



**Informed Healthcare Solutions (IHS)**

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## FAX COVER SHEET

<b>To:</b>	Graham Pike of IHS	<b>From:</b>	
<b>Fax:</b>	086 627 7012	<b>Company:</b>	
<b>Tel:</b>	021 712 6686	<b>Tel:</b>	
<b>Pages:</b>		<b>Date:</b>	
<b>Re:</b>	Bonitas Medical Aid Application		

**Comments:**

**Instructions:**

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 086 627 7012 or scan and email it to [forms@medicalaidcomparisons.co.za](mailto:forms@medicalaidcomparisons.co.za)
4. Sit back while we do all the complicated stuff.

*Save time and hassle with your medical aid application and make sure it gets the best possible chance of success*

**IMPORTANT**

- 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
- You **must** complete all sections of the application form

**FOR ADMINISTRATIVE USE**

Membership number

Pay-point code

**Your Check List**

**IMPORTANT: WE CANNOT PROCESS YOUR APPLICATION IF IT IS incomplete, incorrect, or if you have not attached the correct documents. Please use this check list to make sure that you are sending us everything we need.**

- |   |  |
|---|--|
| <input type="checkbox"/> Have you completed all blocks within these sections?   | <input type="checkbox"/> Have you provided your employer's details?  |
| <input type="checkbox"/> Have you given us the correct contact details?   | <input type="checkbox"/> If you have selected the BonCap option, or your contributions are paid via Persal, have you provided proof of income (salary advice)? |
| <input type="checkbox"/> Do we have your bank details so that we can collect your contributions and pay your claim refunds?     | <input type="checkbox"/> Have you chosen one option only?  |
| <input type="checkbox"/> Have you signed the form? (Unsigned forms will be returned to you for signature.)                      | <input type="checkbox"/> If you are a government employee, have you provided a Persal number and attached a copy of your latest payslip?                       |
| <input type="checkbox"/> If applicable, has your broker or intermediary completed and signed the relevant section of this form? |  |

**BROKERAGE/AGENCY STAMP**

**Section 1 INTERMEDIARY – This section MUST be signed by the broker / agent**

Broker code

Name of brokerage, broker and agent

**Informed Healthcare Solutions (Pty) Ltd**

**Graham Pike**

Telephone (W)

Fax

E-mail address

**Intermediary Declaration**

- I acknowledge that I am an accredited Bonitas Financial Adviser. I am licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act 37 of 2002.
- I accept that the applicant has appointed me as his/her financial adviser and that the applicant is entitled to cancel my services at any time.
- I confirm that my personal details have been provided to the applicant, physical, postal address and telephone number.
- I am aware that a monthly commission of 3% of the total monthly premium up to a maximum of R60.70 will be paid to me in terms of the Medical Schemes Act 131 of 1998 (or as amended)
- I confirm that there has been no misrepresentation by me and that in the event of misconduct or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation or conduct.
- The applicant fully understands the information requested in the application form and all the relevant information was provided by the applicant.
- The advice and assistance provided to the applicant was impartial and in the interest of the applicant.
- The applicant has signed the application form in person.

Broker's / agent's signature \_\_\_\_\_ Date

Name of broker / consultant where applicable \_\_\_\_\_

**Section 2 MARKETING FEEDBACK**

How did you get to know / hear about Bonitas?  Print media  Television  Radio  Friend  Family Member  Broker

Other (please specify)

Would you recommend Bonitas?  Yes  No  How do you rate our marketing campaign?  Excellent  Good  Average  Poor

**Section 3 CHOICE OF OPTION – Choose ONE option only**

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> <b>BONCOMPREHENSIVE</b>   | <input type="checkbox"/> <b>BonEssential</b> | <input type="checkbox"/> <b>BONSAVE</b>     | <input type="checkbox"/> <b>STANDARD</b>        | <input type="checkbox"/> <b>PRIMARY</b> |
| <input type="checkbox"/> <b>BONCAP – If you select BonCap, please note that you may only obtain treatment from a Prime Cure network doctor and hospital. If you select this option you must attach a copy of your salary advice. Please contact the Prime Cure call centre on 0861 665 665 or visit www.primecure.co.za for a list of contracted service providers in your area.</b> |  | <input type="checkbox"/> <b>R0 – R4 400</b> | <input type="checkbox"/> <b>R4 401 – R7 200</b> | <input type="checkbox"/> <b>R7 201+</b> |

**Income bands (BonCap only) tick the applicable band**









**Section 8 MEDICAL DETAILS**

Please note:  
Failure to disclose medical conditions could limit and / or exclude you from receiving certain benefits, or result in the termination of your membership.

1. Do you or any of your dependants suffer from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and / or thyroid disorders)? If yes, provide details.

Yes	No
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

2. Do you or any of your dependants suffer from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and / or a spastic colon)? If yes, provide details.

Yes	No
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

3. Do you or any of your dependants suffer from muscle, bone, skin or nerve illnesses or disorders (e.g. back- and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc.)? If yes, provide details.

Yes	No
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

4. Do you or any of your dependants suffer from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts, menstrual disorders)? If yes, provide details.

Yes	No
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

5. Do you or any of your dependants suffer from ear, nose or throat disorders (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics)? If yes, provide details.

Yes	No
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

6. Do you or any of your dependants suffer from any blood disorders, immune deficiency state, HIV / Aids, cancer, etc.? If yes, provide details.

Yes	No
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

7. Are you or any of your dependants pregnant? If yes, provide details.

Yes	No
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Name of beneficiary	Expected delivery date	Attending doctor



**Section 11 ACKNOWLEDGEMENT AND DECLARATION**

1. I warrant that the information I have provided pertaining to me and my dependants is true and correct. Should there be any non-disclosure or material misrepresentation, I understand that my membership may be terminated and that I may forfeit my contributions to Bonitas. Bonitas also has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation.
2. Should any of my or my dependants' circumstances alter subsequent to the date of filling in this application, but prior to acceptance of my membership by Bonitas, I shall promptly notify Bonitas of the change. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership, and Bonitas shall also be entitled to reclaim any amounts it may have erroneously paid to any service provider on my or my dependants' behalf.
3. I warrant that I have been advised that the Rules will be made available on request and I understand that I am responsible to read the Rules and any amendments to the Rules. I agree that I will read the Rules and the amendments to the Rules and be bound by them.
4. I authorise and instruct my employer to deduct and pay over any amounts (that may become due and owing on my behalf) to Bonitas from time to time and I also authorise any persons, bodies or institutions who may hold retirement funds for my benefit, to deduct and pay to Bonitas all amounts that may become due and owing to Bonitas from time to time. I agree that should Bonitas incur any legal costs or expense to recover any contributions, I shall be responsible for such costs and expenses on the attorney/client scale.
5. Notwithstanding the above, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by Bonitas.
6. Should any contribution be unpaid, it may result in me and my dependants being suspended from Bonitas until all arrear contributions have been settled. Should two months' contributions be outstanding, Bonitas shall have the right to immediately cancel my Bonitas membership. I also understand that should my membership be suspended or terminated, I shall not be entitled to any benefits arising from my membership whatsoever.
7. I shall inform the scheme of any changes to my dependants' health or personal status, as required by the scheme rules, within 30 days of the change in circumstances.
8. I authorise my healthcare provider to disclose information to the scheme and it's contracted third parties, provided such information is treated as confidential at all times.
9. I agree to provide Bonitas with any medical or historical information or grant Bonitas access to medical information reasonably requested pertaining to a particular ailment, disease, disorder, condition or disability.
10. I agree that should I be accepted as a member of Bonitas, I shall provide Bonitas with all information including medical information that Bonitas may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Bonitas Rules. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.
11. I declare that my dependants are not beneficiaries of another registered medical scheme.
12. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

- 12.1 a 3 (three) month general waiting period in respect of all benefits;
- 12.2 a 12 (twelve) month exclusion in respect of a pre-existing condition;
- 12.3 a late-joiner contribution penalty.
13. I authorise and permit Bonitas to take all reasonable steps to verify information provided by me in this application form.
14. I agree to submit proof of identification to Bonitas on demand.
15. I consent to my telephone conversations with Bonitas being recorded and forming part of Bonitas' records. I also agree that such records shall remain the sole property of Bonitas.
16. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any monies owing to Bonitas.
17. I warrant that the information provided above is true and accurate and should my application be accepted by Bonitas, the contents of this application form shall constitute the basis of my agreement with Bonitas.
18. As a government employee, I acknowledge that Bonitas Medical Fund will strictly adhere to Persal policies and procedures.
19. As a direct paying member, I acknowledge that monthly contributions are payable in advance in accordance with the Rules of Bonitas Medical Fund.
20. I hereby consent that all contact details given in Section 5 of this application and any amendments to those contact details, may be used by Bonitas or any appointed agent of Bonitas for sending any information of any nature (confidential or other).

I acknowledge that I have read and understood the content of this application form. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

All information declared on the application form will be kept confidential by the medical scheme.

Signed at \_\_\_\_\_ on this \_\_\_\_\_

day of \_\_\_\_\_ 20\_\_\_\_\_

Signature of principal member \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>