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

Application form 2019

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

Medical aid start date: D D M M Y Y

Instructions
Please attach the following documents to this form:

- Government employees must attach a copy of their latest salary advice
- A copy of your identity document or passport
- Copies of your previous medical aid membership certificates
- We require proof of registration for child dependants between 21 and 24 years of age who are currently studying full-time.

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

Would you like pre-underwriting? Yes ☐ No ☐

Section 1: Choosing your option
Please select one option only.

BonComprehensive ☐ BonClassic ☐ BonComplete ☐ BonSave ☐ BonFit ☐ Standard ☐ Standard Select ☐
Primary ☐ Primary Select ☐ Hospital Standard ☐ BonEssential ☐ BonEssential Select ☐ BonCap ☐

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

R0 to R8 030 ☐ R8 031 to R13 050 ☐ R13 051 to R17 830 ☐ R17 831+ ☐

Please note: If you have selected **BonCap,** you will also need to send us proof of your earnings. If you have chosen **Standard Select, Primary Select** or **BonCap** you will need to complete **section 7**.

Section 2: Intermediary details
This section must be completed by the broker or agent.

Name of broker/agent:
Broker code:
Name of brokerage:
Telephone (w):
Cellphone:
Email:

Brokerage/agency stamp

I declare that:

- I am an accredited healthcare broker contracted to Bonitas Medical Fund as a financial advisor.
- I am licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act No. 37 of 2002 and accredited by the Council for Medical Schemes in terms of the Medical Schemes Act of 1998.
- 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 were impartial and in the best interest of the applicant.

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.
- A monthly commission of the total monthly premium plus VAT will be paid to me in terms of the Medical Schemes Act No. 131 of 1998 (or as amended).
- 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.

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.
Government employees: Please attach a current copy of your latest salary advice.

Name of employer:
Department/Division:
Employee/Persal number: Employment date: D D M M Y Y
Number of child dependants: Number of adult dependants:

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 paypoint 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 Fund 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 Other

Cellphone: Telephone (h):

Telephone (w):

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 termination date.

Please note:
- An adult dependant is a person 21 years or older.
- Child rates apply to students between 21 and 24 years of age, 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:

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 Select, Primary Select** or **BonCap** 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: Declaration of income
Please complete this section if you have selected the BonCap option.

Description of income	Main member R per month	Spouse/partner R per month
Salary or wages		
Commission and other rewards		
Pensions or annuities		
Rental income		
Trust distributions		
Government grants		
UIF payments		
Interest on investments		
Subsidies of any kind		
Maintenance		
Other income		
Total income	**R**	**R**

We also require the documents in the table below to be attached to this form for you and your spouse/partner. **If the required documents are not submitted with this form, you will be defaulted to the highest income band.**

If you	We need
Earn a monthly salary or salary with commission	Your latest payslip + Your bank statements for the last three months (showing the monthly income you receive)
Get paid weekly/fortnightly wages	Four latest weekly payslips or two latest fortnightly payslips OR A letter from your employer/company confirming your income + Your bank statements for the last three months (showing the monthly/weekly/fortnightly income you receive)
Earn commission only	Proof of earnings OR Your last three commission statements + Your latest IRP5 + Your bank statements for the last three months (showing the monthly income you receive)
Are self-employed	A copy of your latest IT34A (SARS notice of assessment) + A letter from an external auditor/accounting firm confirming your income + Your bank statements for the last three months (showing the monthly income you receive)
Are unemployed	Your UIF statement OR A retrenchment letter or dismissal letter if you were dismissed/retrenched in the past twelve months + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Are a minor (including children at primary and secondary school)	A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid

If you	We need
Are a full-time student (tertiary education)	Proof of registration from your tertiary institution (student card only will not be accepted) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Are a foreign student	A copy of your passport + Proof of registration from your tertiary institution + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Are a foreign national (a person living in South Africa who is a citizen of another country)	A copy of your passport + A copy of your work permit + A copy of your contract reflecting your contract period and monthly income + Your bank statements for the last three months (showing the monthly income you receive)
Are temporarily disabled	A copy of your IT34A (SARS notice of assessment) + A full medical report from your doctor + Your disability grant letter OR A letter from the Department of Social Development + Your bank statements for the last three months (showing the monthly income you receive)
Are permanently disabled	A full medical report from your doctor + Your disability grant letter + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Earn a Government pension (SASSA)	Your most recent SASSA pension statement OR A copy of an ATM slip confirming your monthly pension OR A copy of a withdrawal slip from a SASSA paypoint confirming your monthly pension OR A SASSA pension income letter (that is not older than six months) + Your bank statements for the last three months (showing the monthly income you receive)
Earn any other pension	A copy of your IT34A (SARS notice of assessment) OR Your most recent pension statement OR A pension income letter (not older than 6 months) + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid

Please note: Bank statements submitted must clearly show the money earned being deposited into the account.

Section 9: 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: _____

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 these, please complete the relevant tables below.

1. Chronic illnesses (for example, raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression or 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. Gastrointestinal disorders (for example, heartburn, stomach disorder, Crohn's disease or 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 or menstrual disorders).

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 or 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 or 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 dependants 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 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 10: 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. It is important that you specify exact membership join and termination dates for each medical scheme. Please attach a copy of your previous certificate of membership to this form. The certificate must show the termination date. If you need additional space to provide the necessary information, please make a copy of this section and attach it to your application.

Member's name	Scheme	Membership 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 ☐

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Section 11: Banking details

Use this account for contribution collections and refunds		**Use this account for refunds only**	
Bank name:		Bank name:	
Branch code:		Branch code:	
Branch name:		Branch name:	
Name of account holder:		Name of account holder:	
Account number:		Account number:	
Account type:		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. I, further, instruct Bonitas to deposit claims and savings refunds into my account using the details above.

Account holder's signature: _____

If the account holder's details differ from the main member, we require a letter from the account holder instructing and authorising Bonitas to collect contributions from their bank account. We will also require a copy of the account holder's identity document and a bank statement or a letter from the bank confirming the account holder's details.

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 staf 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
   - Compliance with legal and regulatory requirements
   - Verifying your identity
   - Certain marketing and related activities which may be applicable from time to time, subject to such rights as you may have in law.
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.

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, 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 Fund 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 Fund 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 Bonitas, 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 Fund to share my and my dependants' personal and healthcare information with the Fund healthcare management facility, the Fund's administrator or the relevant government authorities for administrative and statistical purposes, provided such information shall be treated as confidential at all times.
22. I understand that it is my responsibility to provide the Fund with notice of my intention to terminate my membership, as per the Fund's Rules, in writing by completing the relevant Termination of Membership form.
23. I agree that my and my dependants' personal healthcare data may be shared with third parties for the purpose of membership trend analysis (e.g. employer) and for any other such purposes as may be related to our membership of the Fund. 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:** _____

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Please note:
Late-joiner penalties and waiting periods may apply to your membership. This is a requirement of the Medical Schemes Act No. 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.

Contact us on: **0860 tel arc / 0860 835 272,** P.O. Box 1874, Parklands, 2121, www.aon.co.za
FSB number: 20555; CMS number: ORG895

Acknowledgement of appointment

I hereby authorise Aon South Africa (Pty) Ltd to be my duly appointed Broker with immediate effect, I acknowledge and appoint the financial advisor contracted by my employer from time to time for all matters related to my membership.

My ID ☐☐☐☐☐☐☐☐☐☐☐☐☐ and membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

I have also been informed that the commission due to Aon, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT).

Signed at (town or city) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on yy/mm/dd ☐☐☐☐☐☐

Signature ☐☐☐☐☐☐☐☐☐☐☐☐

Permission to make certain information available to Aon South Africa (Pty) Ltd

I give consent for the disclosure of information about me.

Membership number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Medical Scheme ☐☐☐☐☐☐☐☐☐☐☐☐ Aon Broker Code ☐☐☐☐☐☐☐☐☐☐☐☐

Title ☐☐☐☐ Initials ☐☐☐☐ Surname ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name(s) (as per identity document) ☐☐

ID or passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐

To clarify this, the following information will be made available:

Personal examples	Benefit examples	Financial examples	Medical examples
Membership number Date of birth ID number Postal and e-mail Address Contact details Physical address Telephone numbers	Plan type Medical Savings Account amounts available Medical Savings Account choice Scheme Rate or Cost Current Medical Savings Account spent Limits Waiting period: details Wellness benefits Self-payment Gap Above Threshold Benefit	Tax certificate and tax reports Banking details Total contribution and breakdown	Chronic indicator Chronic condition PMB Chronic condition details Confirmation of claims paid (excluding amount and paid from where) Claims transaction history Hospital procedures Procedures codes Procedures done in doctor's rooms paid from Hospital Benefit

I hereby also authorise Aon South Africa (Pty) Ltd to provide me with any products that they consider appropriate to me.

Yes ☐ No ☐

When you sign this document, you confirm that you have read and understood the document.

Signed at (town or city) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ on yy/mm/dd ☐☐☐☐☐☐

Signature ☐☐☐☐☐☐☐☐☐☐☐☐