Application form 2016

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Instructions

- Complete this application form in black ink
- Print clearly using capital letters
- Mark with an X where necessary
- This form must be completed after reading through the Bonitas Product Brochure.

Please note: We cannot process your application if it is incomplete, incorrect or you have not attached the correct documents to it.

Section 1: Choosing your option

Please select one Option only.

BonComprehensive ☐ BonClassic ☐ Standard ☐ Standard Select ☐ BonSave ☐ BonFit ☐ Primary ☐

BonEssential ☐ BonCap ☐

Please note: BonCap contributions are income-based. If you select BonCap, you must complete the BonCap income declaration form and attach the required documents to it. If you do not do so you will be defaulted to the highest monthly income band **BonCap:** Subject to a BonCap GP and BonCap Network hospital. **Standard Select**: Subject to GP nomination of Network GP and Standard Select Hospital Network and **BonFit**: Subject to a GP network and BonFit Hospital Network.

Section 2: Intermediary details

This section must be completed by the broker or agent.

Name of broker/agent:	Aon South Africa
Broker code:	AON001
Name of brokerage:	Aon South Africa
Telephone (w):	0860 0833
Cellphone:	
Email:	

Broker House Name: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code:
AON001M16

Brokerage/agency stamp

I declare that I am an accredited healthcare broker contracted to Bonitas Medical Fund as a financial advisor and that I am licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act 37 of 2002 and accredited by Council for Medical Schemes in terms of the Medical Schemes Act of 1998.

I acknowledge that the applicant has appointed me as his / her financial advisor and that he/she is entitled to cancel my services at any time. I confirm that the applicant was provided with my personal details, physical and postal address and telephone number.

I acknowledge that a monthly commission of 3% of the total monthly premium plus VAT will be paid to me in terms of the Medical Schemes Act 131 of 1998 (or as amended).

I acknowledge that there has been no material misrepresentation of any fact by me and that in the event of material misconduct or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation or conduct.

I declare that the applicant is familiar with the information requested in the application form and all the relevant information was provided by the applicant. The advice and assistance given to the applicant was impartial and in the best interest of the applicant.

Signature of broker/agent: _____ **Date:** _____

Section 3: Employee information

Please complete this section. You must submit the completed application form to your HR Department if your medical aid is through your employer.

Name of employer:

Department/Division:

Employee number:

Employment date: / / 20

Medical scheme start date: / / 20

Number of child dependants:

Number of adult dependants:

Government employees – attach a current copy of your salary advice.

Persal number:

Section 4: Employer information

If your medical aid is through your employer, this section must be completed by your employer and have your employer's stamp on it.

Name of company representative:

Title of company representative:

Telephone:

Email:

Bonitas pay-point code:

Employer stamp

We, the Employer confirm that the applicant is employed by us and began employment on the employment date stated in **section 3**. Contributions will be deducted according to the Scheme Rules and option chosen.

Signature of employer representative: _____ **Date:** _____

Section 5: Details of main member

Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Title: **Surname:**

First names:

Identity number:

Date of birth: **Tax number:**

Marital status: **Gender:** M F

Ethnic group: Black Coloured Indian White Asian

Cellphone: **Telephone (h):**

Telephone (w) **Medical scheme start date:** / / 20

Email:

Postal address:

Code:

Street address:

Code:

Section 6: Details of dependants

Please enter the details for any dependants you want to be covered on your option. You may register up to four dependants on this form. Please provide identity numbers or passport numbers for all dependants and attach copies of these. You must also attach copies of marriage certificates, birth certificates, adoption papers or foster care court orders where applicable. We require an affidavit for life partners. We also require copies of previous membership certificates with the terminated date.

Please note:

- An adult dependant is a person 21 years or older.
- Child rates apply to full-time students between 21 and 24, provided that proof of registration, from a recognised tertiary institution, for the current year is attached to the application.

Dependant 1

Adult ☐ **Child** ☐ **Relationship to main member:**

Title: **Surname:**

First names:

Identity number:

Date of birth: / / **Tax number:**

Marital status: **Gender:** M F

Ethnic group: Black Coloured Indian White Asian

Cellphone: **Telephone (h):**

Telephone (w)

Email:

Dependant 2

Adult ☐ Child ☐ Relationship to main member:

Title: Surname:

First names:

Identity number:

Date of birth: / / Tax number:

Marital status: Gender: M F

Ethnic group: Black Coloured Indian White Asian

Cellphone: Telephone (h):

Telephone (w)

Email:

Dependant 3

Adult ☐ Child ☐ Relationship to main member:

Title: Surname:

First names:

Identity number:

Date of birth: / / Tax number:

Marital status: Gender: M F

Ethnic group: Black Coloured Indian White Asian

Cellphone: Telephone (h):

Telephone (w)

Email:

Dependant 4

Adult ☐ Child ☐ Relationship to main member:

Title: Surname:

First names:

Identity number:

Date of birth: / / Tax number:

Marital status: Gender: M F

Ethnic group: Black Coloured Indian White Asian

Cellphone: Telephone (h):

Telephone (w)

Email:

Section 7: GP Nomination

If you choose the Standard Select option you must nominate a GP from the Bonitas GP network.

Main Member

Members First names:

Members Surname:

Doctor's name:

Practice number: Doctors Contact number:

Dependant 1

Members First names:

Members Surname:

Doctor's name:

Practice number: **Doctors Contact number:**

Dependant 2

Members First names:

Members Surname:

Doctor's name:

Practice number: **Doctors Contact number:**

Dependant 3

Members First names:

Members Surname:

Doctor's name:

Practice number: **Doctors Contact number:**

Dependant 4

Members First names:

Members Surname:

Doctor's name:

Practice number: **Doctors Contact number:**

Section 8: Medical details

Please enter the medical details and history of you and your dependants below. Failure to disclose medical conditions could limit your benefits, exclude you from receiving some benefits or result in the termination of your membership.

Current doctor's name:

Telephone: **Doctor since:** / /

Do you or any of your dependants currently suffer or have suffered from any Chronic illnesses? **Yes** ☐ **No** ☐

If you or any of your dependants have a history of any of the following illnesses or currently suffer from them, please complete the relevant tables below.

1. Chronic illnesses (for example raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression and thyroid disorder).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

2. Gastro-intestinal disorders (for example heartburn, stomach disorder, Crohn's disease and ulcerative colitis).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

3. Muscle, bone, skin or nerve disorders (for example back and neck-related conditions, arthritis, multiple sclerosis, knee or hip ailments and psoriasis).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

4. Urinary and reproductive disorders (for example kidney stones, prostate disorders, endometriosis, ovarian cysts and menstrual disorder).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

5. Ear, nose or throat disorders (for example glaucoma, cataracts, visual disorders, deafness and orthodontics).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

6. Blood diseases or cancer (for example lymphoma, thalassemia)

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

7. Are you or any of your dependents pregnant? If yes, provide details.

Name	Trimester	Has a doctor confirmed the pregnancy?	Expected due date	Complications (if any)	Name of GP or specialist

8. 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? If yes, please provide details.

Name	Surgery type	Date of surgery	Name of medicine	Name of GP or specialist

9. 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? If yes, please provide details.

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

Section 9: Previous medical scheme information

Have you or any of your dependants had previous medical aid cover? **Yes** ☐ **No** ☐

If yes, please give full details of the previous membership. If you need additional space to provide the necessary information, please make a copy of this section and attach it to your application. It is important that you specify exact membership join and termination dates for each medical scheme. Please attach copy of your previous certificate of membership to this form. The certificate must show the termination date.

Member's name	Scheme	Member number	Join date	Termination date

Are you changing your medical scheme due to change in employment? **Yes** ☐ **No** ☐

Have any condition specific waiting periods been imposed by your previous medical scheme? **Yes** ☐ **No** ☐

Section 10: Banking details for contributions

Please attach a copy of the following to the form:

- The accountholder's identity document, and
- A bank statement, cancelled cheque or letter from the bank confirming the accountholder's details.

If the accountholder's details differ from the main member, an affidavit is required.

Bank name:	
Branch code:	
Branch name:	
Name of accountholder:	
Account number:	
Account type:	

I instruct Bonitas to collect my contributions by debit order using the information above. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorise Bonitas to adjust any incorrect transactions and/or correct any electronic transfer or funds errors without prior notice.

Accountholder's signature: _____

Section 11: Banking details for refunds

Please attach a copy of the following to the form:

- The accountholder's identity document, and
- A bank statement, cancelled cheque or letter from the bank confirming the accountholder's details.

Bank name:	
Branch code:	
Branch name:	
Name of accountholder:	
Account number:	
Account type:	

I instruct Bonitas to deposit claims and savings refunds into my account using the information above. I also irrevocably instruct Bonitas to adjust any incorrect transactions and/or correct electronic transfers or funds errors without prior notice.

Accountholder's signature: _____

Section 12: Protection of your information

1. We will keep your information and your dependants' information confidential. We and our administrator have data security measures in place to do this. Personal information refers to information that identifies you or relates specifically to you or your dependants, such as an identity number, name or email address.
2. We have data security measures in place to protect you and your dependants' personal information. This may include access control to restrict the disclosure of personal information to only authorised individuals, confidentiality agreements with service providers and staff members.
3. We will only use your information for the following purposes:
   - Underwriting
   - Assessing and processing medical services claims
   - Fraud prevention and detection
   - Statistical analysis
   - Audit and record-keeping purposes
   - Compliance with legal and regulatory requirements
   - Verifying your identity
4. We may share your information with the service providers for the purpose of processing it and rendering services to you.
5. You may access the personal information we hold and request us to correct any errors or delete it.

Section 13: Acknowledgement and declaration

1. I, the undersigned, apply to be admitted as a member of Bonitas Medical Fund. If accepted, I agree to follow the rules of Bonitas Medical Fund. I know that the rules are available at www.bonitas.co.za and will be provided to me upon my request to Bonitas.
2. I declare that the information contained in this application form, relating to me and my dependants, is correct. I also declare that I have the permission of my dependants to disclose personal information about them to Bonitas and will provide written proof of this, if asked.
3. I declare that any false information in this application form or the non-disclosure of any material information will result in my membership being declared null and void and that any money paid to Bonitas will be forfeited.
4. I accept that Bonitas has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation or fraudulent behaviour. If any of my or my dependants' circumstances changes after the date of signing in this application or the acceptance of my membership, I will promptly notify Bonitas of the changes. I understand that failure to do so may lead to the termination or amendment of the terms and conditions of my membership and Bonitas shall also be entitled to reclaim any amounts, it may have erroneously paid to any service provider on behalf of me or my dependants, from me.
5. I instruct and allow my employer to deduct and pay over amounts (that may become owing or due on my behalf) to Bonitas from time to time. I also authorise any persons, bodies or institutions that may hold retirement funds for my benefit, to deduct and pay to Bonitas all amounts that may become due and owing to Bonitas from time to time.
6. I agree that should Bonitas incur any legal costs or expenses to recover any contributions owed by me or any other amount due by me to Bonitas for any reason; I shall be responsible for such costs and expenses on the attorney / client scale. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any money owed to Bonitas.
7. I understand that it is my responsibility as the main member to ensure that the monthly contributions are received by Bonitas. I also understand that if any contributions are unpaid, it may result in my dependants and I being terminated from Bonitas until all arrear contributions have been settled. I also understand that should my membership be suspended or terminated, I will not be entitled to any benefits arising from my membership whatsoever.
8. I will inform Bonitas of any changes to my or my dependants' health or personal status within 30 days of the change in circumstances as required by Bonitas' rules.
9. I authorise my and my dependants' healthcare providers to disclose information to Bonitas and its contracted service providers and partners, provided that the information is treated as confidential.
10. I agree to provide Bonitas with any medical or historical information and grant Bonitas access to medical information reasonably required relating to a specific ailment, disease, disorder, condition or disability.
11. I agree that should I be accepted as a member of Bonitas, I shall provide Bonitas with all information including medical information that Bonitas may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Bonitas rules.
12. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.
13. I declare that me and my dependants are not registered on another registered medical scheme.
14. I understand that the following underwriting conditions, may be applicable to my membership as prescribed by the Medical Schemes Act No. 131 of 1998:
    i. A 3-month general waiting period in respect of all benefits
    ii. A 12-month exclusion in respect of a pre-existing condition
    iii. A late-joiner contribution penalty.
15. I understand that the underwriting conditions will impact my and my dependants' rights to benefits if applied.
16. I allow Bonitas to take all reasonable steps to verify information provided by me in this application form and agree to submit proof of identification to Bonitas on demand.
17. I consent to my telephone conversations with the Bonitas contact centre being recorded and forming part of Bonitas' records. I also agree that such records will remain the sole property of Bonitas.
18. I declare that the information provided in this document is true and accurate and if accepted will form the basis of my agreement with Bonitas.
19. I acknowledge that I have read and understood the content of this application form. I confirm that the content of this application form and the implications thereof have been read and explained to me if necessary.
20. I hereby confirm that as the main member on the Scheme I have received permission from my dependants to access and view their healthcare claims made on my membership and deal with all matters relating to the claims on my membership.
21. I hereby authorise the Scheme to share my and my dependants personal and healthcare information with the Scheme healthcare management facility , the Scheme's administrator or the relevant government authorities for administrative and statistical purposed, provided such information shall be treated as confidential at all times. I agree that my and my dependants personal healthcare data may be shared with third parties for the purpose of our membership trend analysis (e.g. employer). I have read and understood this statements and my permission and the permission of my dependants is given voluntarily. My signature below confirms that I give permission.

Signature of main member: _____ **Date:** _____

Your checklist

- Are all the sections of the application form complete?
- Are your contact details correct?
- Are your banking details correct?
- Did you choose one Option only?
- If applicable, has your broker completed and signed the relevant section of this form?
- Have you provided your employer's details?
- Have you signed the declaration?
- Have you attached all copies required?
- Have you attached a copy of your payslip?
- Have you attached your previous membership certificate with termination date?
- Have you read and understood the underwriting rules (if applicable)?

BROKER APPOINTMENT

I _____Membership number: _____

ID number: _____ hereby appoint **Aon South Africa Pty Ltd**

Broker code **AON001M16 - AON CONSULTING SANDTON** to be my health care intermediary.

I am fully aware that with the signing of this Broker Appointment, I hereby acknowledge and accept that the appointed broker will receive a monthly commission of 3%, capped at R80.00 excluding VAT. This commission is paid by the Medical Scheme and I as the Member have no liability to the Broker in respect of payment and receipt of such commissions.

I understand that the broker has to render the following services to me:

Handling enquiries on Products and Services of the Scheme:

Regarding
1. Benefit structures offered and furnish advice on best suited choice
2. Premiums to be paid on each product and/or parts thereof
3. Exclusions related to specific circumstances
4. Enrolment conditions applying to specific situations
5. Service provider details where necessary
6. Rules of Medical Scheme
7. Administrative Procedures to be followed

Continuous updating on:
1. The Scheme's products and benefits
2. The Scheme's Rules and where applicable, procedures

In exceptional circumstances and upon specific request, confirmation of the following:
1. claims received
2. claims status
3. claims paid
4. claims payment date
5. Enquiries on additional products of the Scheme

Contact details of member

Tel: _____
Fax: _____
Email: _____
Postal Address: _____
_____
_____

_____ _____
Member signature Date

NB: Please attach a signed copy of the membership card / recent medical aid statement