Broker House: Aon South Africa (Pty) Ltd
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medihelp
Medical Aid in Action

My Medihelp application form 2024

Enquiries: 086 0100 678
Email: newbusiness@medihelp.co.za
www.medihelp.co.za

Thank you for choosing to join Medihelp medical scheme. Medihelp is registered with the Council for Medical Schemes in terms of the Medical Schemes Act 131 of 1998 and is a self-administered non-profit scheme.

How to complete this form

- If you complete the editable PDF form, please add your signature electronically before you email it to us. Printed forms must be completed in print using black ink. Make sure that you email or post all pages of the form to Medihelp.
- Complete all sections in full and sign the application form, also at Sections 5, 7, and 10. Please read the conditions for membership in Section 10 carefully before you sign the form. Incomplete information may delay the application process.
- Email the completed and signed form to newbusiness@medihelp.co.za.

The next steps after we receive your application

- Medihelp will contact you should any details be omitted or if any additional information is required. You can also use the Application in Motion (AiM) functionality on our website at https://onlineapplication.medihelp.co.za to track your application and provide further details, if necessary.
- If we offer you membership under the standard terms, your membership will be activated without issuing enrolment conditions. We will notify you and/or your adviser by letter.
- If we offer you membership under any non-standard terms (with waiting periods and/or late-joiner penalties), we will notify you and/or your adviser by letter and stipulate the conditions that will apply to your membership. If you accept these terms, you must sign the letter and return it to us, after which we will activate your membership. The enrolment conditions can also be accepted on AiM.
- You will be notified when your application has been finalised.

1. When would you like your cover to start?

2	0	y	y	m	m	d	d

Please note that no person may be enrolled as a member of Medihelp while such person is a member of another medical scheme. Refer to paragraph 10 of Section 10 of this application form.

2. Your information (person who requests membership)

ID/passport number | | | | | | | | | | | | | |

Title: Mr | Mrs | Ms | Other (specify)

A copy of your passport must be attached if you use your passport number.

Surname _____ Initials _____

First names _____ Gender: Male | Female

Known as _____

Marital status: Married in community of property/ customary marriage | Married out of community of property | Single/ not married | Engaged/ cohabitant/ life partner | Divorced | Widow/ widower | Other (specify)

Date of birth: y y y y m m d d

Date of marriage: y y y y m m d d

Income tax number | | | | | | | | | | | | | |

Language: Afrikaans | English

Please indicate your race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

3. Your contact information

Cell phone number* | | | | | | | | | | |

Personal email address* _____

* This information is compulsory and is required to communicate important information to you about your rights, benefits, and duties as a member. If not completed, your application for membership cannot be finalised.

Telephone number (W) | | | | | | | | | | Telephone number (H) | | | | | | | | | |

May Medihelp use your and your dependants' personal details to get your opinion on the quality of our service? Yes | No

To improve the quality of our communication to you, please indicate if the following applies to you:

Visually impaired: Yes | No

Hearing impaired: Yes | No

* If "Yes", refer to the medical questionnaire at Section 9.2 for more details.

3. Your contact information (continued)

Is your postal and residential address the same? Yes | No

Residential address

House/unit number and building name _____ House/building number and street name _____

Suburb _____ City _____

Province _____ Postal code ☐☐☐☐

Postal address

House/unit number and building/organisation name _____ PO Box/house/building number and street name _____

Suburb _____ City _____

Province _____ Postal code ☐☐☐☐

This information is compulsory. If not completed, your application for membership cannot be finalised. Refer to paragraph 8 of Section 10 of this application.

4. Details of your employer/the institution responsible for paying your contributions

NB: Complete only if contributions are paid in full or partially by your employer or any other institution.

Name of employer/institution _____ Campus/site _____

Branch code/employer group number _____

Payroll number _____

Appointment date y y y y m m d d Appointment

Pay area _____ Permanent | Temporary

Office stamp of employer
d

5. Select a plan that will suit your needs by marking your choice with an "X"

5.1 Plans

Note

- **If you choose a plan with a savings option (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect or MedElite), please refer to Section 5.3; and**
- **If you choose MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect, please refer to Section 5.4.**

Basic plans	Saving plans	Comprehensive plans	
☐ MedMove!	☐ MedAdd	☐ MedPrime	☐ MedElite
☐ MedVital	☐ MedAdd Elect	☐ MedPrime Elect	☐ MedPlus
☐ MedVital Elect	☐ MedSaver	☐ MedElect	

5.2 Students with a monthly income of no more than R800 – MedElect only

Do you want to enrol as a student member on the MedElect plan? Yes | No

If "Yes", please provide proof of your enrolment as a student. Proof of your monthly income may also be requested.

- Acceptable proof of enrolment as a student is proof of registration for studies on an official letterhead of the tertiary institution or vocational training college where you are registered as a student.
- Acceptable proof of income, should Medihelp request this, is the past three months' official bank statements containing the initials and surname of the account holder and reflecting your income. Other additional proof of income may also be required.

5.3 Utilisation of savings account funds

MedAdd, MedAdd Elect, and MedSaver

Please indicate your preference. If you do not select an option, Medihelp will pay all qualifying medical expenses from your savings account.

- Do you prefer that Medihelp should pay all in-hospital co-payments from your savings account? Yes | No

MedPrime, MedPrime Elect, and MedElite

- If you enrol on the MedPrime, MedPrime Elect or MedElite plan, all qualifying day-to-day medical expenses will be paid from your savings account first.

5. Select a plan that will suit your needs by marking your choice with an "X" (continued)

5.4 Declaration by applicants who apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect or MedElect

I confirm that I am aware of the following:

1. I will be liable for co-payments if I do not use Medihelp's network facilities, designated service providers (DSPs), and formulary medicine.
2. I must register my prescribed minimum benefits (PMB) conditions with Medihelp and my PMB chronic medicine must be pre-authorised by Medihelp. Medihelp uses a DSP for PMB chronic medicine and a formulary applies. I will be responsible for a co-payment* on my PMB chronic medicine should I fail to get this medicine from the DSP or deviate from the formulary for my plan.
3. My treating specialists should form part of Medihelp's DSP specialist network to prevent co-payments on PMB treatments.
4. I must use Medihelp's network facilities for all planned hospital admissions. If there is no network facility available near my place of residence, I will need to travel to the nearest network facility for medical services. If I use a non-network facility instead, I will be liable for a co-payment*, unless the treatment required is for an emergency medical condition** which warrants the involuntary use of a non-network facility. I further note that in a medical emergency, authorisation for admission to the network facility should be obtained on the first workday after the admission if I am unable to get the authorisation on the day of admission.

* Please refer to your plan's guide/brochure for all applicable co-payments.

** Please refer to your plan's guide/brochure for the definition of an emergency medical condition.

Signature of applicant _____ Date 2 0 y y m m d d

6. Your dependants whom you want to register

You may register the following dependants:

- Spouse/partner
- Own children of the applicant and spouse/partner
- Stepchildren of the applicant and spouse/partner
- Adopted children or in the process of adoption/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner

If any of the following persons are dependent on the applicant for family care and support, they may be registered as dependants:

- Father/mother/brother/sister of the applicant
- Grandchildren of the applicant

PLEASE NOTE

- Grandchildren of the applicant pay the same contribution as that of an adult dependant, unless legally adopted.
- Foster children and children in temporary safe care may be registered as dependants only up to the age of 21 years in terms of legislation.
- In the case of dependants who are not South African citizens, a copy of their passport must be submitted with the completed application.

The following persons may not be registered as dependants of the applicant:

- Stepbrothers and stepsisters
- Step-grandchildren
- Stepparents
- Grandchildren of the applicant's partner
- In-laws
- Godchildren
- Cousins

We require the following supporting documents to ensure your quick enrolment:*

Dependants	Document required
• Adopted children or children in the process of adoption/ foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement of the applicant and spouse/partner.	• Legal documentation confirming that the child was adopted or in the process of adoption/placed in foster care/temporary safe care of the applicant. • Official proof of the Court, clerk of the Court or appointed social worker must be provided in terms of the set criteria determined by Medihelp.
• Child (if surname differs from the applicant's surname).	• Unabridged birth certificate confirming the birth parents of the child.

* This information is compulsory. If not submitted, your application for membership cannot be finalised.

Spouse/partner (complete only if applying for registration as a dependant)

Surname _____ Title Mr | Mrs | Ms | Other (specify)

First names in full _____

Known as _____

ID/passport number _____ Gender Male | Female

Date of birth y y y y m m d d Cell phone number _____

Email address _____

6. Your dependants whom you want to register (continued)

Spouse/partner (complete only if applying for registration as a dependant) (continued)

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired | Yes | No | Hearing impaired | Yes | No

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

Relationship to applicant (please select **one** by marking with an X) Spouse ☐ Partner ☐

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

Is this dependant's residential address the same as the principal member's residential address? Yes | No

If "No", provide your dependant's residential address.

House/unit number and building name _____ House/building number and street name _____

Suburb _____ City _____

Province _____ Postal code ☐☐☐☐

Dependant 2

Surname _____ Title | Mr | Mrs | Ms | Other (specify)

First names in full _____

Known as _____

ID/passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Gender | Male | Female

Date of birth y y y y m m d d Cell phone number ☐☐☐☐☐☐☐☐☐☐

Email address _____

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired | Yes | No | Hearing impaired | Yes | No

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

Relationship to applicant (please select **one** by marking with an X)

Child dependant
☐ Own child ☐ Child born in terms of a surrogate motherhood agreement
☐ Adopted child ☐ Stepchild
☐ Foster child ☐ Child in temporary safe care

Other relative
☐ Grandchild ☐ Brother
☐ Mother ☐ Sister
☐ Father

If you have marked one of the options at **"Other relative"** and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), indicate the following:

Married? Yes | No Financially dependent on you? Yes | No

Does the dependant earn an income? Yes | No If so, how much does the dependant earn per month? R ☐☐☐☐☐☐☐

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

Is this dependant's residential address the same as the principal member's residential address? Yes | No

If "No", provide your dependant's residential address

House/unit number and building name _____ House/building number and street name _____

Suburb _____ City _____

Province _____ Postal code ☐☐☐☐

6. Your dependants whom you wish to register (continued)

Dependant 3

Surname _____ Title | Mr | Mrs | Ms | Other (specify) |

First names in full _____

Known as _____

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d | Cell phone number | | | | | | | | | | |

Email address _____

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired | Yes | No | Hearing impaired | Yes | No |

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

Relationship to applicant (please select **one** by marking with an X)

Child dependant
- ☐ Own child
- ☐ Child born in terms of a surrogate motherhood agreement
- ☐ Adopted child
- ☐ Stepchild
- ☐ Foster child
- ☐ Child in temporary safe care

Other relative
- ☐ Grandchild
- ☐ Brother
- ☐ Mother
- ☐ Sister
- ☐ Father

If you have marked one of the options at **"Other relative"** and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), indicate the following:

Married? | Yes | No | Financially dependent on you? | Yes | No |

Does the dependant earn an income? | Yes | No | If so, how much does the dependant earn per month? R | | | | | | | |

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

☐ Black ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

Is this dependant's residential address the same as the principal member's residential address? | Yes | No |

If "No", provide your dependant's residential address.

House/unit number and building name _____ House/building number and street name _____

Suburb _____ City _____

Province _____ Postal code | | | | |

Dependant 4

Surname _____ Title | Mr | Mrs | Ms | Other (specify) |

First names in full _____

Known as _____

ID/passport number | | | | | | | | | | | | | | Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d | Cell phone number | | | | | | | | | | |

Email address _____

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired | Yes | No | Hearing impaired | Yes | No |

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

Relationship to applicant (please select **one** by marking with an X)

Child dependant
- ☐ Own child
- ☐ Child born in terms of a surrogate motherhood agreement
- ☐ Adopted child
- ☐ Stepchild
- ☐ Foster child
- ☐ Child in temporary safe care

Other relative
- ☐ Grandchild
- ☐ Brother
- ☐ Mother
- ☐ Sister
- ☐ Father

6. Your dependants whom you wish to register (continued)

Dependant 4 (continued)

If you have marked one of the options at **"Other relative"** and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), indicate the following:

Married? Yes / No

Financially dependent on you? Yes / No

Does the dependant earn an income? Yes / No

If so, how much does the dependant earn per month? R

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

Black / Coloured / Indian/Asian / White / Other

Is this dependant's residential address the same as the principal member's residential address? Yes / No

If "No", provide your dependant's residential address.

House/unit number and building name

House/building number and street name

Suburb

City

Province

Postal code

Dependant 5

Surname

Title: Mr / Mrs / Ms / Other (specify)

First names in full

Known as

ID/passport number

Gender: Male / Female

Date of birth (y y y y m m d d)

Cell phone number

Email address

To improve the quality of our communication to your dependant, please indicate if the following applies to your dependant:

Visually impaired Yes / No

Hearing impaired Yes / No

* If "Yes", refer to the medical questionnaire in Section 9.2 for more details.

Relationship to applicant (please select **one** by marking with an X)

Child dependant

- Own child
- Child born in terms of a surrogate motherhood agreement
- Adopted child
- Stepchild
- Foster child
- Child in temporary safe care

Other relative

- Grandchild
- Brother
- Mother
- Sister
- Father

If you have marked one of the options at **"Other relative"** and/or your dependant is 26 years and older (for all options except MedElect) or 21 years and older (for MedElect), indicate the following:

Married? Yes / No

Financially dependent on you? Yes / No

Does the dependant earn an income? Yes / No

If so, how much does the dependant earn per month? R

Please indicate your dependant's race only if you wish to do so (the information is compiled for national statistical purposes by the Council for Medical Schemes):

Black / Coloured / Indian/Asian / White / Other

Is this dependant's residential address the same as the principal member's residential address? Yes / No

If "No", provide your dependant's residential address.

House/unit number and building name

House/building number and street name

Suburb

City

Province

Postal code

7. Banking details

7.1 Complete this section if you will pay your own contributions

I authorise Medihelp to recover the applicable contributions payable by me to Medihelp by debit order from my bank account, monthly on the date indicated below. I further authorise Medihelp to increase or decrease the contribution, should it be necessary, and recover the amended amount, or any contributions in arrears, from my bank account.

Please deduct my monthly contributions by debit order from my bank account on the following date (choose only one option by marking an "X"):

- ☐ On the first workday of the month in which I requested enrolment and thereafter on the first workday of every subsequent month.
- ☐ On the 25th day of the month prior to my enrolment and thereafter on the 25th day of the subsequent months of my membership.
- ☐ On the last calendar day of the month prior to my enrolment and thereafter on the last calendar day of the subsequent months of my membership.

Note

- Your contributions are payable in advance, and if your membership cannot be finalised in time for the deduction date chosen above, Medihelp will make two separate debit order deductions in your first month of membership, namely on the first available workday following the activation of your membership AND on the actual date you have chosen in the same month. Medihelp will thereafter collect your contributions monthly on the date you have chosen above.
- If the debit order deduction date falls on a weekend or a public holiday, your contributions will be deducted on the first workday after the selected deduction date.
- If no debit order deduction date is selected, Medihelp will make the deduction on the first workday of the month.

7.2 Mark this section if your employer or an institution will pay your contributions

☐ My employer/institution as my authorised agent authorises Medihelp to recover the applicable contributions payable by my employer/institution as my authorised agent to Medihelp by debit order from my employer/institution as my authorised agent's bank account monthly on the last workday of each month as from the date of enrolment. I authorise Medihelp to increase or decrease the contributions, should it be necessary, and recover the amended amount, or any contributions in arrears, from my employer/institution as my authorised agent's bank account.

7.3 Complete your banking details for debit order deductions and credit refunds (all applicants must complete this information)

☐ 1. Use the account below for all transactions

☐ 2. Use the account below only for the recovery of contributions

NB: **If you select this option, you must complete your banking details for credit refunds in the table on the right.**

Bank _____

Branch _____

Branch code | | | | | | | | | | | |

Type of account | Savings | Cheque |

Name of account holder _____

Account number _____

☐ Use the account below for credit refunds only

NB: **If you selected option 2 on the left, you must complete your banking details below.**

Bank _____

Branch _____

Branch code | | | | | | | | | | | |

Type of account | Savings | Cheque |

Name of account holder _____

Account number _____

If you provide only one bank account number, we will use this account for both the recovery of contributions and refunding credit amounts. In the case of a trust, the responsible trustee must sign this section and submit a copy of the trust deed.

Signature of account holder/authorised signatory for recovery of contributions

Signature of account holder for credit refunds

8. Previous and/or current membership of medical schemes

8.1 Is your application necessitated by a change in employment which resulted in the cancellation of your membership of a previous medical scheme? (This question is not applicable to employees who have retired and are entitled to remain at their previous or current medical scheme.)

Yes	No

Who was the principal member of the previous scheme? Name and surname

8.2 Please provide details of ALL the medical schemes where you and your dependants are currently or have previously been enrolled:

NB:
- The date joined and date ended are important to place you and your dependants in the correct enrolment category.
- Indicate "current" if your and/or your dependants' membership of the particular scheme is still active.
- Ensure that the dates of your and/or your dependants' membership at the different schemes do not overlap.
- Information about previous and current membership must be indicated **separately** for you and your dependants.
- The Medical Schemes Act makes provision for a late-joiner penalty (LJP) to be imposed on an applicant who is 35 years or older at the time of joining a scheme and has not enjoyed previous coverage with a medical aid. The penalty, which is added to the member's monthly contribution, is calculated as a percentage of the member's contribution based on the total number of years without creditable coverage since the age of 35 years, as shown below:

LJP intervals and penalty percentages	
1 – 4 years	5%
5 -14 years	25%
15 – 24 years	50%
25 years +	75%

of the contribution of the beneficiary (excluding savings account contribution)

Name of medical scheme*	Name and surname*	Membership number	Date joined*	Date ended*

* This information is compulsory. If not completed, your application for membership cannot be finalised.

8.3 Did your or your dependants' previous medical scheme apply any late-joiner penalty?

Yes	No

If "Yes", provide the following details:

Name of applicant/dependant	Late-joiner penalty			
	5%	25%	50%	75%
	5%	25%	50%	75%
	5%	25%	50%	75%

8.4 Did your or your dependants' previous medical scheme apply any condition-specific waiting period and was it still active at the time of termination of membership? (The treatment of a specific condition was excluded from benefits for a certain period.)

Yes	No

If "Yes", provide the following details:

Name of applicant/dependant	Condition-specific waiting period (CSW)	End date of CSW
		y y y y m m d d
		y y y y m m d d
		y y y y m m d d

Note: If the space provided is insufficient, please provide additional information on a separate page.

9. Medical history

- Please ensure that you have completed **Section 8** of this application form in full.
- To ensure quick and easy enrolment, please complete **Section 9.1.**
- If you answered "Yes" to any of the questions in Section 9.1, please complete the full medical questionnaire in **Section 9.2.**

NB: Medihelp will review all requests for hospital admission or chronic medicine authorisation made by members during their first year of membership before we authorise benefits. If we find that you did not complete your application form in full, had withheld information or provided inaccurate details, we may terminate your membership.

Doctors consulted in the past 12 months

If your family has consulted a doctor in the past 12 months, please provide us with the details:

Name and surname _____

Telephone number (W) | | | | | | | | | | How long has he or she been your doctor (in years)? | |

Name and surname _____

Telephone number (W) | | | | | | | | | | How long has he or she been your doctor (in years)? | |

Name and surname _____

Telephone number (W) | | | | | | | | | | How long has he or she been your doctor (in years)? | |

9.1 Short medical questionnaire

		Mark with an "X"	
1.	Have you or any of your dependants been admitted to hospital and/or diagnosed with an illness within the last 12 months prior to submitting this application? If "Yes", please complete **Section 9.2.**	Yes	No
2.	Are you or any of your dependants currently taking or should be taking regular and/or ongoing medicine, including homeopathic, natural or over-the-counter medication, and/or receiving treatment for a medical condition or symptom? (Please take note of question 18 in Section 9.2). If "Yes", please complete **Section 9.2.**	Yes	No
3.	Are you or any of your dependants currently pregnant, suspect that you are pregnant or undergoing testing for pregnancy, and/or currently in hospital and/or aware of or planning to have any test, examination, treatment and/or procedure done, and/or to obtain medical advice that could result in a claim in the next 12 months? If "Yes", please complete **Section 9.2.**	Yes	No

9.2 Full medical questionnaire

Please note that this medical questionnaire does not constitute an application to register or authorise chronic medicine, PMB services, planned procedures or treatment for benefits. Should you need to get authorisation for chronic medicine, please phone Medihelp on 086 0100 678 once your membership has been finalised and request an application form for chronic medicine benefits. Alternatively, you can download an application form from the Medihelp website at www.medihelp.co.za by logging on to the secured website for members, the Member Zone.

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).

1. Cancer, tumours, abnormal growths, and related test results

Cancer or tumours of any organ or skin, cancerous tumours, non-cancerous tumours, (please list if removed and enter removal date under last date of follow-up). **Examples:** blood-related cancers, lymphoma, leukaemia, skin lesions, warts or moles, breast disease, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal Pap smear result, abnormal prostate-specific antigen result, any other abnormal cancer screening or diagnostic test result.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: **Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

2. Blood conditions

Examples: blood clots or bleeding problems, high or low iron, anaemia, deep vein thrombosis, lung clots, ITP and platelet deficiencies, any other bleeding or blood-related disorders.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

3. Metabolic and endocrine conditions

Examples: diabetes, thyroid disease, Addison disease, Cushing syndrome, obesity, growth problems, metabolic syndrome, parathyroid disease, Paget disease, osteoporosis, osteopenia, growth deficiency, any other metabolic or endocrine condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

4. Mental health

Examples: depression, bipolar disorder, anxiety disorder, panic attacks, post-traumatic stress disorder, obsessive compulsive disorder, schizophrenia, personality disorders, insomnia, sleeping disorders (for example, narcolepsy), eating disorders, Alzheimer disease, dementia, autism, attention deficit hyperactivity disorder, drug or alcohol dependency or abuse, rehabilitation for drug or alcohol dependency or abuse, suicide attempt, counselling, any other psychological condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

5. Brain and nerve conditions

Examples: migraine, chronic headaches, stroke, weakness or paralysis, bleeding on the brain, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, Parkinson disease, Guillain-Barré syndrome, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, intellectual disability, any other brain or nerve condition or if you had a previous MRI or CT scan.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: **Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

6. Eye and eyelid conditions

Examples: vision problems, cataracts, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, retinal detachment, retinopathy, macular degeneration, retinal vein occlusion, cornea transplant, eye surgery including blepharoplasty, glasses, partial or full blindness, any other eye or eyelid condition.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

7. Ear, nose, and throat conditions

Examples: hearing problems or deafness, middle ear infection (otitis media), external ear infection (otitis externa), any chronic ear infection or ear discharge, perforated eardrum, hearing aid, cochlear implant, tonsillitis or enlarged tonsils, adenoid problems, dizziness, vertigo, tinnitus, blocked nose, sinus problems or allergies, nasal surgery, dental or orthodontic treatment, dental surgery, any other ear, nose or throat condition, jaw problems, impacted teeth, or any other anticipating or current orthodontic, dental or maxillofacial treatment.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

8. Heart and circulation conditions

Examples: high blood pressure (hypertension), high cholesterol, angina, chest pain, coronary heart disease, heart attack, stents, coronary artery bypass surgery, palpitations, arrhythmia, shortness of breath, heart failure, cardiomyopathy, valvular heart disease or heart murmurs, heart valve replacement, congenital heart disease, rheumatic fever, previous heart surgery, pacemaker, aneurysm, arterial disease, chronic venous insufficiency, varicose veins, any other condition affecting the heart or blood vessels.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

9. Breathing and respiratory conditions

Examples: asthma, bronchitis, chronic cough, chronic obstructive pulmonary disease, emphysema, bronchiectasis, tuberculosis, cystic fibrosis, sarcoidosis, pneumonia, any other breathing or respiratory condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: **Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

10. Abdominal and digestive conditions

Examples: reflux, heartburn, hiatus hernia hepatitis, irritable bowel syndrome or chronic bloatedness, previous gastroscopy or colonoscopy, cirrhosis, piles, fistulae or rectal bleeding, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder conditions, gall stones, oesophageal disease, stomach or duodenal ulcers, any hernia, digestive problems or malabsorption, Crohn disease, ulcerative colitis, diverticulitis, any other abdominal or digestive condition.

Mark with an "X"

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

11. Skin conditions

Examples: chronic wounds, eczema, psoriasis, acne, sunspots, skin cancer, melanoma, any other condition affecting the skin.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

12. Back, bone, muscle, and autoimmune conditions

Examples: lower back, neck or spinal area pain, rheumatoid arthritis, osteoarthritis, knee, hip or shoulder problems or any other joint pain, joint replacements, ankylosing spondylitis, lupus, gout, clubfoot, bunions, Sjögren syndrome, scleroderma, polymyositis, polyarteritis nodosa, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, fractures, physical disability, prosthesis, amputation, any other autoimmune conditions, any other condition affecting the back, bones or muscles.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

13. Gynaecological and obstetric conditions

Examples: abnormal Pap smear result, menstruation problems or abnormal bleeding, endometriosis, polycystic ovarian syndrome, infertility, ovarian cysts, ectopic pregnancy, miscarriage, missed periods, conditions or complications related to pregnancy, emergency Caesarean section, any other gynaecological or obstetric condition.

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: **Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

14. Pregnancy

Mark with an "X"

Are you or any of your dependants pregnant, suspect that you are pregnant or undergoing testing for pregnancy? | Yes | No |

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

15. Kidney and urinary conditions

Examples: kidney or renal failure, acute or chronic renal dialysis, kidney stones, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, urinary tract infections, bladder infections, any other kidney or bladder problems, sexually transmitted diseases. | Yes | No |

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

16. Male urinary and genital conditions

Examples: prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence and urine retention, any other male urinary or genital condition. | Yes | No |

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

17. Chronic or regular medication

Are you or any of your dependants currently taking regular, ongoing medicine, and/or are you receiving treatment for a medical condition or symptom even for a condition not mentioned in the medical questionnaire, including homeopathic, natural or over the counter medication? | Yes | No |

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

9.2 Full medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If you answer "Yes" to any question, please provide full details, as all applications for pre-authorisation are reviewed. If you do not disclose all information it may result in the termination of your membership.
- Kindly note that the conditions listed below are only examples and not a full list of all possible conditions, symptoms or disorders.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: **Please complete the following questionnaire to indicate whether you and/or your dependants mentioned on this application form have a history of any medical conditions, illnesses or disorders (disorder includes affection or condition of illness).**

18. HIV/Aids

Mark with an "X"

Yes	No

Are you or any of your dependants mentioned on this application HIV positive or have you been diagnosed with Aids?*

Please note that if you do not make a selection, Medihelp will regard your answer as "No".

*If you or any of your dependants prefer not to disclose your HIV status on this application form, you will remain responsible to inform the Scheme and to register on the Medihelp HIV/Aids programme within 21 days from your enrolment date by phoning LifeSense on 0860 50 60 80.

It is important to disclose this information to prevent the possible termination of your membership. When we receive your application to register on the HIV/Aids programme, we will determine whether underwriting conditions must be applied and, if this is the case, issue an amended proof of membership document to you.

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

19. Possible services

Are you and/or your dependants aware of or planning to have any test, examination, treatment and/or procedure done, or obtain medical advice that could result in a claim in the next 12 months?

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

20. Any other conditions not mentioned

Has any person indicated in this application form been examined (for example, medical tests, X-rays, scans), diagnosed and/or treated (with/without procedures) for any condition or disorder not mentioned in the medical questionnaire (including any injuries sustained at home, work or in a vehicle-related accident)?

Yes	No

Name of patient	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate type of treatment, therapy, and the name of the medicine used during the past 12 months
		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	y y y y m m d d	

10. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information

Medihelp confirms that:

1. Your and your registered dependants' personal and medical information will be treated confidentially and will not be sold to a third party or used for commercial or related purposes.
2. Security measures have been implemented to protect your data and that Medihelp employees and contracted parties have access to your data to process and pay claims, among other things, and that they have signed a confidentiality agreement in terms of which they undertake not to disclose your personal information to any unauthorised parties.
3. Your personal information will only be used for purposes such as processing your application for membership, paying your medical claims, determining whether you are entitled to benefits, managing risks, and for any communication purposes or marketing initiatives undertaken by Medihelp.

10. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information (continued)

Medihelp confirms that: (continued)

4. The Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy.
5. Should you make use of a Medihelp-contracted brokerage's services then relevant membership information will be made available to the appointed brokerage in order to render a service to you, and any authorised person at the brokerage may instruct Medihelp to change any of your personal information except for your banking details, unless you instruct Medihelp otherwise.

Your responsibilities as a member of Medihelp

6. I will ensure that I know all the provisions of Medihelp's Rules and will read all the correspondence from Medihelp, such as newsletters and statements. I will also study my benefit guide and familiarise myself with the coverage offered by the benefit plan that I have chosen.
7. I undertake to abide by the Rules, as amended from time to time and available at www.medihelp.co.za on the secured website for members, and to not submit any fraudulent claims or commit any fraudulent acts.
8. I declare that the information provided in this application for membership is accurate and complete. I understand that any false declaration or omission of information may result in the termination of my membership and that of my registered dependants or any other measures which Medihelp, in its sole discretion, may decide to take, subject to appeal procedures. I understand that it is my responsibility to ensure that the details provided in this application are true and complete for myself and my dependants, even if this application was completed by my financial adviser or any other third party on my behalf. **I undertake to notify Medihelp in writing should there be any changes in my health status or that of my dependants after my application for membership has been submitted but prior to my membership commencement date. I confirm that the residential address stated on page 1 is the address that I choose for the purpose of serving any legal documentation. I undertake to notify Medihelp in writing should there be any future changes in my personal details and/or banking details and I understand that any non-adherence hereto may result in my membership being terminated in accordance with the provisions of the Medical Schemes Act and Medihelp's registered Rules.**
9. I understand that this application form is valid for a period of 30 days from the date of signature. The period may be further extended, subject to Medihelp's discretion, up to a maximum of 60 days, whereafter the application form will be cancelled and I will be required to submit a new application form.
10. I confirm that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme on the date on which I requested membership of Medihelp.
11. I take note that the monthly contribution fees will be due on the first day of enrolment and thereafter on the first day of each subsequent calendar month, and it shall be payable on the date selected by me at Section 7. Should my employer/institution, as my authorised agent, undertake to pay my contributions to Medihelp, I give permission to my employer/institution to deduct the amount payable to Medihelp from my salary and pay such amount over to Medihelp. I furthermore give permission that Medihelp may provide the following information to my employer/institution in order to pay contributions: my identity number, my tax certificate information, as well as my dependants' dates of birth, ages and relationship. I am also responsible for repaying any debt outstanding on my medical savings account, if applicable, should I terminate my membership of Medihelp.
12. I confirm that I am responsible to give advance notice of termination of membership, and that neither my dependants nor I will be registered as beneficiaries of another registered medical scheme while still members of Medihelp.

Medihelp's rights as a medical scheme

13. I am aware that a three-month general waiting period and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on my membership and that of my registered dependants in terms of the Medical Schemes Act 131 of 1998. Medihelp may finalise my membership without issuing a document containing the conditions of my membership in the event that no waiting period and/or late-joiner penalty is imposed.
14. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid in respect of particular services, for example by enforcing co-payments and exclusions.
15. Medihelp's Rules may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and using designated service providers.
16. Medihelp may also restrict interchanges between benefit plans to the beginning of a year, and require a notice period as set out in the Rules.
17. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
18. I am further aware that my benefits may be suspended should I not pay my contributions or debt in full, that my membership may be terminated should any amount still be outstanding 30 days after the date of suspension, and that my account will be handed over for collection.
19. I am aware that Medihelp may increase its contributions annually at the beginning of the year.

Protection of information

20. I hereby give permission, and declare that I have obtained the consent of all my dependants, that –

20.1 Medihelp may enquire about my health status or that of my dependants at any medical doctor or any person who is in possession of such information, and give permission for the doctor or person concerned to make such information available to Medihelp and its contracted third parties for the administration of my health plan;

20.2 My dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;

20.3 Any adviser whom I appointed and whose appointment Medihelp accepts, may have access to my personal and medical information and that of any of my registered dependants at Medihelp's disposal, and that such adviser or an authorised person at the brokerage may instruct Medihelp to change any of my personal information for the purpose of proper administration and underwriting, except for my banking details;

20.4 Medihelp may disclose my and my dependants' medical and personal information to medical service providers for the purpose of delivering medical services to me and my dependants and to pay for such services; and

20.5 Medihelp may share my information for statistical analysis and academic research purposes.

21. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).

10. Conditions of membership, declaration by applicant and consent for Medihelp to process personal information (continued)

Protection of information (continued)

22. I agree that all my telephone conversations and/or that of my dependants with Medihelp and/or its contracted third parties may be recorded for quality control purposes and to help detect and prevent fraud.
23. I agree that Medihelp may, for the purpose of considering my application for membership or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependants from medical practitioners, financial advisers, industry regulatory bodies or employers/institutions.
24. I further consent, and declare that I have obtained the consent of my dependants, that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependants' consumer credit record, including and not limited to information about my/ my dependants' credit history, financial history, personal information (excluding medical information) and judgment or default history.
25. If you believe that Medihelp has used your personal information contrary to its Privacy Policy, you have the right, under the Protection of Personal Information Act, to lodge a complaint with the Information Regulator, but we encourage you to first follow our internal complaints process to resolve the matter. If, thereafter, you believe that we have not resolved the matter adequately, you can contact the Information Regulator at: The Information Regulator (South Africa), JD House, 27 Siemens Street, Braamfontein, 2017, Telephone number: **010 023 5207,** Email: PAIAComplaints@inforegulator.org.za or POPIAComplaints@inforegulator.org.za.
26. If you believe that Medihelp has not handled your enquiry satisfactorily, please first follow our internal complaints process to resolve the matter. If thereafter, you believe that we have not resolved the matter adequately, you can contact the Council for Medical Schemes (CMS), as Medihelp is a registered medical scheme and regulated by the CMS. The CMS' contact details are as follows: Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, Customer Care Centre: **0861 123 267,** Email: complaints@medicalschemes.co.za, Website: www.medicalschemes.co.za.

Signature of applicant

Date 2 0 y y m m d d

Should you be applying on behalf of another person as guardian, curator or authorised representative, please complete the following:

In your capacity as Guardian ☐ Curator ☐ Power of attorney (legal appointment) ☐

ID/passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐ Title Mr Mrs Ms Other (specify)

A copy of your passport/ID document, as well as the document confirming your appointment as guardian/curator/power of attorney, must accompany this application. If you are signing as the applicant's parent, a copy of your passport/ID document and the applicant's birth certificate must accompany this application.

First name _____ Surname _____

Telephone number (W) ☐☐☐ ☐☐☐☐☐☐☐ Cell phone number ☐☐☐☐☐☐☐☐☐☐

11. Undertaking and declaration by adviser

NB: If this section is not completed in full by the adviser, no commission will be paid.

I declare that:

1. the applicant has appointed me as his or her adviser and is entitled to cancel my services at any time;
2. I have signed a valid contract with my Medihelp-contracted brokerage; and
3. the applicant has signed the application in person.

I take note that the adviser/brokerage indemnifies Medihelp against any non-adherence to the legal requirements as quoted above.

Name of brokerage _____

Brokerage code A ☐☐☐☐ Adviser code ☐☐☐☐

Name and surname of adviser _____

Telephone number ☐☐☐ ☐☐☐☐☐☐☐

Email address _____

Signature of adviser

Date 2 0 y y m m d d

For office use only

Lead reference number ☐☐☐☐☐☐☐☐☐☐☐☐☐ M H ☐☐☐☐☐

In case of a dispute, the registered Rules of Medihelp will apply.

Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, www.aon.co.za
FSP number: 20555; CMS number: ORG895
Follow our website link for further information on Aon's processing of your personal information

Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: _____ and membership number: _____

Signed at (Town or City): _____ on yy/mm/dd: _____

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly 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).

Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.

I give consent for the disclosure of information about me.

Membership number: _____ ID or passport number: _____

Title: _____ Initials: _____ Surname: _____

First name(s) (as per identity document): _____

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
* Name and Surname * Membership number * Date of birth * ID number * Postal Address * Physical address * E-mail Address * Telephone numbers * Cellular Number * Number of dependents	* Plan type * Medical Savings Account (MSA) * Balance Medical Scheme benefits * Spent for the year Accumulated * Medical scheme Savings Account * Medical Savings Carry over from previous year * MSA reimbursement, Scheme Rate or cost * Self-payment Gap * Above Threshold Benefit * Waiting period details * Late joiner penalty indicator * Wellness benefits	* Total Contribution * Contribution breakdown	* Chronic Indicator/ confirmation (Yes/No) * In Hospital Indicator/ confirmation (Yes/No) * Confirmation of claims paid and from what benefit * Claims transaction history * Procedures done in doctor's rooms paid from Hospital Benefit

By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): _____ on yy/mm/dd: _____

Signature: _____

Benefits of appointing

Aon South Africa Healthcare as your intermediary

Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:

Guide:
our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.

Educate:
our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.

Protect:
the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
  - Alert - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
  - Member letter - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - Guidance letter - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
  - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission 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). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to **www.aon.co.za**

http://www.facebook.com/Aonhealthcare
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

Disclaimer:

Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.