MEDSHIELD
medical scheme

GROUP TAKE-ON APPLICATION

Please complete all the relevant sections of this form in BLOCK LETTERS.

Please ensure that the following documentation accompanies your application: copies of ID / Passport / birth certificates.
Should this be outstanding, your application cannot be processed.

Email: newapplication@medshield.co.za

Broker code

Membership number: (for office use only):

Section A TO BE COMPLETED BY PRINCIPAL MEMBER : (Copy of ID required)

Option selection

First Name:

Surname:

ID/Passport Number:

Date of Birth: Y Y Y Y M M D D

Postal Address:

Postal Code:

Residential Address:

Postal Code:

E-mail Address:

Telephone No:

Gender M F

Cell No:

Title

Section B DEPENDANT DETAILS (attach copies of ID or Birth Certificate)

Name of Beneficiary	Surname (If different to Principal Member)	ID Number	Gender (M/F)	Relationship to principal member	Adult over 21 (Yes/No)
1					
2					
3					
4					
5					

Section C MediPhila only (Select GP from network)

Name of Beneficiary	Name of Doctor	Practice Number
1		

Section D Employer Information

Name of Employer:

Paypoint (If Applicable):

Employee Payroll No.:

Employer's Email Address:

Employer Representative's Name:

Tel number:

Fax number:

COMPANY STAMP

Section E BANK DETAILS OF PRINCIPAL MEMBER

I, the undersigned, hereby give Medshield Medical Scheme permission to use the following bank details provided as instructed. I give Medshield the authority to reverse any erroneous transactions and/or rectify any electronic transfer or fund error without prior notice. Proof of banking details reguired (Stamped Bank Statement / Cancelled Cheque)

*Should the bank details provided for debit order details not be that of the principal member of the scheme a bank statement is required.

Use this account for: claims refunds only ☐ contributions only ☐ contributions and claim refunds ☐

Name of Account Holder:

Bank Name:

Branch Name:

Bank Branch Code:

Bank Account Number:

Type of Account: Current | Transmission | Savings

Signature of Account Holder: _____

Section F IMMUNE DEFICIENCY STATUS (confidential disclosure)

If you or any of your dependants have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Program on 086 050 6080 for more information on how to join the Programme.

Section G MEMBER DECLARATION

1. I, the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree to abide by its Rules and Regulations in accordance with the provisions of the Medical Schemes Act (Act 131 of 1998) as amended. I have been informed that the Scheme rules will be made available on request and that I am responsible to read and be bound by them.

2. I certify that all the information given is true and correct and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void and that all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me, or any person on my or my dependant's behalf, under such contracts.

3. I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

4. As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

5. Notwithstanding point 3 and 4, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

6. As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

7. I hereby authorise the Scheme, or any of its nominated representatives, to confirm my bank details.

8. Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

9. I hereby authorise and request any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my / the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my / their death, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of any nature, which may be made against them as a result of, or arising out of, the disclosure of any test results or medical information.

10. The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi which will be deemed to be my postal address unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi shall be deemed to have been received by me on the 7th day after the date of posting.

11. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

    - a 3 (three) month general waiting period in respect of all benefits;
    - a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
    - a late joiner contribution penalty.

12. Should my state of health change significantly from the date of signing this application to the date of acceptance, I will notify the Scheme in writing.

13. I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Principal Member Signature: _____

Date: | Y | Y | Y | Y | M | M | D | D |