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Medihelp application form 2025

medihelp
Medical Aid in Action

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

- Submitting your application online on Medihelp's website allows for immediate confirmation of receipt and faster processing. Please visit https://onlineapplication.medihelp.co.za.
- Complete all sections in full using black ink and sign 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.

Next steps after we receive your application

- Medihelp will contact you if we need any additional information. 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 with standard terms, your membership will be activated without issuing enrolment conditions. We will notify you and/or your adviser in writing.
- If we offer you membership with any non-standard terms (with waiting periods and/or late-joiner penalties), we will notify you and/or your adviser in writing, and stipulate the conditions that will apply to your membership. To accept these terms, you can go to AiM and accept the enrolment conditions to activate your membership.
- We will notify you when we have finalised your application.
- Once you receive communication with a link to register on the Member Zone, you can download your digital membership card.

1. When would you like your cover to start?

2 0 y y m m d d

Please note the enrolment date will be the first day of the month after the application is finalised or the future date requested. No person may be enrolled as a member of Medihelp while they are a member of another medical scheme. Please refer to paragraph 10 of section 10 of this application form.

2. Your information (person who requests membership)

If you use your passport number, please attach a copy of your passport.

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

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

Surname _____ Initials _____

First names _____ Gender: Male | Female

_____ Preferred name _____

Marital status: Married | Unmarried 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 used for national statistical purposes by the Council for Medical Schemes.

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

3. Your contact information

Please note: We communicate with our members exclusively through electronic channels.

Residential address*

House/unit number _____ Complex/building name _____

Street name _____

Suburb _____ City _____

Province _____ Postal code _____

Cell phone number*

Personal email address* _____

Telephone (W) Telephone (H)

3. Your contact information (continued)

* All contact information is compulsory, as we need it to communicate important information about your rights, benefits, and duties as a member. Without this information, we will not be able to finalise your application for membership.

To enable us to communicate effectively with you, we would like to know if the following applies to you:

Visually impaired** | Yes | No

Hearing impaired** | Yes | No

** If "Yes", please complete section 9 of the medical questionnaire part of this form

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

NB: Complete only if your contribution is paid, either in full or in part, 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 type | Permanent | Temporary |

Pay area _____

Office stamp of employer

5. Mark your plan choice with an "X"

5.1 Plans

Note

- **If you choose a plan with a savings account (MedAdd, MedAdd Elect, MedSaver, MedPrime, MedPrime Elect, or MedElite), please read section 5.3; and**
- **If you choose MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect, or MedElect, please read 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 R900 (MedMove! only)

Do you want to join as a student member on the MedMove! plan? | Yes | No

If "Yes", please provide proof of your enrolment as a student. If necessary, we will let you know if we require proof of your monthly income.

- 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, if Medihelp requests this, is the past three months' official bank statements containing the initials and surname of the accountholder reflecting your income. Other additional proof of income may also be required.
- Acceptable proof of continued studies must be provided to Medihelp annually by the requested date, or more frequently if requested by Medihelp.

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 want Medihelp to 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.

5.4 Declaration if you apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect, or MedElect

I confirm that I am aware of the following:

1. **Co-payments:** I will be liable for co-payments if I do not use Medihelp's network facilities, designated service providers (DSPs), and formulary medicine.
2. **Chronic medicine:** I must register my prescribed minimum benefit (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 (medicine list) applies. If I do not get my PMB chronic medicine from the DSP or if I deviate from the formulary for my plan, I will be responsible for a co-payment* on my PMB chronic medicine.
3. **Network doctors:** To avoid co-payments on PMB treatments, any specialists consulted must form part of Medihelp's DSP specialist network.

5.4 Declaration if you apply for enrolment on MedMove!, MedVital Elect, MedAdd Elect, MedPrime Elect, or MedElect (vervolg)

4. **Network facilities:** 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 have 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 a medical emergency* that 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 the Member guide 2025 for all applicable co-payments and the definition of a medical emergency. Visit the Medihelp website at www.medihelp.co.za, click on Plans, then Compare plans, and download the 2025 plan comparison.

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

6. Dependants 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, you may register them 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 they have been legally adopted as children.
- 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.
- If a dependant is not a South African citizen, a copy of their passport must be submitted with the completed application.
- When registering a partner as a dependant, you confirm that you are in a domestic partnership, and undertake to inform Medihelp within 30 days if your relationship status changes.

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
- Grandparents
- Nieces and nephews

To avoid delays in your enrolment process, please attach the following supporting documents:*

Dependant	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 has been 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)

Dependant 1

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

First names in full _____

Preferred name _____

If a passport number is used, please attach a copy of the passport

ID/passport number _____ Gender Male | Female

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

6. Dependants you want to register (continued)

Dependant 1 (continued)

Personal email address * _____

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

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

* If "Yes", please complete section 9 of the medical questionnaire part of this form.

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 used for national statistical purposes by the Council for Medical Schemes.

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

Dependant 2

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

First names in full _____

Preferred name _____

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

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

Personal email address * _____

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

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

* If "Yes", please complete section 9 of the medical questionnaire part of this form.

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

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

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

Dependant 3

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

First names in full _____

Preferred name _____

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

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

Personal email address * _____

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

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

* If "Yes", please complete section 9 of the medical questionnaire part of this form.

6. Dependants you want to register (continued)

Dependant 3 (continued)

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

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

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

Dependant 4

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

First names in full _____

Preferred name _____

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

Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d |

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

Personal email address * _____

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

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

* If "Yes", please complete section 9 of the medical questionnaire part of this form.

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

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

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

Dependant 5

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

First names in full _____

Preferred name _____

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

Gender | Male | Female |

Date of birth | y | y | y | y | m | m | d | d |

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

Personal email address * _____

*This information is compulsory and is required to communicate important information to your dependant if they are 18 years or older.

To enable us to communicate effectively with your dependant, please indicate if the following applies to this dependant:

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

* If "Yes", please complete section 9 of the medical questionnaire part of this form.

6. Dependants you want to register (continued)

Dependant 5 (continued)

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

Please indicate your dependant's race only if you wish to do so. The information is used for national statistical purposes by the Council for Medical Schemes.

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

7. Banking details

7.1 Complete this section if you will pay your own contribution

I authorise Medihelp to deduct the applicable monthly contribution from the bank account specified below by debit order on the indicated date. I further authorise Medihelp to adjust the contribution if necessary and to deduct the amended amount, or any outstanding contribution from the specified bank account.

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

☐ My employer/institution, as my authorised agent, authorises Medihelp to deduct the applicable monthly contribution from my employer/institution's bank account on the last workday of each month, starting from the date of enrolment. I authorise Medihelp to adjust the contribution amount if necessary and to deduct the amended amount, or any outstanding contribution amount from my employer/institution's bank account.

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

If you provide only one bank account number, we will use this account to deduct your monthly contribution and to refund any credit amounts.

☐ 1. Use account below for all transactions

☐ 2. Use the account below only for the deduction of monthly contribution

NB: If you select option 2, you must complete your banking details for credit refunds in the column on the right.

Bank _____

Branch _____

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

Type of account Savings | Current

Initials and surname of accountholder _____

Account number _____

☐ Use the account below for credit refunds only

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

Bank _____

Branch _____

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

Type of account Savings | Current

Initials and surname of accountholder _____

Account number _____

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

☐ First workday of the month ☐ Last calendar day of the month ☐ 25th day of the month

Note

- Your contribution is payable in advance. 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. These will be the first available workday following the activation of your membership and the actual date you have chosen in the same month.
- After the first month, Medihelp will collect your contribution monthly on the date you have chosen above.
- If the debit order deduction date falls on a weekend or a public holiday, your contribution 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.
- In the case of a trust, the responsible trustee must sign this section and submit a copy of the trust deed.

Complete this section if a third party pays the contribution on behalf of the applicant

This information is compulsory as this is a requirement for South African Revenue Services (SARS) purposes.
I, the undersigned, hereby agree to pay the monthly medical scheme contribution on behalf of the member. I also authorise Medihelp Medical Scheme to deduct the contribution from my bank account.

If a third party will be paying the contribution on behalf of the member, please attach the following supporting documents, not older than three months:
- Accountholder's identity document/passport/driver's license
- Accountholder's bank statement/confirmation of bank account

ID/passport number

Title

Mr	Mrs	Ms	Other (specify)

Surname

Initials

First name

Nature of payer (for example, individual, company, trust, etc.)

Physical address

Registered company name

Company registration number

Income tax number

Cell phone number

Relationship to member

Email address

Signature of applicant

Signature of accountholder

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:

- 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%	of the beneficiary's contribution (excluding savings account contribution)
5 –14 years	25%	
15 – 24 years	50%	
25 years +	75%	

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

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 penalties? 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 periods (meaning treatment of any specific conditions were excluded from benefits for a certain period) and were they still active at the time of termination of membership? 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

- If you answer "Yes" to any of the questions in section 9.1, please complete the full medical questionnaire in sections 9.2, 9.3, and 9.4.

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 you have not completed your application form in full, withheld information, or provided inaccurate details, we may terminate your membership.

9.1 General medical questionnaire

Mark with an "X"

1. Have you or any of your dependants been admitted to hospital and/or diagnosed with any illness within the last 12 months prior to submitting this application? If "Yes", please complete sections 9.2, 9.3, and 9.4. 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 questions 17 and 18 in section 9.2). If "Yes", please complete sections 9.2, 9.3, and 9.4. 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 sections 9.2, 9.3, and 9.4. Yes | No

9.2 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. If 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 in to our self-service platform 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. (Disorders include affection or condition of illness.)

1. Cancer and cancerous growths

Cancer or tumours of any organ or skin, including all stages of cancer, or historic cancer that is now in remission. Examples may include breast cancer, prostate cancer, gastro-intestinal cancer, lung cancer, and skin cancer such as melanoma or basal cell carcinoma. Cancer also includes any blood-related cancers such as lymphoma, leukaemia, aplastic anaemia, myeloma, myelodysplastic syndromes, or others. Cancer may have been diagnosed through abnormal test results, for example, abnormal mammogram result, abnormal Pap smear result, abnormal prostate-specific antigen result, any other abnormal cancer screening, etc.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

2. Blood conditions

Examples: blood clots, bleeding problems, high or low iron, anaemia, deep vein thrombosis, lung clots, ITP and platelet deficiencies, any other bleeding or blood-related disorders that may not be included in the examples provided.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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: obesity (BMI ≥ 35), diabetes type 1, diabetes type 2, diabetes insipidus, thyroid disease, metabolic syndrome, parathyroid disease, osteoporosis, osteopenia, growth problems or deficiency, Paget's disease, Addison's disease, Cushing's syndrome, or any other metabolic or endocrine condition.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

4. Mental health (including behaviour disorders, substance dependency, and other psychosocial conditions)

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. Furthermore, examples include Alzheimer's disease, dementia, as well as autism and attention deficit hyperactivity disorder. Examples also include drug or alcohol dependency or abuse, rehabilitation for drug or alcohol dependency or abuse, suicide attempt(s), counselling, or any other psychological condition. Admissions to any facility for the treatment of any mental health conditions, not limited to the examples mentioned above, must be indicated in the column "indicate type of treatment" below.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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: multiple sclerosis, stroke, weakness or paralysis, bleeding on the brain, epilepsy, polyneuropathy, motor neuron disease, myasthenia gravis, Parkinson's disease, Guillain-Barré syndrome, cerebral palsy, hemiplegia, paraplegia, quadriplegia, spinal cord injury, hydrocephalus, ventriculoperitoneal (VP) shunt, migraine, chronic headaches, or any other brain or nerve condition .

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

6. Eye and eyelid conditions

Examples: vision loss or impairment (partial or full blindness), cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachment, retinal vein occlusion, keratoconus, corneal ulcer, squint, ptosis, and uveitis. Examples of procedures or devices include cornea transplant, eye surgery including blepharoplasty, glasses, or any other eye or eyelid condition.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

7. Ear, nose, and throat conditions

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

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 conditions and heart-or peripheral related circulation conditions

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

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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, pneumonia, tuberculosis, interstitial lung disease, cystic fibrosis, sarcoidosis, any other breathing or respiratory condition. If you work in a specific occupation or industry that may affect your lungs, please specify.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

10. Abdominal and digestive conditions

Examples: reflux, heartburn, hiatus hernia, hepatitis, Crohn's disease, ulcerative colitis, irritable bowel syndrome or chronic bloatedness, 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, diverticulitis, and any other abdominal or digestive condition. Examples of procedures may include previous gastroscopy or colonoscopy.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 and non-cancerous growths

Examples: abscesses, cysts, wounds, eczema, psoriasis, acne, sunspots, any non-cancerous lesions such as skin lesions, warts, moles, or any other conditions affecting the skin.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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. Spinal, bone, muscle, and related autoimmune conditions

Examples: knee, hip or shoulder problems or any other joint pain, tendon and soft tissue injuries, gout, clubfoot, bunions, osteoarthritis and procedures such as joint replacements, prosthesis or removal of prosthesis, and amputation. Related auto-immune conditions may include rheumatoid arthritis, ankylosing spondylitis, lupus gout, Sjögren's syndrome, scleroderma, polymyositis, polyarteritis nodosa, fibromyalgia, prosthesis, any other autoimmune conditions, any other condition affecting the back, bones, or muscles.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

13. Gynaecological conditions

Examples: menstruation problems or abnormal bleeding, endometriosis, polycystic ovarian syndrome, myomas, cervical dysplasia or abnormalities, infertility, ovarian cysts, any other gynaecological condition, or procedures that may include previous cervical biopsies (including cone biopsies and large loop excision of the transformation zone procedures).

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

14. Pregnancy and obstetric (pregnancy-related) conditions

Please confirm if you or any of your dependants are pregnant, if you or any of your dependants suspect that you are pregnant, or are undergoing testing for pregnancy. Examples of pregnancy-related conditions also include ectopic pregnancy, miscarriage, missed periods, conditions or complications related to pregnancy, emergency Caesarean section, etc.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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, kidney stones, urinary incontinence, urinary tract infections, bladder infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, sexually transmitted diseases, any other kidney or bladder problems. Examples of procedures include acute or chronic renal dialysis, cystoscopy, stents, or any other procedure related to your kidneys and urinary system.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

16. Male urinary and genital conditions

Examples: prostate disorders, enlarged prostate, chronic infection, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, urinary retention, and any other male urinary or genital condition. Examples of procedures include biopsies, transurethral resection of the prostate, hormone therapy for prostate conditions, etc.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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. HIV/Aids

Are you or any of your dependants mentioned on this application HIV-positive or have you been diagnosed with Aids?*
Please note: 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 must still inform the Scheme and 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. If underwriting conditions are applied, we will issue an amended proof of membership document to you.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

18. Chronic or regular medication

Please list all the medicine that you or your dependants have been using over the past 12 months.
It also includes prescription medication or any other medication you have been using over a period of more than 30 days. This includes over-the-counter medicines, natural or homeopathic medicines, etc.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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 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. (Disorders include affection or condition of illness.)

19. Potential future services, treatments, procedures, tests, or medical advise

Are you and/or your dependants aware of, or planning to have any tests, examinations, treatments and/or procedures done in the next 12 months? If this is the case, please provide all relevant reports, referral letters, and relevant blood tests results.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures.	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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? This may include any injuries sustained at home or work, or specifically sustained in a vehicle-related accident.

Mark with an "X"

Yes	No

Name of beneficiary	Specify illness/ condition/disorder in full	Date of diagnosis	Last date of follow-up consultation, tests, medicines, procedures.	Indicate type of treatment such as hospital admission, surgery or procedure, type of 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	

9.3 Disability

This information is compulsory as this is a requirement for South African Revenue Services (SARS) purposes. Declare any disability, for example, hearing, vision, speech, mental, physical, and intellectual.

Name of beneficiary	Specify disability	Nature: temporary or permanent	Date of diagnosis	End date of disability (if temporary)	Limitation of disability: mild, moderate or severe	Practice number (HPCSA number)

9.4 Doctors consulted for medical conditions

- Doctors consulted in the past 12 months
- Doctors who diagnosed and treated disability

☐ General consultations ☐ Disability consultation

Name and surname _____

9.4 Doctors consulted for medical conditions (continued)

Telephone number (W)

How long have this been your doctor (in years)?

Cell phone number

Email address

*If disability was selected, please complete the following information according to SARS requirements.

☐ General consultations ☐ Disability consultation

Name and surname

Telephone number (W)

How long have this been your doctor (in years)?

Cell phone number

Email address

*If disability was selected, please complete the following information according to SARS requirements.

☐ General consultations ☐ Disability consultation

Name and surname

Telephone number (W)

How long have this been your doctor (in years)?

Cell phone number

Email address

*If disability was selected, please complete the following information according to SARS requirements.

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 Medihelp employees and contracted parties have access to your data to process and pay claims, among other things. All employees and contracted parties who have access to your data for these purposes have signed a confidentiality agreement 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.
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, 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 the Rules of Medihelp and will read all the correspondence from Medihelp, such as newsletters and statements. I will also study my plan guide and familiarise myself with the cover offered by the plan I choose.

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

Your responsibilities as a member of Medihelp (continued)

7. I will abide by the Rules of Medihelp, as amended from time to time and available at www.medihelp.co.za on the self-service platform for members and 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 me and my dependants, even if this application was completed by my financial adviser or any other third party on my behalf. I will notify Medihelp in writing if there are any changes in my health status or that of my dependants after my application for membership has been submitted, but before my membership start date. I confirm that the residential address stated in section 3 is the address I choose for serving any legal documentation. I will notify Medihelp in writing of any future changes to my personal details and/or banking details. I understand that failure to do so may result in my membership being terminated in accordance with the Medical Schemes Act 131 of 1998 and the registered Rules of Medihelp.
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, after which 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 in section 7. Should my employer/institution, as my authorised agent, undertake to pay my contribution 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 contribution: 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 note that a third party paying the contribution on my behalf is not part of the contract with Medihelp and will not receive communication regarding changes in the monthly payable contribution. I undertake to inform the third party of any changes in my contribution and accept that I remain responsible for the payment thereof.
13. 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

14. 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 if no waiting period and/or late-joiner penalty is imposed.
15. 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.
16. The Rules of Medihelp may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as pre-authorisation and using designated service providers.
17. Medihelp may also restrict interchanges between plans to the beginning of a year and require a notice period as set out in the Rules.
18. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.
19. I am further aware that my benefits may be suspended if I fail to pay my contribution or debt in full, that my membership may be terminated if any amount remains outstanding 30 days after the date of suspension, and that my account will be handed over for collection.
20. I am aware that Medihelp may increase its contribution annually at the beginning of the year. I also authorise Medihelp to adjust the contribution if necessary due to a change in my membership and to deduct the amended amount or any outstanding contribution amounts from me or the third-party payer/employer/institution I indicated as the authorised payer of my contribution.

Protection of information

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

21.1 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 I 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;

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

21.3 Any adviser I appoint 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;

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

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

22. I take note that Medihelp complies with the stipulations of the Protection of Personal Information Act 4 of 2013 (POPIA).
23. 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.
24. 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.

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

Protection of information (continued)

25. 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.
26. 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 Stiemens Street, Braamfontein, 2017, telephone number: 010 023 5207, email: POPIAComplaints@inforegulator.org.za.
27. 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's 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.

If you are signing as the applicant's parent and your child is younger than 18, please attach a copy of your passport/ID document and the applicant's birth certificate.

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

If you are signing as the applicant's parent and your child is 18 years and older, please attach the following:

A copy of your passport/ID document as well as the document confirming your appointment as guardian/curator/power of attorney.

If you are applying on behalf of another person as parent, guardian, curator, or power of attorney, please complete the following:

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

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

First name _____ Surname _____

Telephone number (W) ☐☐☐ ☐☐☐☐☐☐☐ 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.

Relationship to applicant _____

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 their 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

Lead reference number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

Email: newbusiness@medihelp.co.za
189 Clark Street, Brooklyn, Pretoria, 0181, **www.medihelp.co.za**

Medihelp is an authorised financial services provider (FSP No 15738)

MHNN005 SEPTEMBER 2024

medihelp
Medical Aid in Action

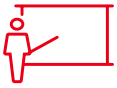
Benefits of appointing

Aon South Africa Healthcare as your intermediary

Across Aon, we are united in our passion to provide you with the insights and support to make Better Decisions around all aspects of your holistic wellbeing, medical scheme, gap cover and primary care insurance. 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 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 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.
  - **Client Assistance Programme** - We are delighted to offer you access to a range of essential services at absolutely no charge. The Aon Client Wellbeing Programme is a telephonic, online, and structured e-mail support program (excluding in-person or video sessions). The following services are available through our third- party service provider, LifeAssist:
    - Structured Telephonic Counselling
    - Telephonic Trauma Support
    - Financial Wellbeing Coaching
    - Legal Advisory Services
    - Health and Wellness Services (professional advice from a dietician and a biokineticist)
- **General Updates:**
  - Ad-hoc updates pertaining to Medical schemes industry and 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.

For more information, contact Aon South Africa:

0860 100 404 | arc@aon.co.za | www.aon.co.za

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.

http://www.aon.co.za/disclaimer
On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at http://www.aon.co.za/terms-of-trade or will be sent to you upon request.

Privacy Notice

Disclaimer:

The Benefits and contributions are subject to approval by the council for medical schemes. 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.

21 February 2024 | V1 | CH

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: _____