SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

0860 100 871
086 608 0771
membership@sizwehosmed.co.za
7 West Street,
Houghton Estate,
Johannesburg,
2198

MEMBERSHIP APPLICATION FORM

Broker Stamp

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: 1009

Broker No.

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

Preferred Option: Titanium Executive ☐ Plus ☐ Platinum Enhanced ☐ Platinum Enhanced EDO ☐ Gold Ascend ☐ Gold Ascend EDO ☐
Value ☐ Value Core ☐ Access ☐ Access Core ☐ Essential Copper ☐

Start date

FOR OFFICE USE ONLY

Membership no.		Company number	
Joining date		Subscription code	

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss	Initials	First name	
Surname			KINDLY ATTACH COPY OF ID
Identity no.			
Date of birth	Gender Male Female	Marital status (please mark appropriate)	S M D
Employee no.	Monthly income R		Kindly attached sufficient proof of income
Tel no. (h)	(w)	(Cell)	
Email			
Residential address			
		Postal code	
Postal address			
		Postal code	
Name of previous medical aid scheme	1.	2.	
Period of membership	1. From	To	
	2. From	To	KINDLY ATTACH CERTIFICATE/S OF MEMBERSHIP Full details over last two years must be given
Race (please tick)	African / Coloured / Indian/Asian / White	Preferred method of communication (please tick)	Email ☐ SMS ☐ Post ☐

SECTION B: EMPLOYER DETAILS

Company			
Region		Date of employment	

Name ____________ Employer signature ____________ Designation ____________ Date ____________

SECTION C: DEPENDANTS DETAILS

	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Name and Surname of dependant					
ID number (compulsory)					
Relationship to member (spouse, partner, daughter etc.)					
Sex (M/F)					
Race (African, Coloured, Indian/ Asian, White)					
State if living with you (yes or no)					
Address, if different from member					
Cell no.					
Income					

Member initials ____________

SECTION D: MEDICAL QUESTIONNAIRE

Do you or your dependants have, or ever had the following? If "yes" state full details below (complete all questions).

Question			Details	Name
1. Any disorder of the heart e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	No	Yes		
2. High blood pressure, chronic headache or disease of the blood vessels including cholesterol or circulatory disorder?	No	Yes		
3. Any respiratory or lung trouble,e.g. asthma, bronchitis, persistent cough, tuberculosis?	No	Yes		
4. Any disorder of the digestive system, gall bladder or liver e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?	No	Yes		
5. Disease or disorder of the kidneys, bladder or reproductive organs, e.g. albumin in urine, stones, prostatitis or infertility?	No	Yes		
6. Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety state or depression, alcoholism or narcotism?	No	Yes		
7. Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, tonsilitis and sinus problems?	No	Yes		
8. Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?	No	Yes		
9. Diabetes, acne or skin problems, sugar in urine, thyroid or other glandular or blood disorders?	No	Yes		
10. Cancer, growth or tumour of any kind?	No	Yes		
11. Any tropical disease, e.g. Bilharzia?	No	Yes		
12. Any other illness, disorder, operation, disability or injuries from any accident or HIV/Aids infection?	No	Yes		
13a. Any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement, e.g. Caesarian section or miscarriage? If "Yes", state full details including dates.	No	Yes		
13b. Are you now pregnant? If "Yes", how many months? ____________ If "Yes" is this a multiple birth?	No	Yes		
14. Any special dental treatment, e.g. crowns, bridges, orthodontic, etc?	No	Yes		
15. Any illness or physical defect likely to necessitate medical or dental treatment, e.g. headaches, lumps, orthodontic work etc.??	No	Yes		
16. Do you expect any medical or dental treatment within the next three months?	No	Yes		
17. Do you or your dependants have a medical condition not disclosed?	No	Yes		
18. Detail all medication used by applicant and dependants during the last 2 years, as well as all Pathology and Radiology tests.				

Provide details of all current medical and chronic conditions.
If there is not enough space, please attach an additional page

No.	Patient	Date of treatment	Full details of the disorder, consulting doctor, type of medication, dosage and degree of recovery.

SECTION E: MEDICAL PRACTITIONER'S DETAILS

Please give name of the general practitioner you or any of your dependants have consulted

Name of General Practitioner			
Tel no.		Number of years consulted	
Name of Regular Pharmacist			
Tel no.		Number of years consulted	

Member initials ____________________

SECTION F: BANKING DETAILS FOR DEDUCTION OF MONTHLY CONTRIBUTIONS (BY DEBIT ORDER)

Account holder								
Account number		Account type (please mark appropriate)	Current		Transmission		Savings	
Name of bank								
Branch								
Branch code								
Debit order run date								

I authorise Sizwe Hosmed to draw from my bank account (wherever it may be), the contribution and members portion of claims due in terms of the Rules of Sizwe Hosmed, without prejudice to the rights of Sizwe Hosmed. I further authorise Sizwe Hosmed to increase the amounts due, in terms of the rules, and authorise my bank to effect payment of such increased amounts upon receipt of a written notice from Sizwe Hosmed stating the increased amount and the date from which it is payable. This authorisation is to remain in effect until I cancel it by giving written notice to Sizwe Hosmed. I agree that I am not entitled to recover any amount drawn from my account by means of this debit order and that should my bank repay such amount to me, I will refund it immediately to Sizwe Hosmed. I undertake to notify Sizwe Hosmed immediately of any change in respect of my details. I acknowledge that Sizwe Hosmed may not cede or assign any of their right to any third party without my prior consent and that I may not delegate any of my obligations in terms of the contract to any third party without prior written consent of the authorised party. Sizwe Hosmed is hereby authorised to debit by bank account with my portion of accounts paid on my behalf by Sizwe Hosmed.

SECTION G: BANKING DETAILS FOR REIMBURSEMENT OF CLAIMS (BY CREDIT ORDER)

Account holder								
Account number		Account type (please mark appropriate)	Current		Transmission		Savings	
Name of bank								
Branch								
Branch code								

I hereby instruct and authorise you to pay any claim reimbursement which may accrue to me, to the credit of my account with the abovementioned bank or any other bank or branch to which I may transfer my account.

I understand that remittance advice/payment advices will be supplied to me in the normal way and that they will indicate the date on which funds will be available in my account.

I acknowledge that the party hereby authorised to effect a credit against my account may not cede or assign any of its rights to any third party without my prior written consent and that I may not delegate any of my obligations in terms of this contract/authority to any third party without written consent of the authorised party.

This authority may be cancelled by me giving you thirty day's notice in writing.

SECTION H: CONDITIONS OF MEMBERSHIP

MEMBERSHIP APPLICATION FORM:

I, ... hereby declare that:

(a) The information furnished herein is to the best of my knowledge and ability completely true. No relevant information has been omitted.

(b) If, after my admission to Sizwe Hosmed, it is found that any statement or information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to Sizwe Hosmed all payments which Sizwe Hosmed may have made on my behalf and to relinquish any claim to any benefits on the part of Sizwe Hosmed, should Sizwe Hosmed request me to do so.

(c) Should there be any deterioration or change in my state of health or in that of any of my dependants before the date or event to be set by Sizwe Hosmed for commencement of membership or the date of acceptance of this application by Sizwe Hosmed or the date of receipt of the first contribution, (whichever date is the latest) or thereafter, Sizwe Hosmed will be entitled to reconsider the application and purport new terms of admission or declare the membership null and void, depending on the relevant circumstances. Any sum of money paid to Sizwe Hosmed in terms of this membership, before Sizwe Hosmed is informed of the said change, shall be forfeited by me and any benefits paid by Sizwe Hosmed on my behalf shall immediately be refunded by me to Sizwe Hosmed, on the request of Sizwe Hosmed.

SECTION I: UNDERTAKINGS

(d) I accept that I and/or my dependants may be subjected to a general waiting period of three months. For any pre-existing conditions within the last twelve months, a waiting period of twelve months may be applied.

(e) I accept that should any sum of money due to Sizwe Hosmed not be timeously paid by me for any reason whatsoever, I shall be liable for all costs incurred by Sizwe Hosmed in recovering such a claim, including tracing charges and all fees and costs charged to Sizwe Hosmed by its attorneys, including collection commission or fees.

(f) I undertake to notify Sizwe Hosmed within (30) thirty days of any change in my marital status and or dependant status that occurred since the commencement of my membership with Sizwe Hosmed.

(g) Should I decide to resign my membership from Sizwe Hosmed voluntarily, I undertake to give one month's written notice.

(h) I will call Sizwe Hosmed Customer Services on 0860 00 00 48 for any pre-authorised treatment inquiries.

(i) I herewith authorise my healthcare provider to disclose information to Sizwe Hosmed and its contracted third parties, provided such information is treated as confidential at all times.

(j) Should I be enrolled as a member of Sizwe Hosmed, I will subject myself to the Rules of Sizwe Hosmed.

Member initials ____________________

SECTION J: GENERAL

(k) I irrevocably grant my permission to any physician, person or party who may be in possession of, or obtain information concerning my health, or that of my dependants, to divulge such information to Sizwe Hosmed, also after my death.

(l) I confirm that I am employed by my Employer in a full time capacity and I undertake to notify Sizwe Hosmed of any change in my salary structure.

(m) I undertake to pay any other amounts due to Sizwe Hosmed, on default.

(n) I hereby authorise my Employer to deduct my contribution to Sizwe Hosmed from any salary or any other sum of money due to Sizwe Hosmed by me.

(o) Where applicable: Member Savings Account allocations will be pro-rated depending on when joining the option.

(p) I must register my chronic medication with Sizwe Hosmed.

(q) I agree to access www.sizwehosmed.co.za to access full conditions and undertakings of the Scheme as a member of Sizwe Hosmed Medical Scheme.

Member name

Member signature

Date

Company Stamp

DOCUMENTS REQUIRED

	Yes	No
• Dependant's copy of ID	☐	☐
• Main member's copy of ID	☐	☐
• Birth certificate of child (where ID is not available)	☐	☐
• Clinic card for new born baby (within 30 days of birth to avoid waiting period)	☐	☐
• Documentary proof if dependant is adopted/foster child/student/disability status/adult dependant	☐	☐
• Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting period)	☐	☐
• Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable)	☐	☐
• Membership certificate from previous medical aid (where applicable)	☐	☐
• Proof of latest income salary advance / 3 months bank statements	☐	☐

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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

Aon South Africa (Pty) Ltd, an Authorised Financial Services Provider, FSP # 20555

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: ____________________

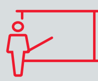
Aon South Africa (Pty) Ltd, an Authorised Financial Services Provider, FSP # 20555

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

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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.