Group take-on application form 2018

P.O. Box 1101, Florida Glen, 1708 Call 0860 002 108
Fax (011) 671 5380 Email newapplications@bonitas.co.za

Instructions

- Complete this application form in black ink
- Print clearly using capital letters
- Mark with an X where necessary
- This form is for group take-ons and must be completed after reading through the Bonitas Product Brochure
- We require proof of registration for child dependants between the ages of 21 and 24 years, who are studying
- Government employees must attach a copy of their latest salary advice
- If you are adding any special dependants, for example a parent or sibling, you will need to complete the application form for individual members instead. Please provide us with proof of depandancy.

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	☐	BonComplete	☐	BonSave	☐	BonFit	☐	Standard	☐	Standard Select	☐
Primary	☐	Hospital Plus	☐	Hospital Standard	☐	BonEssential	☐	BonCap	☐				

BonCap contributions are income based. Please select the income band that applies to your gross monthly salary.

R0 to R7 500	☐	R7 501 to R12 194	☐	R12 195 to R16 659	☐	R16 660+	☐

Please note: If you have selected **BonCap** you will also need to send us proof of your earnings. **BonCap:** Subject to a BonCap GP and BonCap network hospital. **Standard Select:** Subject to nomination of a network GP and Standard Select hospital network. **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:	
Broker code:	AON001M17
Name of brokerage:	Aon
Telephone (w):	
Cellphone:	
Email:	

Brokerage/agency stamp

Section 3: Employee information

Please complete this section. You must submit the completed application form to your HR Department.

Name of employer:					
Department/Division:					
Employee/Persal number:		Employment date:		Medical aid start date:	
Number of child dependants:		Number of adult dependants:			

Section 4: Employer information

This section must be completed by your employer. This form will not be processed if it does not have your employer's stamp on it.

Name of company representative:	
Title of company representative:	
Telephone:	
Email:	
Bonitas paypoint code:	BON040TNN

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:** _____

Broker House Name: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: AON001M17

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 | Other

Cellphone: | Telephone (h):

Telephone (w):

Email:

Postal address:

Code:

Street address:

Code:

Section 6: Details of dependants

Please fill in 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 termination date.

Please note:

- An adult dependant is a person 21 years or older
- Child rates apply to 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

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

Cellphone: | Telephone (h):

Telephone (w):

Email:

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

Dependant 3

Adult: ☐	Child: ☐	Relationship to main member:	
Title:		Surname:	
First names:			
Identity number:			
Date of birth:		Tax number:	
Marital status:		Gender: M ☐ F ☐	
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 ☐	
Cellphone:		Telephone (h):	
Telephone (w):			
Email:			

Section 7: GP nomination
If you choose the Standard Option, you must nominate a GP from the Bonitas GP network for each beneficiary.

	Name	Surname	Doctor's name	Practice number	Doctor's contact number
Main member					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

Section 8: Banking details for contributions
Please attach a copy of the following to the form:
- The account holder's identity document, and
- A bank statement, cancelled cheque or letter from the bank confirming the account holder's details.

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

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. I, further, instruct Bonitas to deposit claims and savings refunds into my account using the details above.

Use this account for contribution collections and refunds

Bank name:	
Branch code:	
Branch name:	
Name of account holder:	
Account number:	
Account type:	

Use this account for refunds only

Bank name:	
Branch code:	
Branch name:	
Name of account holder:	
Account number:	
Account type:	

Account holder's signature: _____

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

Section 9: 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.

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

Section 10: 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, 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.
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 change after the date of signing 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.
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 to ensure that the monthly contributions are received by Bonitas. I also understand that if any contributions are unpaid, it may result in me and my dependants 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 as required by Scheme 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 Scheme 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 my dependants and I 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 affect my rights 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 call 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 purposes, 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 these statements and my permission and the permission of my dependants are given voluntarily. My signature below confirms that I give permission.

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

Please note:
Late-joiner penalties and waiting periods may apply to your membership. This is a requirement of the Medical Schemes Act 131 of 1998.

A late-joiner penalty applies to members over 35 years of age or older, who have had a break in medical aid membership for more than 3 months from 1 April 2001. Late-joiner penalties will result in your premium being increased. This is based on a specific calculation considering the number of years you have not been a member of a medical aid.

A general waiting period lasts 3 months. During this period you and your dependants are not entitled to claim any benefits, except, in some circumstances, Prescribed Minimum Benefits.

A condition-specific waiting period lasts 12 months. During this period you and your dependants are not entitled to claim benefits related to a specific condition.

Bonitas

You will need to appoint Aon as your healthcare broker in order to access your employer subsidy.
Tel No: 0860 835 272

BROKER APPOINTMENT

I _____Membership number: _____

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

Broker code **AON001M17 - 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

ATTENTION:

TO WHOM IT MAY CONCERN

TENDERING OF RESIGNATION OF TRANSMED MEMBERSHIP

DATE: ____/____/_____

SURNAME: _____

FULL NAMES: _____

MEMBERSHIP NUMBER: _____

ID NUMBER: _____

CONTACT NUMBERS: _____

E-MAIL ADDRESS: _____

I would like to tender my resignation from the **TRANSMED Medical Scheme** effective immediately.

Since the rules of the scheme state I have to give **A ONE MONTH CALANDER NOTICE**, my last day on **TRANSMED Medical Scheme** will be: ____/____/_____

Kind regards

_____

Signature

PLEASE EMAIL THIS RESIGNATION TO ENQUIRIES@TRANSMED.CO.ZA BUT ATTACH THE COPY TO YOUR NEW APPLICATION.

ATTENTION:

TO WHOM IT MAY CONCERN

TENDERING OF RESIGNATION OF MEMBERSHIP

DATE: ____/____/_____

SURNAME: _____

FULL NAMES: _____

MEMBERSHIP NUMBER: _____

ID NUMBER: _____

CONTACT NUMBERS: _____

E-MAIL ADDRESS: _____

I would like to tender my resignation from the _____

Medical Scheme effective immediately.

Since the rules of the scheme state I have to give _____ days' notice, my last day on

_____ Medical

Scheme will be: ____/____/_____

Kind regards

_____

Signature

PLEASE SEND TO YOUR MEDICAL SCHEME BUT ATTACH A COPY TO YOUR APPLICATION FORM.