



**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>	Oxygen 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*







**SECTION G: PREVIOUS MEDICAL SCHEME HISTORY**

Please provide details of all medical schemes that you (or any of your dependants) previously belonged to. If you do not provide full details of your previous membership, waiting periods and late joiner penalties may be imposed. The Scheme reserves the right to request documented proof of membership if required.

	Scheme Name	Member No.	Registration Date	Cancellation Date	Reason for cancellation of membership
Applicant					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					
Dependant 5					





**SECTION L: MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS**

To be completed by the applicant in respect of himself/herself and for his/her dependant(s). Please complete all the required information by placing a mark in the appropriate box. **If the answer to any of questions 1 to 7 is “YES”, provide details in Section M.** Please attach relevant medical reports. I understand that if I do not provide full information regarding all previous and current medical conditions of myself and my dependants, the Scheme may cancel my membership.

	Applicant		1		2		3		4		5	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
1. Are you or any of your nominated dependants pregnant?												
2. Have you or any of your dependants ever been treated for, or had any indication of the following conditions within the last 12 months:												
2.1 Any disorder of the heart, blood vessels or circulatory system? (e.g. chest pain, rheumatic fever, raised cholesterol, high blood pressure, coronary artery disease, stroke, etc.)												
2.2 Any respiratory or lung disorders? (e.g. tuberculosis, asthma, chronic bronchitis, bloodspitting, emphysema, shortness of breath, etc.)												
2.3 Any disorder of the digestive system, gall bladder, pancreas or liver? (e.g. hepatitis, jaundice, ulcer, persistent diarrhoea, intestinal bleeding, etc.)												
2.4 Any disorder of the urogenital system, kidneys, bladder or reproductive organs? (e.g. stones, protein in urine, venereal disease, urinary infection, prostatitis, nephritis, etc.)												
2.5 Any disorder of the nervous system? (e.g. epilepsy, blackouts, paralysis, Alzheimer’s disease, Parkinson’s disease, multiple sclerosis, motor neurone disease, memory loss or fainting spells, etc.)												
2.6 Any psychiatric or mental disorders? (e.g. depression, anxiety state, panic attacks, post-traumatic stress disorder, etc.)												
2.7 Any ear, eye, nose or throat disorder (e.g. ear discharge, defective vision, wear spectacles/contact lenses, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment, chronic sinusitis, allergic rhinitis)?												
2.8 Any disorder of the back, neck, limbs, skin, bones, muscles or joints? (e.g. spinal cord trouble, slipped disc, arthritis, sclerosis, recurrent fractures, etc.)												
2.9 Any glandular or blood disorders? (e.g. diabetes, sugar in urine, anaemia, thyroid disorders, haemophilia, etc.)												
2.10 Cancer, a growth or tumour of any kind?												
2.11 Any tropical disease (e.g. bilharzia, malaria, cholera)?												
2.12 Have you or your dependants or any sexual partners ever been tested positive for, received or expect to receive medical advice, counselling or treatment in connection with HIV, AIDS, an AIDS-related condition or any sexually transmitted disease?												
2.13 Have you or are any of your dependants receiving any surgical, medical, major dental (implants), chiropractic, optical, refractive surgery or gynaecological treatment, hormone replacement therapy, procedures, advice or tests?												
3. Are there any personal attributes or physical weaknesses which could lead to you or your dependants being unable to perform the main duties related to your main occupation? (impaired hearing, weak eyesight)												
4. Have you or your dependants during the past 12 months received any medical, chiropractic or psychological attention, treatment or medication? (excluding colds, influenza and general children’s ailments)												
5. Are there any other factors not already disclosed herein, which already have affected, or may affect your or your dependants’ health in future? (e.g. diseases, ailments, injuries, accidents, physical abnormalities, medical procedures, etc.)												
6. Are you or any of your dependants expecting to undergo any procedure, operation, hospitalisation, confinement or receive any major dental treatment during the next 12 months, or have any of your dependants undergone any procedure, operation, hospitalisation, confinement or received any major dental treatment during the past 12 months?												
7. Has any member of your (or your spouse’s) immediate family, e.g. parents, brothers, sisters, suffered from diabetes, heart disease, high blood pressure, raised cholesterol, mental disease, porphyria, or any other hereditary disease?												

If additional space is required for more dependants, please add details (as per the above format) on a separate sheet and attach it to the application.

**SECTION M: ADDITIONAL MEDICAL INFORMATION**

	YES to question number □□□□□□	YES to question number □□□□□□	YES to question number □□□□□□	YES to question number □□□□□□	YES to question number □□□□□□
1. Name of person suffering from illness					
2. Type of illness/condition (diagnosis)					
3. Date on which illness began					
4. Frequency of attacks (hourly/daily/weekly/monthly)					
5. Date of last attack					
6. If hospitalised, when? 6.1 How many days?					
7. Duration of illness or condition?					
8. Treatment and/or type of medication received in the past? 8.1 Treatment 8.2 Medication					
9. Current treatment and/or type of medication received? 9.1 Treatment 9.2 Medication					
10. Approximate monthly cost of treatment/type of medication 10.1 Treatment 10.2 Medication					
11. Details of operations previously performed					
12. Operations and/or treatment needed in future					
13. Name of attending doctor					
14. Attending doctor's contact telephone number					



If additional space is required for more dependants, please add details (as per the above format) on a separate sheet and attach it to the application.



**SECTION O: DECLARATION BY APPLICANT (Must be signed by the applicant)**

1. I, the undersigned, hereby make application to the Scheme to be admitted as a member of Oxygen Medical Scheme. If admitted, I agree to abide by the Rules of the Scheme.
2. I warrant that all the answers given in this application are true, correct and complete in every aspect.
3. I declare that any false statements in this application or the non-disclosure of any material information will render my membership null and void, benefits may be reversed and all contributions shall be forfeited to the Scheme.
4. I understand and accept that my benefits or that of my dependant(s) benefits may be subject to a three month general waiting period, and/or a 12 month condition-specific waiting period in respect of a condition, for which I or my dependant(s) received or it was recommended that we receive medical advice, diagnose, care or treatment within a 12 month period ending on the date of application. I understand and accept that under certain circumstances the Scheme may impose the unexpired balance of waiting periods imposed by my previous Scheme.
5. I understand and accept that the Scheme may impose Late Joiner Penalties, on myself and/or my dependants where applicable.
6. I am also aware that my membership shall not commence until the Scheme specifically notifies me of their acceptance of my application.
7. I am aware and accept that a medical examination and/or the taking of pathological (e.g. blood) specimens may be required in order to proceed with this application. I understand that any cost of such medical examination shall be paid by the Scheme.
8. 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.
9. I accept that if contributions are not paid by its due date it will be regarded as being in arrears and the Scheme will be entitled to suspend benefits with immediate effect. Should contributions remain outstanding for sixty days from the due date, my membership will be cancelled.
10. I agree that any amounts due by me, may be offset against any amounts due to me by the Scheme.
11. I accept that the Scheme will not be liable for losses occasioned by non-receipt of posted cheques.
12. I consent to all conversations between myself and the Scheme being recorded and all information obtained through these conversations forming part of the Scheme's records. I further consent to all of these recordings remaining the sole property of the Scheme.
13. I shall give the Scheme one month written notice of my intention to cancel my membership of the Scheme. I acknowledge that any failure to give proper notice will result in the full three months contribution becoming immediately due and payable.
14. Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits in respect of me as a member, I irrevocably authorise the Scheme to obtain from any person, whom I hereby so authorise and request to give, any information which the Scheme deems necessary, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by the Scheme.
15. I hereby authorise Oxygen Medical Scheme to furnish my bank account detail to ONECARE. I authorise ONECARE to pay any medical scheme benefits that may be due to me to this bank or any other bank to which I might change the account.
16. I hereby confirm that where applicable the relevant intermediary has satisfied me that he/she is accredited by the Council for Medical Schemes and authorised to render financial services in respect of the benefits provided by the Scheme.
17. I undertake to disclose to the Scheme any material alteration to the facts disclosed in this application and any illness or injury suffered by myself or my dependants between the date of signature of the application by me and the date the application is received by the Scheme at its registered office. I accept that the failure to make such disclosure will render my membership null and void, benefits may be reversed and all contributions shall be forfeited to the Scheme.

Signed at  this  day of  20

Signature of applicant:

Do you want to appoint the selling intermediary as your Preferred Servicing Intermediary (PSI) for all your future financial services needs?

YES I appoint and give the Preferred Servicing Intermediary access to information on all my existing financial services products.

NO I will complete an Intermediary Appointment Note (IAN) selecting my services intermediary of preference.