Broker House: Aon South Africa (Pty) Ltd
Broker Code: AON104
Tel No: 0860 100 404

MEDSHIELD medical scheme

MEDSHIELD MEMBER APPLICATION

Email: newapplication@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary. All sections must be completed.

Selection of Benefit Option: _____

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Start Date of Membership: | D | D | M | M | Y | Y | Y | Y |

Applicant Signature: _____ Date: | D | D | M | M | Y | Y | Y | Y |

CONSULTANT DECLARATION

Brokerage Name:

Broker Code:

DOCUMENT CHECKLIST

In order to avoid rejection of your application please provide the following documents:	Please Tick
ID document copy(ies) for all beneficiaries (e.g. ID/birth certificate/passport)	
Student(s) (child dependant age 21-27 that is studying or turning 21 in the next 3 months) • Proof of registration at a recognised tertiary institution	
Proof of previous medical scheme for all beneficiaries (certificate of membership reflecting an end date)	
Stamped bank statement or stamped confirmation letter from the bank. If contributions are paid by a third party, the required documents as per the bank details section should accompany this form.	
Additional documents for Special Dependants (foster/adopted children, niece, nephew, sibling, grandchild): **Adopted/Foster Child:** • Legal documentation of adoption or foster arrangement **A parent or grandparent of the Principal Member:** • Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent • Proof of income such as payslip, bank statement, or proof of pension **A grandchild, niece, nephew, or sibling:** • Certified affidavit from Principal Member and parent(s) confirming residency, employment, and income of child and both parents • Proof of income if dependant is employed	
ID copy(ies) of the nominated 3rd Party(ies) Consent (To whom we may provide specified information)	

I, _____ hereby understand that it is an offense to submit fraudulent business and have explained Non-disclosure, General and condition specific waiting periods, Late Joiner Penalty, PMB and proration of benefits to the applicant. I further declare that I have attached all documents as per the document checklist above to this application form, and that the application form is submitted to the Scheme within 30 calendar days of the member declaration sign date.

Consultant's Signature: _____ Date: | D | D | M | M | Y | Y | Y | Y |

Medshield is an Authorised Financial Services Provider (FSP 51381)

SECTION A — PRINCIPAL MEMBER DETAILS (attach copy of ID document)

Title: Initials:

First Name/s:

Surname:

ID/Passport Number:

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

Postal Address:

Postal Code:

Residential Address:

Please provide at least one email address

Personal Email Address:

Business Email Address:

Telephone Number (W): C O D E

Telephone Number (H): C O D E

Cell Number:

Fax Number: C O D E

Tax Number:

Please complete for marketing purposes:

Gender: (Mark with an X) M F

Marital Status: Single Married Divorced Widowed

Please complete for statistical purposes. If you do not wish to disclose your race, please mark the relevant box with an X.

Race: African | Caucasian/ White | Coloured | Indian | Asian | Other

I do not wish to disclose:

SECTION B — DEPENDANTS YOU WISH TO REGISTER (attach copy of ID document)

Spouse or Partner: Spouse | Life Partner | Divorced Spouse

Title: Initials:

First Names:

Surname:

Previous Surname:

ID/Passport Number:

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

Country of Residence:

Dependant Email Address:

Dependant Tel Number (W): C O D E

Dependant Cell Number:

Please complete for marketing purposes:

Gender: (Mark with an X)	M	F	Marital Status:	Single	Married	Divorced	Widowed

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

For special dependants (e.g. parents, foster/adopted children, niece, nephew, grandchild, parents) please attach the following:

Adopted/Foster Child:
Legal documentation of adoption or foster arrangement

A parent or grandparent of the Principal Member:
Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent
Proof of income such as payslip, bank statement, or proof of pension

A grandchild, niece, nephew or sibling:
Certified affidavit from Principal Member and parent(s) confirming residency, employment, and income of child and both parents
Proof of income if dependant is employed

If the dependant is classified as a student and falls within the age range of 21 to 27 or will reach the age of 21 in the next three months, student proof in the form of a stamped or signed letter, on a letterhead from the accredited institution for tertiary education for the current year must accompany this form.

Include copies of the dependants' ID, birth certificate or passport.

Acceptance of dependants will be in accordance with the Rules of the Scheme.

Dependant 1

Name of Dependant:																			
Surname: (If Different to Principal Member)																			
ID Number/Passport number for non-South Africans citizens:																			
Date of Birth:																			
Dependant Email Address:																			
Dependant Cell Number:																			
Relationship to Principal Member:																			

Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

If the dependant is classified as a special dependant (e.g. parents, adopted/foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions:

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N

If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?

If yes, what is the monthly income? R

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 2

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number/Passport number for non-South Africans citizens:

Date of Birth:

Dependant Email Address:

Dependant Cell Number:

Relationship to Principal Member:

Gender: (Mark with an X) | M | F | Adult Over 21: (Mark with an X) | Y | N |

If the dependant is classified as a special dependant (e.g. parents, adopted/foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions:

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N

If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?

If yes, what is the monthly income? R

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 3

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number/Passport number for non-South Africans citizens:

Date of Birth:

Dependant Email Address:

Dependant Cell Number:

Relationship to Principal Member:

Gender: (Mark with an X) | M | F | Adult Over 21: (Mark with an X) | Y | N |

If the dependant is classified as a special dependant (e.g. parents, adopted/foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions:

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N

If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?

If yes, what is the monthly income? R

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 4

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number/Passport number for non-South Africans citizens:

Date of Birth:

Dependant Email Address:

Dependant Cell Number:

Relationship to Principal Member:

Gender: (Mark with an X) | M | F | Adult Over 21: (Mark with an X) | Y | N |

If the dependant is classified as a special dependant (e.g. parents, adopted/foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions:

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N

If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?

If yes, what is the monthly income? R

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 5

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number/Passport number for non-South Africans citizens:

Date of Birth:

Dependant Email Address:

Dependant Cell Number:

Relationship to Principal Member:

Gender: (Mark with an X) | M | F | Adult Over 21: (Mark with an X) | Y | N |

If the dependant is classified as a special dependant (e.g. parents, adopted/foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions:

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N

If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?

If yes, what is the monthly income? R

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

SECTION C — FAMILY PRACTITIONER (FP) NOMINATION – MediPhila, MediCurve, MediValue Compact and MediPlus Compact

If you have selected MediPhila, MediCurve or one of the Compact options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP). If you do not nominate a FP as per the criteria listed per option below, your application form will not be processed by the Scheme.

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediCurve: Each Beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

MediValue Compact and MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where a FP was nominated from the FP Network & Day-to-Day benefit is depleted the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION D — PREVIOUS MEDICAL AID HISTORY

Where applicable, please provide details and proof of all previous registered South African medical schemes you and your dependants belonged to (proof in the form of membership certificates reflecting the join and end dates, must be attached to this application form). This information is used to determine whether waiting periods and or late joiner penalties are applicable.
Where late joiner penalties have already been imposed and evidence of credible cover is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the following month. No backdate will be allowed unless evidence of previous submission is provided to the Scheme.

Select relevant box with a tick:

Principal Member:										Dependant:										
Name & Surname:																				
Name of Scheme:																				
Membership Number:																				
Date Joined:	D	D	M	M	Y	Y	Y	Y		Date Terminated:	D	D	M	M	Y	Y	Y	Y		

Principal Member:										Dependant:										
Name & Surname:																				
Name of Scheme:																				
Membership Number:																				
Date Joined:	D	D	M	M	Y	Y	Y	Y		Date Terminated:			D	D	M	M	Y	Y	Y	Y

Principal Member:										Dependant:										
Name & Surname:																				
Name of Scheme:																				
Membership Number:																				
Date Joined:	D	D	M	M	Y	Y	Y	Y		Date Terminated:			D	D	M	M	Y	Y	Y	Y

Principal Member:										Dependant:										
Name & Surname:																				
Name of Scheme:																				
Membership Number:																				
Date Joined:	D	D	M	M	Y	Y	Y	Y		Date Terminated:			D	D	M	M	Y	Y	Y	Y

SECTION E MEDICAL HISTORY (yes or no)

To be completed by each applicant in respect of himself/herself and all his/her dependants. All questions must be answered with a "Yes" or "No".

All conditions, symptoms and or disorders have to be declared, no matter how insignificant they may seem. Incomplete, inaccurate information or information that is withheld may result in the termination of your membership effective from date of registration.

If additional space is required, please complete a separate sheet of paper and attach it to the application.

1. Have you or any of your dependants sought advice, been diagnosed or treated for any condition within the past 12 months? Y N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

Any additional information:

2. Do you, or any of your dependants take chronic medication or are you expecting to take medication on an ongoing basis? Y N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.
Your doctor or pharmacist can contact Chronic Medicine Management on 086 000 2120 to telephonically register you for chronic medication.
Any additional information:

3. Have you or any of your dependants been admitted to hospital or undergone any procedure (other than routine medical or dental treatment) in the past 12 months? Y | N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		
Any additional information:						

4. Are you or any of your dependants planning or reasonably expecting to be hospitalised or to have a procedure or treatment in the next 12 months - including pregnancy? Y | N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		
Any additional information:						

5. Are there any other conditions or symptoms not mentioned above for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months that you would like to disclose? Y | N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		
Any additional information:						

IMMUNE DEFICIENCY STATUS (Confidential Disclosure)

If you, or any of your dependants, have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Programme on 086 050 6080 to register on the HIV/AIDS Disease Management Programme. Failure to do so within 21 days of joining the Scheme will be considered as non-disclosure of information and may result in termination of your membership.

SECTION F BANK DETAILS

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account(s).
A stamped bank statement (Not older than 3 months) or a stamped confirmation letter from the bank in the name of the Principal Member is required. Should contributions be paid by a 3rd party, the following supporting documents are required:

Account in the name of an Individual other than the Principal member (for example, spouse, parent, child etc.):

- ID Copy of the Principal Member or copy of passport for non-SA citizens
- ID Copy of the account holder or copy of passport for non-SA citizens
- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the account holder.
- Signed letter of authority from the account holder which include the details of the member(s)

Account in the name of a Company:

- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the Company
- Signed letter of authority on a Company letterhead including the details of the member(s)
- ID Copies of each signatory who has authority to sign on behalf of the company
- Copy of Company Registration Certificate

Trust Account:

- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the Trust
- Signed letter of authority including the details of the member(s)
- ID Copies of each trustee
- Copy of Trust Resolution showing the trustees

Select relevant box with a tick:

To be completed by the Account Holder

Select Account Holder:

Principal Member ☐ **Company** ☐

Trust ☐ **Individual other than Principal Member** *(for example spouse, parent, child etc.)* ☐

Account Holder Title:	
Account Holder First Name(s):	
Account Holder Initial(s):	
Account Holder Surname:	
Account Holder Date of Birth:	D D M M Y Y Y Y
Account Holder ID Number:	
Account Holder Passport Number (for non-SA citizens):	
Country of Issue:	
Account Holder Tax number (SARS):	
Registered Company Name (if the account is in the name of a company):	
Company Registration Number:	
Account Holder Residential Address:	
Postal Code:	
Account Holder Postal Address:	
Postal Code:	

Select relevant box with a tick:

Use this account for: **Contributions only** ☐ **Contributions and Claim Refunds** ☐

Bank Name:			
Branch Name:			
Branch Code:			
Type of Account: (Mark with an X)	Current	Transmission	Savings
Bank Account Number:			

Select relevant box with a tick:

Use this account for: **Refunds only** ☐

Bank Name:	
Branch Name:	
Branch Code:	
Type of Account: (Mark with an X)	Current / Transmission / Savings
Bank Account Number:	

Direct paying members have the option to select from the following dates for debit order collections:

- 1st of the month ☐
- 5th of the month ☐
- 25th of the month ☐
- 27th of the month ☐

In the event that you do not specify a preferred date, the Scheme will automatically set your debit order collection to the 1st of the month.

I _____ (account holder's full name) the undersigned, declare that: I understand that Medshield will rely upon the facts set out herein for the accurate loading of bank details. I understand and accept that should any details contained herein prove to be incorrect, or should I fail to inform Medshield of any subsequent change to the bank details, Medshield will not be held responsible. I also agree that I am the account holder of the bank details provided and I hereby authorise Medshield to electronically collect monthly contributions and/or pay refunds to the above bank via the Elektropay system using the information provided. I also irrevocably authorise Medshield to reverse any erroneous transaction and/or rectify any electronic transfer of funds error without prior notice.

I hereby authorise Medshield Medical Scheme, or any of its nominated representatives, to verify the bank details as stipulated on this form.

Give consent that Medshield Medical Scheme, may collect, process, store and share our personal information with the Scheme's respective Service Providers including South African Revenue Services. This information includes, but is not limited to details such as, name, surname or registered name (in the cases of companies and trusts), identity numbers, registration number, tax number, addresses and other details which could include financial information and banking details.

Date: D D M M Y Y Y Y

_____ Principal Member Signature

_____ Account Holder Signature

SECTION G EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:	
Paypoint Code:	
Employee Payroll No.:	
Employment Date:	D D M M Y Y Y Y

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section G have been completed:

Employer's Email Address:	
Employer's Representative's Name:	
Employer's Representative's Designation:	
Date:	D D M M Y Y Y Y

Signature of Employer's Representative: _____

SECTION H | CONSENT (Consent for Medshield Medical Scheme to process personal information)

The Scheme understands that your personal information and that of your dependants is important to you. Medshield undertakes to keep this information confidential and shall take all reasonable steps to comply with the provisions of legislation protecting your personal information. We require your consent to obtain, process and disseminate your personal information so we can provide you with the services stipulated in our contractual agreement, as detailed for your chosen benefit option and in compliance with the Medical Schemes Act 131/1998. These services include but is not limited to:

a. Treatment Authorisations;
b. Claims Assessment;
c. Claims Payment;
d. Communication;
e. Disease Management; and
f. Wellness Initiatives.

While your consent is voluntary, it is a requirement for the administration of your Medshield membership.
If you object to the processing of your personal information, the Scheme will not be able to activate and service your membership.

Please read and consent to the items listed below

I hereby consent, with the permission of my dependants, that the Scheme may collect, use, process, retain and share my and my dependant's personal information for the purpose of providing medical scheme benefits, managed healthcare services and medical scheme specific value adds. This includes the collecting and sharing of my personal information with the Scheme's partners and facilities who are essential to the administration and ongoing membership process.

You can access more details on the Protection of your Personal and Health Information on the Medshield website www.medshield.co.za. When you accept these terms and conditions you will allow us to provide your family with the full range of our Medshield services.

1. I hereby acknowledge and declare that as the Principal Member of the Scheme, I have received the necessary consent from my dependant(s) and act on their behalf in any matter relating to this application and the administration of our Medshield Membership and to access and view their healthcare claims.

2. Confirm that if I (Principal Member) am part of a group membership by virtue of employment, I grant permission to Medshield Medical Scheme to share information relating to my membership with my employer and my employer's appointed broker This will be limited to information that is relevant to my application, collection of contributions and information that is required for the ongoing servicing of my membership, but will not include any health information unless I have given Medshield permission to do so.

3. Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Advisor/ Broker, if any, who is an accredited Medical Aid Broker of my choice.

Principal Member Signature: _____ Date: | D | D | M | M | Y | Y | Y | Y |

SECTION I MEMBER DECLARATION

Please carefully read and agree to the declarations below.

1. I the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree that my dependants and I shall abide by its Rules as amended from time to time which are available on Medshield's website www.medshield.co.za

2. I understand that the Scheme's brochures are a summarised version and do not supersede the rules of the Scheme.

3. I acknowledge that I have familiarised myself with the benefits covered on my benefit option of choice and that I may only change my benefit option during year-end for an effective date of 01 January.

4. I am aware of the fact that on joining the Scheme during the course of a calendar year, the maximum benefits to which I may be entitled shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular calendar year

5. I certify that all the information given is true and correct, whether completed by me or on my behalf, and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void, effective from date of registration. In such event, the Scheme will have the right to offset applicable costs against contributions paid and refund the difference, if any.

6. I understand that should a period greater than three (3-month) lapse since contributions were paid to Medshield, that my membership will not be reinstated and that I have to re-apply subject to full underwriting.

7. I undertake to give notice to the Scheme to terminate my membership in accordance with the Rules of the Scheme.

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

If applicable:

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

If applicable:

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

11. Notwithstanding point 9 and 10, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

If applicable:

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

13. I hereby authorise the Scheme, or any of its nominated representatives to verify my bank details, as well as the identification of both myself and my dependants, together with any other information provided by me in this application form.

14. I acknowledge and agree that it's my responsibility to advise the Scheme in writing of any change in banking details. The Scheme will not be liable should an incorrect account be credited under any circumstances

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

16. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:
    - a 3 (three) month general waiting period in respect of all benefits;
    - a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
    - a late joiner contribution penalty.

17. I agree to inform the Scheme of any deterioration or change in my state of health or in that of my dependant(s) before the commencement date of membership, or the date of acceptance of this application form by the Scheme, or the date of receipt of the first subscription, whichever date is the latest shall entitle Medshield to reconsider the application and propose new terms of admission.

18. It is illegal to be a member of more than one medical scheme at the same time. I acknowledge that it is my responsibility to resign from my existing medical scheme and agree that neither me, nor any of my dependants, will be registered on both Medshield and another medical scheme simultaneously.

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

Signed at: _____ Date: | D | D | M | M | Y | Y | Y | Y |

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form be submitted to the Scheme within 30 calendar days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

SECTION J THIRD PARTY CONSENT (To allow disclosure of information to a third party)

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words.
Mark with a tick where required. All sections must be completed.

ABOUT THE INFORMATION WE PROVIDE TO THE THIRD PARTY

This section needs to be completed if you want to nominate someone to manage your medical aid membership on your behalf. For instance your financial adviser/broker or a family member or a friend who you trust to administer your membership. We call this giving a Third Party Consent by nominating them on this form, which provides us with your approval that the Scheme may share specific personal information and/or discuss your membership with the specific Third Party you nominated below.

Additonally, please specify what type of information may be accessed by your financial adviser, employer representative and/or nominated Third Party, and for how long (if no date is specified, the consent will be in effect from the signature date until you revoke the consent in writing).

PRINCIPAL MEMBER DETAILS (attach copy of ID)

Membership Number:

Title: Initials:

Principal Member Name/s:

Principal Member Surname:

Principal Member ID number:

E-mail Address:

FINANCIAL ADVISER/BROKER (If applicable)

Your Financial Adviser/Broker

Broker code:

Financial Adviser/Brokerage Name:

Financial Adviser Email address:

Financial Adviser Telephone Number (W):

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my Financial Adviser/Broker as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

EMPLOYER REPRESENTATIVE (If applicable)

Your employer representative (if you form part of a group membership by virtue of employment) ☐

Company Name:

Employer Representative Name and Surname:

Employer Representative Email address:

Employer Representative Telephone Number (W):

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my employer representative as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

THIRD PARTY NOMINEE (Another adult that you choose to administer your membership on your behalf.

DOCUMENT CHECKLIST

For third party nomination and consent, please attach the below documents	Please Tick
ID copy(ies) of Principal Member and/or person giving consent	
ID copy(ies) of your nominated Third Party	

Third Party Nominee 1 ☐

Relationship to Principal Member:

Title: Initials:

First Name/s:

Surname:

ID Number:

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

Email Address:

Telephone Number (W):	C	O	D	E							
Telephone Number (H):	C	O	D	E							
Cell Number:											
Gender: (Mark with an X)	M		F								

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my nominated Third Party as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

Third Party Nominee 2 ☐

Relationship to Principal Member:																				
Title:					Initials:															
First Name/s:																				
Surname:																				
ID Number:																				
Date of Birth:	D	D	M	M	Y	Y	Y	Y												
Email Address:																				
Telephone Number (W):	C	O	D	E																
Telephone Number (H):	C	O	D	E																
Cell Number:																				
Gender: (Mark with an X)	M		F																	

YOUR LEGAL DECLARATION

1. I acknowledge and understand that this document authorises Medshield Medical Scheme and its outsourced providers to disclose and/or distribute the above information to the nominated third party(s)/employer representative/financial adviser, if any indicated herein.
2. I agree that by making this information available, Medshield Medical Scheme and its outsourced providers accepts no liability whatsoever for any loss, including direct, indirect and consequential loss, that may arise from the use of this information other than where it is due to, or attributable to, gross negligence or fraudulent conduct by the Scheme.
3. I understand that the consent provided to Third Party(s) will be in force during the specified time periods. If I have not specified the dates, the consent will be in effect from the signature date below until I revoke the consent in writing.

4. Confirm that if I am part of a group membership by virtue of employment, the consent granted to my employer representative will cease when my employment with the company comes to an end. I hereby agree to inform Medshield Medical Scheme immediately of any employment changes.
5. The consent granted to my financial adviser (if applicable) will become null and void in the event that I appoint a new financial adviser.
6. This consent will become null and void in the event of the death of a member or person providing consent, and a new consent form should be completed by the appointed executor of the deceased estate.
7. I may choose to change or revoke my consent at any time by informing the Scheme in writing.

Signed at: _____ Date: | D | D | M | M | Y | Y | Y | Y |

Signature of Person Giving Consent: _____

Name of Person Giving Consent: | | | | | | | | | | | | | | | | | | | | |