Surname | Relationship

Date of Birth (Y Y Y Y M M D D) **Gender:** M F

Identity Number/ Passport Number

Cellphone Number

Physical Address
Street Number / Street Name
Suburb
City
Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: R

Adult Dependant Consent Section:
You give permission to make information available to the third party/family member specified below.

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: (Y Y Y Y M M D D)

ID/Passport Number:

Note: If the dependant is 18 and older kindly complete the consent section.

D3

First Names | Surname | Relationship

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

Gender: M F

Identity Number/ Passport Number

Cellphone Number

Physical Address

Street Number / Street Name

Suburb

City

Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: **R**

Adult Dependant Consent Section:

You give permission to make information available to the third party/family member specified below.

Title | Initials | First Names | Surname

Identity / Passport Number

Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: (Y Y Y Y M M D D)

D4

First Names | Surname | Relationship

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

Gender: M F

Identity Number/ Passport Number

Cellphone Number

Physical Address

Street Number / Street Name

Suburb

City

Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: **R**

Adult Dependant Consent Section:

You give permission to make information available to the third party/family member specified below.

Title | Initials | First Names | Surname

Identity / Passport Number

Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: (Y Y Y Y M M D D)

ID/Passport Number:

SECTION 7: BANKING DETAILS

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.

Account Holders Signature:

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 AND PRIVATE MEMBERS – *Contribution payments deducted in Advance*)

☐ USE THIS ACCOUNT FOR CLAIM REFUNDS

BANK NAME

BRANCH NAME

ACCOUNT HOLDER NAME

ACCOUNT HOLDER ID NO

BANK ACCOUNT NUMBER

BANK DATE STAMP REQUIRED

ACCOUNT TYPE ☐ CURRENT ☐ CHEQUE ☐ SAVINGS ☐ TRANSMISSION

*Submit confirmation of banking details for collecting contributions and/or claim refunds.

*If the bank account is in another person's name, then the account holder should also sign this form, giving the Scheme permission to deduct the contributions from his/her account with a copy of the account holder's ID document

SECTION 8: MEDICAL HEALTH QUESTIONAIRE

SECTION A: Information on symptoms, conditions or disorders

(Must be completed for the main applicant, spouse/partner and all dependants).

Please indicate if you or any dependant in this application have experienced any of the below medical incidents within the 12-month period prior to your application for membership.

We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

IMPORTANT - PLEASE SUPPLY DETAILS ON PAGE 7 FOR ANY CONDITION THAT HAS BEEN TICKED.
This section is extremely important. Any omission or misrepresentation of information may lead to refusal to admit to pay any claims for treatment received, or the scheme can terminate your membership. All conditions, symptoms or disorders have to be declared, no matter how insignificant they may seem.

1. Tumours, growths and skin disorders ☐ YES ☐ NO — **List member or dependant name/s**

Example: abnormal pap smear results, skin lesions, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal PSA result.	

2. Heart and circulation conditions ☐ YES ☐ NO — **List member or dependant name/s**

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure cardiomyopathy, valvular heart disease or heart valve replacement, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.	

3. Gynaecological and obstetric conditions ☐ YES ☐ NO — **List member or dependant name/s**

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, menopause, ectopic pregnancy.	

Are you or any dependants pregnant or suspect pregnancy? ☐ YES ☐ NO

If yes, list dependant name and date of last menstrual period Y Y Y Y M M D D

4. Mental health ☐ YES ☐ NO — **List member or dependant name/s**

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, autism, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, counselling, bulimia.	

ID/Passport Number:

5. Metabolic or endocrine conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: diabetes (high blood sugar), thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency.	

6. Gastrointestinal conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, stomach ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.	

7. Brain and nerve conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: stroke, epilepsy, multiple sclerosis, motor neuron disease,myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, vetriculo-peritoneal shunt (VP shunt), mental retardation, CVA, bleeding on the brain.	

8. Breathing and respiratory conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia.	

9. Musculoskeletal (back, bone and muscle pain) ☐ YES ☐ NO

	List member or dependant name/s
Example: arthritis (any form), ongoing neck and/or back pain, ankylosing spondylitis, lupus, Sjögren's syndrome,scleroderma,polymyositis, dermatomyositis, polyarteritis nodosa,Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease,scoliosis, kyphosis,spinal stenosis,neurogenic bladder, gout, fractures, physical disability	

10. Kidney or urinary conditions including current or past dialysis ☐ YES ☐ NO

	List member or dependant name/s
Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndromepolycystic kidney disease, urinary incontinence, bladder infections, other bladder or kidney problems	

11. Blood conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders.	

* **HIV and AIDS:** If you and/or any of your dependants are HIV positive or have AIDS and would prefer not to disclose your and/or their HIV status on this form due to confidentiality you or they must call us on **WELLNESS NUMBER** with in seven working days from the date we activate your Medical Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the Wellness Programme. The Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period may therefore apply to this condition. If you do not let us know about your HIV status within 7days of your membership being active, we may end your Medical Scheme membership.

12. Eye conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.	

13. Ear, nose and throat (ENT) and dentistry conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery,dental treatment or dental surgery.	

14. Male urogenital conditions ☐ YES ☐ NO

	List member or dependant name/s
Example: prostate disorders, urogenital defects, varicoceles, tumours, undescended testes, phimosis, urinary incontinence.	

Are there any other conditions or symptoms not listed above, for which medical advice, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months?

☐ YES ☐ NO *If yes, please provide details in Section B on the next page*

ID/Passport Number: | | | | | | | | | | | | |

Have you or any of your dependants had surgery in the past, or are you planning to have a surgery in the next 12 months? ☐ YES ☐ NO *If yes, please provide details in Section B below.*

Do you or any of your dependants currently use medication on a daily basis? ☐ YES ☐ NO *If yes, please provide details in Section B below.*

SECTION B: Beneficiary detail on symptoms, condition or disorders

Patient Name	Diagnosis	Date Diagnosed	Date of last symptoms, consult or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD

ID/Passport Number:

SECTION 9: MEDISAVE ESSENTIAL: DOCTOR SELECTION FORM

DOCTOR GROUP CHOICE OF FAMILY:

PORT ELIZABETH ☐ ECIPA ☐ PEGP **MEDISAVE ESSENTIAL** ☐ ☐

Principal Member:

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 and 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.

Name of Selected Practitoner

DEPENDANTS

Surname	First Names	Doctor

Should you require any additional information or assistance please do not hesitate to contact our customer care department: (086) 177 7660

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 acquire. I hereby authorise the medical practitioner, or any provider who has attended to me and/or my dependants 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.
- Contributions due to MEDIMED by me or my dependants will be paid MONTHLY *(due in advance for Private and continuation members)*. Failure to do so will result in my membership being suspended or terminated as per the MEDIMED Scheme Rules.
- Savings due to MEDIMED on termination of membership, shall be paid to the Scheme. If I terminate my membership before the year ends and I have spent more than I have paid, I will owe savings to the Scheme. Failure to pay over utilised savings will result in the account being handed over for debt collection.
- I accept any penalties that may be applied in accordance with the Medical Scheme 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.

Print Name and Surname of Member:

Signature:

Date: Y Y Y Y M M D D

Registration Number 1506
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CONSENT FOR MEDIMED TO PROCESS PERSONAL INFORMATION

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of Medimed Medical Scheme (Medimed).

Medimed and the contracted Administrator will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then Medimed will not be able to administer or offer you membership of the medical scheme.

Please read the statements below and sign your acceptance thereof.

1. I authorise,and give consent to Medimed and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependents, for purposes of my Medimed membership risk profiling and management, administration of my membership and as set out in this section.
2. I confirm that I am authorised to provide consent on behalf of my dependants and that I have their permission to share such information with Medimed and the Administrator. Where I give consent for a minor, I confirm that I am a competent person in respect of such minor and I have the authority to give consent for them.
3. I hereby authorise and give consent to Medimed and its Administrator to share my personal information, including health information, and that of my dependants, with any entity (including an entity forming part of the Administrator/Managed Care Organisation's affiliated group of companies), with whom I and/or my dependants have a contractual relationship with, or have applied for a product or service from such entity. This personal information will be processed and/or used for further processing in order to administer the products or services.
4. I acknowledge that I must give Medimed and the Administrator all information and evidence they may require from time to time. I authorise Medimed and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Medimed may require concerning my or any of my dependants in assessing any risk or claim in relation to this application, my membership of Medimed and risk profiling or management. I consent to that person providing, and instruct that person to provide, Medimed and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
5. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
6. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my persona information unless processing is required by law.
7. I have the right to request my personal information which is in the possession of Medimed and the Administrator, provided that I furnish adequate identification.
8. I have the right to request Medimed and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
9. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.
10. It remains the responsibility of the applicant to make full disclosure of the required information pertaining to the applicant and/or all the dependants. Should you wish to add a medical report from your family practitioner you are welcome to do so. The Medical Schemes Act makes provisions for a membership to be terminated where non-disclosure of material information is proven, and the law does not recognise ignorance as an excuse. Your signature to the application form indicates, amongst others, that you understand the terms and conditions of membership, and that the information furnished in the application form is true and correct. If you are unsure about any of the questions, please do not hesitate to contact the Medical Scheme call centre.
11. Disclosure of information: 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.
12. I hereby give my consent to Medimed's Administrator for me to receive direct marketing of complementary products and services by the Administrator/Managed Care Organisation's affiliated group of companies to be marketed to me by means of electronic communication.

☐ Tick here if you do not wish to receive any direct marketing.

Print Name and Surname of Member:

ID/Passport Number:

Signature:

Date: Y Y Y Y M M D D

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CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication. To download an additional application form visit: www.medimed.co.za
2. Allow one working day for the processing of your application.
3. The original prescription must be given to the provider who dispenses your medication.
4. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
5. Approval of chronic medication is subject to the rules and chronic protocols of the Scheme.
6. You may contact the Pharmacy Benefit Management (PBM) Team at (041) 395 4482 or e-mail chronic@medimed.co.za
7. Send completed forms via fax 086 680 8855, mail PO Box 1672, Port Elizabeth, 6000 or e-mail chronic@medimed.co.za

B. MEMBER DETAILS

Scheme | Option | Membership Number

Title | Initials | First Names | Surname

Identity Number | Date of Birth (Y Y Y Y M M D D) | E-mail Address

Postal Address

Street Number / Street Name
City
Suburb
Province / State
Code

Telephone Number (Home) code
Telephone Number (Work) code
Fax Number code
Cellphone Number

C. PATIENT DETAILS *(Beneficiary who requires Chronic Medication)*

Title | Initials | First Names | Surname

Identity Number | Date of Birth (Y Y Y Y M M D D)

Telephone Number (Home) code | Telephone Number (Work) code | Fax Number code

Cellphone Number | E-mail Address

The outcome of this application must be communicated to me via my email address: ☐ YES ☐ NO

Patient Name: ID Number:

D. PATIENT DECLARATION

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

- My (or my minor dependant's) doctor may provide clinical information regarding my (or my minor dependant's) condition to the PBM Team.
- Any information concerning this application will remain confidential at all times.
- It may be a pre-condition to the approval of the Chronic Medication Benefit that I (or my minor dependant) register and comply with the requirements of a Disease Management Programme.
- My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application.
- This funding authorisation is at all times subject to the Scheme rules even if a beneficiary's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
- This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
- The Scheme and its Administrator shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Name (or member if patient is a minor)

Signature:

Date: Y Y Y Y M M D D

Clinical Information Consent Section

*You give permission to make **clinical information** available to the third party/family member specified below.*

Title | Initials | First Names | Surname | Relationship

Identity/Passport Number | Contact Number

Print Name and Surname of Patient

Signature:

Date: Y Y Y Y M M D D

E. CLINICAL CRITERIA

The following information is required when applying for a new chronic condition.

Certain conditions which do not appear on the form below may be considered for approval on the Chronic Benefit, although not all long-term conditions, which a doctor may define as chronic, will fulfill the criteria for approval.

** Chronic conditions only available on the Extended Chronic Benefit of the Medisave Max, Medisave Standard and Medimed Alpha options.*

Condition	Requirements
Addison's Disease	1. Initial Specialist Application. 2. ACTH Stimulation Test. 3. Serum Cortisol Test.
ADHD*	1. Initial Specialist Application. 2. Specialist motivation if > 12 years of age.
Alzheimer's Disease*	1. Initial Specialist Application. 2. Folstein's Mini Mental Examination State (MMSE) result.
Ankylosing Spondylitis*	1. Initial Specialist Application.
Asthma	1. Lung function test (8 years of age and older).
Benign Prostatic Hypertrophy*	1. Motivation for 2nd tier agents (e.g. Alfuzosin) and Hormone inhibitors.
Bipolar Mood Disorder	1. Specialist to complete Section K.
Bronchiectasis	1. Initial Specialist Application. 2. Attach relevant radiology report.
Cardiac failure	1. Specialist to complete section G.
Cardiomyopathy	1. Initial Specialist Application.
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator.
Chronic Renal Disease	1. Initial Specialist (Nephrologist) Application. 2. Serum Urea, Creatinine and GFR.
Coronary Artery Disease	1. Stress ECG confirming diagnosis. 2. Attach history of previous cardiovascular disease event(s).
Crohn's Disease	1. Initial Specialist Application. 2. Diagnostic reports to be supplied
Cystic Fibrosis*	1. Initial Specialist Application.

Patient Name: ID Number:

Condition	Requirements	
Depression*	1. Prescriber to complete Section K.	
Diabetes Insipidus	1. Initial Specialist Application.	2. Water deprivation test results.
Diabetes Mellitus	1. Prescriber to complete Section G and H.	2. Please attach the diagnostic Fasting/Random Blood Glucose results. *The application cannot be reviewed if this is not submitted*
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code.	2. ECG confirming diagnosis.
Epilepsy	1. EEG report confirming diagnosis.	2. Attach detailed seizure history.
Generalised Anxiety Disorder*	1. Prescriber to complete Section K.	
Glaucoma	1. Initial Specialist Application.	2. Supply initial diagnostic intra-ocular pressure/s.
Haemophilia	1. Initial Specialist Application.	2. Haemophilia A (Factor VIII as % of Normal). 2. Haemophilia B (Factor IX as % of Normal).
HIV & AIDS *(Call 086 010 3228 for more information)*	1. HIV application available on website or complete section L. 2. Eliza test result. 4. Crag test if CD4 count is below 100.	3. Baseline blood tests. 5. TB screening.
Hyperlipidaemia	1. Prescriber to complete Section G and J.	2. Please attach the diagnosing Lipogram. *The application cannot be reviewed if this is not submitted.*
Hypertension	1. Prescriber to complete Section G and I. 2. Initial Specialist Application if younger than 18 years of age.	
Hyperthyroidism	1. Attach initial diagnostic report.	
Hypothyroidism	1. Attach initial diagnostic report.	
Menopause*	1. Motivation required for early-onset menopause (< 40 years of age) and the prescription of Tibolone.	
Multiple Sclerosis	1. Initial Specialist Application. 3. Extended Disability Status score (EDSS).	2. Comprehensive disease history.
Myasthena Gravis*	1. Initial Specialist application	
Osteoporosis*	1. DEXA bone mineral density (BMD) scan and report on any additional risk factors.	
Parkinson's Disease	1. Initial Specialist Application.	
Rheumatoid Arthritis (RA)	1. Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented. 2. Initial Specialist Application for Leflunomide and Specialist Motivation for Biologic DMARDs. 3. Baseline Disease Activity Scores.	
Schizophrenia	1. Psychiatrist to complete Section K.	
Systemic Lupus Erythematosus	1. Initial Specialist Application.	2. Comprehensive disease history
Ulcerative Colitis	1. Initial Specialist Application.	2. Diagnostic reports to be supplied

F. PATIENT HEALTH INFORMATION *(to be completed by doctor)*

Weight: kg Height: m Hip/Waist ratio: Smoker? ☐ YES ☐ NO Ave per day:

Exercise: Frequency times per week Intensity: ☐ Low ☐ Medium ☐ High

Current Blood Pressure mmHg Available Blood Glucose Result mmol/L ☐ Fasting ☐ Random

G. CARDIOVASCULAR *(to be completed by doctor when applying for hypertension, hyperlipidaemia or diabetes mellitus)*

Is microalbuminuria present? ☐ YES ☐ NO Is GFR less than 60ml/min? ☐ YES ☐ NO

Please indicate which of the following co-morbidities/risk factors apply to this patient?

☐ Peripheral arterial disease ☐ Nephropathy ☐ Retinopathy ☐ Heart Failure

☐ Left ventricular hypertrophy ☐ Chronic renal disease ☐ Cardiomyopathy ☐ Prior stroke/TIA

☐ Prior myocardial infarction ☐ Prior CABG ☐ Prior Stent ☐ Angina

If heart failure is present, please indicate classification below:

NYHA/ACC-AHA Classification: ☐ A ☐ B/I(Mild) ☐ C/II(Mild)-III(Moderate) ☐ D/IV(Severe)

Patient Name: ID Number:

H. DIABETES MELLITUS

Please attach the laboratory diagnostic Fasting or Random Blood Glucose results.
The application cannot be reviewed if this is not submitted.

I. HYPERTENSION *(to be completed by doctor when applying for hypertension)*

Please supply two blood pressure readings, performed on two different occasions, before initiating drug therapy, for a newly diagnosed patient.

(1.) Date: Y Y Y Y M M D D mmHg (2.) Date: Y Y Y Y M M D D mmHg

J. HYPERLIPIDAEMIA *(to be completed by doctor when applying for hyperlipidaemia)*

Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.

Is there a family history of early-onset arteriosclerotic disease? ☐ YES ☐ NO *If yes, please provide details below:*

Does the patient suffer from familial hyperlipidaemia? ☐ YES ☐ NO Has this been verified by an Endocrinologist? ☐ YES ☐ NO

If yes, please provide details below:

Please risk your patient as per the Framingham coronary prediction algorithm %

K. PSYCHIATRIC CONDITIONS *(to be completed doctor by when applying for psychiatric disorders)*

Please indicate DSM IV diagnosis

Please indicate number of relapses

L. HIV & AIDS

Date of HIV Diagnosis Y Y Y Y M M D D Viral Load on Diagnosis CD4 count on Diagnosis

Previous ARV regimen	Date Started	Date Stopped	Reason for Change
	Y Y Y Y M M D D	Y Y Y Y M M D D	
	Y Y Y Y M M D D	Y Y Y Y M M D D	

Please describe any abnormality on examination or previous significant illness

All Baseline Investigations to be attached to application: ☐ Current Viral load & CD4 count ☐ Creatinine ☐ Hep B sAg

☐ U & E ☐ FBC ☐ LFT ☐ RPR ☐ Pap Smear ☐ CrAg ☐ Random Cholesterol & Glucose

TB Screen: Symptomatic YES ☐ NO ☐ **Investigations:** CXR YES ☐ NO ☐ Sputum YES ☐ NO ☐ Is member a candidate for IPT? YES ☐ NO ☐

Alternate contact Relationship Cellphone Number

M. MEDICAL PRACTITIONER DETAILS & ADDITIONAL NOTES

Surname Initials Practice Number

Speciality Telephone Number code Fax Number code

Cellphone Number E-mail Address

The outcome of this application must be communicated to me via: ☐ Email address ☐ Fax number

Patient Name: | ID Number:

MEDICAL PRACTITIONER ADDITIONAL NOTES:

N. CONDITION AND MEDICATION DETAILS *(to be completed by doctor)*

ICD-10 Code	Medication prescribed (Name, strength & dosage)	Date medication initiated & prescriber details	Repeats
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	

Name of Medical Practitioner: | Signature: | Date: Y Y Y Y M M D D

P. HOW THE CHRONIC BENEFIT WORKS

The Chronic Benefit includes cover for medication from a specified list of chronic conditions which is in accordance with the Scheme option. These conditions have been selected according to clinical and actuarial criteria.

Chronic Disease List - The Prescribed Minimum Benefit regulations require that medical schemes cover the diagnosis, medical management and medication for a specified list of 27 chronic conditions known as the Chronic Disease List. All such conditions meeting approval criteria will be authorised under the PMB Chronic Medication benefit.

Extended Chronic Disease List - Certain Medimed options provide cover for an Extended Disease List. All approved medication will be paid up to the benefit limit on the respective option. All such conditions meeting approval criteria will be authorised under the Extended Chronic Medication benefit.

The PBM team will authorise an amount for all approved chronic conditions. The approved amount (Chronic Drug Amount - CDA) is determined based on the treatment protocols for all levels of treatment for each condition. The CDA is the maximum Rand amount that will be approved for the class/category of each drug that is authorised.