Informed Healthcare Solutions (IHS)

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110 Main Road
Diep River
Cape Town

Tel: +27 21 712-6686
Fax: 086 627 7012
Email: info@medicalaidcomparisons.co.za
Web: www.medicalaidcomparisons.co.za

FAX COVER SHEET

To:	Graham Pike of IHS	**From:**	
Fax:	086 627 7012	**Company:**	
Tel:	021 712 6686	**Tel:**	
Pages:		**Date:**	
Re:	Spectramed 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
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

Spectramed Reg No: 1141

NATIONAL ACTION LINE: 0861 497 497 • NATIONAL FAX LINE: 0861 492 492 • NATIONAL POSTAL ADDRESS: Private Bag X1, Gardenview 2047

MEMBER APPLICATION FORM

(TO BE COMPLETED IN BLACK INK)

1. USE BY BROKER ORDER TO APPLICANT (FOR OFFICE USE ONLY)

BROKERAGE NAME	Informed Healthcare Solutions (Pty) Ltd	PRODUCT SPECIALIST NAME	Graham
BROKERAGE ACCREDITATION NO.	ORG104	PRODUCT SPECIALIST SURNAME	Pike
BROKER CODE	I H S	PRODUCT SPECIALIST CODE	
SIGNATURE		**SIGNATURE**	
DATE OF SIGNATURE (YEAR/MONTH/DAY)	YYYY MM DD	DATE OF SIGNATURE (YEAR/MONTH/DAY)	YYYY MM DD
DATE OF COMMENCEMENT (YEAR/MONTH/DAY)	YYYY MM DD	DATE OF COMMENCEMENT (YEAR/MONTH/DAY)	YYYY MM DD

2. EMPLOYER INFORMATION

NAME OF EMPLOYER			
PAYPOINT CODE		GROUP CODE	

3. HOW DID YOU HEAR ABOUT SPECTRAMED

PRINT MEDIA	TELEVISION	RADIO	FRIEND / FAMILY MEMBER	INTERNET	BROKER

4. OPTION SELECTION

BENEFIT OPTION CHOSEN

PLUS	ELITE	ALLIANCE	HOSPITAL ELITE	HOSPITAL

5. PRINCIPAL MEMBER PERSONAL DETAILS

TITLE		FIRST NAME		SURNAME	
INITIALS		ID/PASSPORT NO.		DATE OF BIRTH (YEAR/MONTH/DAY)	YYYY / MM / DD
GENDER		PREVIOUS SURNAME IF APPLICABLE			
TAX NO.		COUNTRY OF RESIDENCE			
RISK EQUALISATION FUND NO.					

MARITAL STATUS	**SINGLE**	**MARRIED**	**DIVORCED**	**WIDOWED**	**COHABITING**
HOME LANGUAGE	**ENGLISH**	**ZULU**	**XHOSA**	**AFRIKAANS**	**OTHER**

6. CONTACT DETAILS OF PRINCIPAL MEMBER

ADDRESSES	POSTAL ADDRESS	RESIDENTIAL/PHYSICAL ADDRESS
BUILDING NAME & NO.		
STREET ADDRESS/ BOX NO.		
SUBURB		
TOWN/CITY		
PROVINCE		
AREA CODE		

CONTACT DETAILS

WORK TEL. NO.		CELLULAR NO.	
FAX NO.		HOME TEL. NO.	
E-MAIL			

CAN SPECTRAMED CONTACT YOU VIA SMS? **YES** **NO**

7. DEPENDANT DETAILS

SPOUSE

TITLE | FIRST NAME/S | SURNAME

GENDER: MALE | FEMALE

DATE OF BIRTH (YEAR/MONTH/DAY): YYYY | MM | DD

PREVIOUS SURNAME

I.D. NUMBER

CONTACT NO. SPOUSE

DEPENDANTS

ADULT DEPENDANT | CHILD DEPENDANT

FIRST NAME/S

SURNAME

DATE OF BIRTH (YEAR/MONTH/DAY): YYYY | MM | DD

I.D. NUMBER

GENDER: MALE | FEMALE

ADULT DEPENDANT | CHILD DEPENDANT

FIRST NAME/S

SURNAME

DATE OF BIRTH (YEAR/MONTH/DAY): YYYY | MM | DD

I.D. NUMBER

GENDER: MALE | FEMALE

ADULT DEPENDANT | CHILD DEPENDANT

FIRST NAME/S

SURNAME

DATE OF BIRTH (YEAR/MONTH/DAY): YYYY | MM | DD

I.D. NUMBER

GENDER: MALE | FEMALE

ADULT DEPENDANT | CHILD DEPENDANT

FIRST NAME/S

SURNAME

DATE OF BIRTH (YEAR/MONTH/DAY): YYYY | MM | DD

I.D. NUMBER

GENDER: MALE | FEMALE

8. INCOME (from all sources)

GROSS MONTHLY SALARY

PRINCIPAL MEMBER **R**

SPOUSE **R**

PAID **WEEKLY** **MONTHLY**

Contributions will be calculated on the higher of the two gross monthly incomes.

9. BILLING DETAILS FOR PAYMENT OF CONTRIBUTION/DEBIT ORDER/CLAIMS REFUNDS

PLEASE NOTE: Billing of contributions is done **in advance** on the 1st of every month.
Upon acceptance by SPECTRAMED of my/our membership of SPECTRAMED, I / we hereby authorise SPECTRAMED, utilising the services of its nominated agent, to draw any contributions against my / our account or any other bank or branch to which I / we may transfer my / our account. I / we acknowledge that the nominated agent acts merely as SPECTRAMED'S collecting agent in respect of Debit Orders and, accordingly, all disputes regarding the payment of contributions shall be between SPECTRAMED and me / us. I / we hereby waive any claim which I / we may have against the nominated agent.

BANK NAME

BRANCH NAME

ACCOUNT HOLDER

BRANCH CODE

ACCOUNT NUMBER

TYPE OF ACCOUNT **SAVINGS** **TRANSMISSION** **CHEQUE**

AUTHORISED SIGNATURE
(Mandated Account Holder)

USE THE ABOVE ACCOUNT FOR CLAIMS REFUNDS
(If No, please provide details below) **YES** **NO**

PLEASE NOTE: Refunds of lawful claims by electronic funds transfer or EFT must be completed by all applicants. Documents such as an original bank statement or cancelled cheque must be provided to SPECTRAMED before claims will be refunded.

BANK NAME

BRANCH NAME

ACCOUNT HOLDER

BRANCH CODE

ACCOUNT NUMBER

TYPE OF ACCOUNT **SAVINGS** **TRANSMISSION** **CHEQUE**

AUTHORISED SIGNATURE
(Mandated Account Holder)

10. MEDICAL SCHEME MEMBERSHIP HISTORY

PREVIOUS MEDICAL SCHEME INFORMATION

PRINCIPAL MEMBER NAME	SCHEME NAME	MEMBERSHIP NO.	DATE FROM (YEAR/MONTH/DAY)	DATE TO (YEAR/MONTH/DAY)
			YYYY/MM/DD	YYYY/MM/DD
			YYYY/MM/DD	YYYY/MM/DD
			YYYY/MM/DD	YYYY/MM/DD
			YYYY/MM/DD	YYYY/MM/DD

ALSO COMPLETE IN FULL FOR ALL BENEFICIARIES/ DEPENDANTS

BENEFICIARY NAME	SCHEME NAME	MEMBERSHIP NO.	DATE FROM (YEAR/MONTH/DAY)	DATE TO (YEAR/MONTH/DAY)
			YYYY/MM/DD	YYYY/MM/DD
			YYYY/MM/DD	YYYY/MM/DD
			YYYY/MM/DD	YYYY/MM/DD
			YYYY/MM/DD	YYYY/MM/DD
			YYYY/MM/DD	YYYY/MM/DD

11. MEDICAL QUESTIONNAIRE

PLEASE READ THE FOLLOWING CAREFULLY!

NOTE 1: If you answer "yes" to any of the questions in this section 11, and if the space provided to complete your answer is not sufficient to disclose the necessary information, please provide additional information on separate pages, together with a report by a medical practitioner - if applicable and where necessary.

NOTE 2: Subject to the terms below, answer all questions in full. Provide the name and telephone number of your medical practitioner/s you and/or your dependants have consulted in the 12 months prior to the date on which this application is signed by the applicant **AND** any other material facts that may affect the applicant's right or the rights of any one or more beneficiaries to receive benefits from SPECTRAMED. Non-disclosure of any material information, including, but not limited to, previous or current medical conditions may result in termination of membership.

NOTE 3: All questions must be answered by the applicant and by him/her on behalf of each of his/her beneficiaries.

NOTE 4: If you and/or any one or more of your dependants do not feel comfortable with disclosing your HIV/AIDS status or sexually transmitted disease or infection, for the sake of confidentiality, please contact Optipharm/One Health on 0860 90 60 90 within 24 hours from date of commencement of membership with SPECTRAMED in order to prevent termination of membership due to non-disclosure of the condition.

NOTE 5: The lists of conditions, illnesses or medical conditions in the questions in this section are not to be interpreted as exhaustive lists.

11. MEDICAL QUESTIONNAIRE CONTINUED ▶▶▶

Have you (the applicant) and/or your dependant/s ever received and/or are you and/or your dependant/s currently receiving treatment and/or medication, and/or have been diagnosed for any conditions in the following categories:

QUESTION 1: Cardiovascular Disorders (Heart/Blood/Lungs)

Including, but not limited to, the following:
Rheumatic Fever, Chest Pains (Angina), Coronary Artery Disease, Cardiac Failure, Raised Blood Pressure (Hypertension), Raised Cholesterol (Hypercholesterolaemia / Hyperlipidaemia)

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 2: Respiratory Disorders (Breathing)

Including, but not limited to, the following:
Asthma, Croup, Haemoptysis, Shortness of Breath, Tuberculosis, Pneumonia, Emphysema, Cystic Fibrosis

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 3: Digestive System Disorders (Stomach/Colon)

Including, but not limited to, the following:
Gallbladder, Ulcer, Hiatus Hernia, Colitis, Liver Dysfunction, Oesophagitis, Spastic Colon, Ascites, Crohn's Disease, Hepatitis, Jaundice, Oesophageal Reflux

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 4: Genitourinary System Disorders (Kidneys/Bladder)

Including, but not limited to, the following:
Nephritis, Haematuria, Nephrectomy, Kidney Failure, Kidney Stones, Urinary Tract Infection, Prostatism, Bilharzia

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 5: Mental/Psychiatric Disorders (Emotional)

Including, but not limited to, the following:
Anxiety, Depression, Anorexia, Eating Disorders, Schizophrenia, Attempted Suicide, Sleep Therapy, Bipolar Mood Disorder

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT		DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

QUESTION 6: Ear, Eye, Nose or Throat Disorders

Including, but not limited to, the following:
Glaucoma, Cataracts, Retinitis Pigmentosa, Hearing Impairment, Speech Impediment, Persistent Sinus Congestion, Grommets, Tonsillitis, Allergies

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT		DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

QUESTION 7: Musculoskeletal Disorders (Bones)

Including, but not limited to, the following:
Rheumatism, Arthritis, Slipped Disc, Prosthesis, Spinal Tumors, Osteoporosis, Persistent Back Pain, Ankylosing Spondylitis

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT		DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

QUESTION 8: Endocrine Disorders (Hormonal)

Including, but not limited to, the following:
Anaemia, Diabetes (Sugar), Leukaemia, Lymph Cancer, Hypothyroidism, Hyperthyroidism, Cushing's Disease, Addison's Disease, Haemophilia, Pituitary Gland Disorder, any other Glandular Disorder

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT		DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

QUESTION 9: Dermatological Disorders (Skin Problems/Growths)

Including, but not limited to, the following:
Severe Acne, Benign or Malignant Growths, Melanoma, Skin Cancer

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 10: Neurological Disorders (Brain/Spinal Cord)

Including, but not limited to, the following:
Epilepsy, Paralysis, Stroke, Multiple Sclerosis, Parkinson's Disease, Alzheimer's Disease, Motor Neuron Disease, Narcolepsy, Meningitis, Encephalitis

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 11: Gynaecological Disorders (Uterus/Ovaries)

Including, but not limited to, the following:
Uterine Growths, Ectopic Pregnancy, Ovarian Cysts, Endometriosis, Menstrual Disorders, Hysterectomy, Cervical Laser Treatment, Infertility

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 12: HIV or AIDS, Sexually Transmitted Infections

Including:
Tests, Counselling, treatment or advice in respect of such conditions

YES | NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 13: Any Congenital Disease (Being a condition that was present at birth)

Including, but not limited to:
Porphyria, Haemophilia, Deafness, Cerebral Palsy, Downs Syndrome

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT		DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

QUESTION 14: Alcoholism, Drug Dependancy or Chemical / Substance Addiction

Alcoholism, Drug Dependancy or Chemical / Substance Addiction?

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT		DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

QUESTION 15: Physically or Mentally Handicapped

Physically or Mentally Handicapped?

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT		DATE OF TREATMENT (YEAR/MONTH/ DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

QUESTION 16: Currently Pregnant

Currently Pregnant or suspect that you may be pregnant?
Please include doctor's report

YES NO

NAME OF BENEFICIARY	DATE OF LAST MENSTRUAL PERIOD (YEAR/MONTH/DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
	YYYY/MM/DD	NAME: TEL:
	YYYY/MM/DD	NAME: TEL:

QUESTION 17: Ever been involved in a motor (or other) accident

Ever been involved in a motor (or other) accident that resulted in bodily injury to you or anyone or more of your dependants? If 'yes', please supply full details

YES NO

DATE (YEAR/MONTH/DAY)	NAME OF BENEFICIARY	DETAILS
YYYY/MM/DD		
YYYY/MM/DD		

QUESTION 18: Weight changed

Weight changed by more than 5kg in the last 12 months? If you answered 'yes', please supply full details

YES NO

DATE (YEAR/MONTH/DAY)	NAME OF BENEFICIARY	CHANGE/REASON
YYYY/MM/DD		
YYYY/MM/DD		

QUESTION 19: Ever been refused cover

Ever been refused cover or offered cover with a premium loading by a life assurance company?

YES NO

QUESTION 20: Treatment or Surgery

Have you had, or intend to have any treatment or surgery, and/or are you aware of any pending treatment and/or surgery either scheduled to occur within the 12 month period from the date of signature of this application or acceptance of this application by SPECTRAMED, including, but not limited to, orthodontics, bridgework, dentures?

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 21: Have any condition that is not covered

Have any condition that is not covered by any one of the above questions? If 'yes', please disclose full details of the condition

YES NO

NAME OF BENEFICIARY	CONDITION	NAME OF MEDICATION	ARE YOU CURRENTLY RECEIVING TREATMENT	DATE OF TREATMENT (YEAR/MONTH/DAY)	ATTENDING PRACTITIONER OR SPECIALIST (please provide contact details)
			YES NO	YYYY/MM/DD	NAME: TEL:
			YES NO	YYYY/MM/DD	NAME: TEL:

QUESTION 22: Participate in hazardous sports, hobbies or pursuits

Including, but not limited to:
Skydiving, Bunjee Jumping, Paragliding, Motor Racing YES NO

QUESTION 23:

Use, own or wear?

A) Spectacles	YES	NO
B) Hearing Aid	YES	NO
C) Dentures	YES	NO
D) Orthotics or Prosthetics	YES	NO
E) Any other medical device	YES	NO

If you and/or any one or more of your dependant/s answered 'yes' to question 23 (A), please indicate the date of your last eye examination or receipt of spectacles/lenses:

	YEAR	MONTH	DAY		YEAR	MONTH	DAY
PRINCIPAL MEMBER				SPOUSE			
ADULT DEPENDANT				DEPENDANT 1			
DEPENDANT 2				DEPENDANT 3			

12. DECLARATION

PLEASE NOTE: This application cannot be considered unless all of the following documentation is attached, where applicable, including a salary advice of the applicant, if any.

PLEASE TICK THE APPROPRIATE BLOCK

1) YES NO COPY OF ID DOCUMENT *OR* BIRTH CERTIFICATE *OR* PASSPORT FOR PRINCIPAL MEMBER AND/OR SPOUSE, PARTNER OR ADULT DEPENDANTS

2) YES NO COPY OF LATEST SALARY ADVICE *OR* LAST 3 MONTHS BANK STATEMENTS *OR* 12 MONTHS COMMISSION STATEMENTS *OR* COPY OF LATEST IRP5 OR TAX ASSESSMENT FOR APPLICANT AND FOR SPOUSE / PARTNER MUST BE ATTACHED

3) IF ANY OF THE FOLLOWING APPLIES TO YOU AND/OR ANY ONE OR MORE OF YOUR DEPENDANTS, PLEASE TICK THE APPROPRIATE BOX AND ATTACH THE SUPPORTING DOCUMENT AS INDICATED:

	CURRENT PERSONAL CIRCUMSTANCES IN THE PERIOD TO DATE	**DOCUMENTS TO BE PROVIDED - COMPULSORY**
a) YES NO	SPOUSE OR PARTNER	MARRIAGE CERTIFICATE OR AFFIDAVIT CONFIRMING CO-HABITATION
b) YES NO	NEWBORN	BIRTH CERTIFICATE OR HOSPITAL CONFIRMATION OF BIRTH
c) YES NO	ADULT DEPENDANT (EX SPOUSE)	DIVORCE CERTIFICATE
d) YES NO	MINOR DEPENDANT - ADOPTED OR CUSTODIANSHIP AWARDED FOR WHO MEMBERSHIP IS APPLIED	ORIGINAL ADOPTION CERTIFICATE OR ORIGINAL CERTIFIED COPY OF COURT DOCUMENT AWARDING CUSTODY
e) YES NO	DEPENDANTS STUDYING FULL TIME BETWEEN THE AGES OF 21 - 23 FOR WHO MEMBERSHIP IS APPLIED	STUDENT CERTIFICATE FROM REGISTERED INSTITUTION (A student card is not accepted)
f) YES NO	DEPENDANT OVER THE AGE OF 21 NOT STUDYING FOR WHO MEMBERSHIP IS APPLIED	COPY OF ID DOCUMENT, FULL WRITTEN MOTIVATION AND ORIGINAL AFFIDAVIT OF DEPENDANCY
g) YES NO	HANDICAPPED ADULT DEPENDANT FOR WHO MEMBERSHIP IS APPLIED	DOCTOR'S REPORT SUPPORTING APPLICATION
h) YES NO	CUSTOMARY OR TRADITIONAL UNION	ORIGINAL AFFIDAVIT CERTIFYING EXISTENCE OF RELATIONSHIP AND DURATION
i) YES NO	IF YOU HAVE BEEN A MEMBER OF ANY MEDICAL AID SCHEME/S PREVIOUSLY AT ANY TIME	CERTIFICATE/S OF MEMBERSHIP FROM PREVIOUS MEDICAL SCHEME/S FOR APPLICANT AND ALL DEPENDANTS REFLECTED ON THIS FORM
j) YES NO	IF YOU ARE PRESENTLY A MEMBER OF ANOTHER MEDICAL AID SCHEME	LETTER OF RESIGNATION AND CANCELLATION OF PREVIOUS MEDICAL SCHEME MEMBERSHIP (RESPONSIBILITY TO CANCEL EXISTING SCHEME MEMBERSHIP VESTS WITH THE APPLICANT)
k) YES NO	IF THE SURNAME/S OF THE APPLICANT AND SPOUSE OR PARTNER ARE DIFFERENT AND/OR IF THE APPLICATION IS MADE FOR A PARENT / BROTHER / SISTER	ORIGINAL AFFIDAVIT CERTIFYING CO-HABITATION OR FINANCIAL RESPONSIBILITY FOR THE DEPENDANT

12. DECLARATION

All information disclosed in this form is subject to the provisions of sections 16(b), 29(2) and 66 of the Medical Schemes Act No. 131 of 1998, as amended (or its successor-in-law) and the rules of the SPECTRAMED as amended from time to time.

Kindly note that the “Applicant” for the purposes of this form is the person who signs the declaration of this form.

1. I understand that the statements below apply equally to me and/or my dependants.
2. I, and on behalf of my dependants as stated above, hereby make application to join SPECTRAMED.
3. I, the undersigned, confirm that we understand that it is illegal to belong to more than one registered medical scheme at a time and that all my dependants and I will terminate our current medical membership with my/our current medical scheme (“the current medical scheme”) with effect from / /.
4. Any changes whatsoever to my health or that of any of my dependants will be notified in writing to SPECTRAMED if these changes occur prior to the end of the membership of the current medical scheme or on receipt of a SPECTRAMED Membership Card or on receipt by SPECTRAMED of contributions whichever is the latest.
5. I declare that the contents of this application are true, correct and complete in every aspect.
6. I declare that any false or misleading statement and/or non-disclosure of all and any material information to SPECTRAMED shall result in the termination of any membership granted to me and any contributions paid by me or on my behalf shall be forfeited.
7. I acknowledge that membership of SPECTRAMED is not valid unless confirmed in writing by SPECTRAMED. I understand that certain waiting periods and/or exclusions may apply as defined in the Medical Schemes Act or in the Rules of SPECTRAMED or both.
8. I irrevocably authorize:
    - 8.1 SPECTRAMED to obtain from any person any information that SPECTRAMED requires to assess the information contained in this application and/or to assess claims in respect of benefits to which this application relates and/or to obtain a second opinion; and
    - 8.2 SPECTRAMED and/or its administrator to provide me with any personal information by means of e-mail and/or cellular phone and/or ordinary post and to pass that information on to any third party in order to allow SPECTRAMED to fulfill its functions, duties, obligations and realize its rights in terms of any law.
    - 8.3 SPECTRAMED or its contracted 3rd party service providers or both of them shall keep confidential, subject to the provisions of South African law, all information received by either one or both of them from a member subject to any obligation on either SPECTRAMED or its contracted 3rd party service providers or both of them to utilise such information in order to fulfil their respective obligations pursuant to the registered rules of SPECTRAMED from time to time and the applicable legislation.
9. I acknowledge that it is my sole responsibility to ensure that my contribution is paid to SPECTRAMED.
10. I hereby agree to advise SPECTRAMED, in writing, of any changes to my banking details and acknowledge that failure to do so will result in me being liable for any subsequent banking charges incurred by SPECTRAMED.
11. I understand that according to the Rules, I may terminate my membership of SPECTRAMED on giving three months written notice and that all rights to benefits cease after the last day of my membership.
12. I understand that certain benefits in the first year of my membership, once membership has been confirmed by SPECTRAMED, are pro-rated and that I will not be entitled to a full year’s cover if I join or change my existing option after 31 December of each year.

SIGNED AT

SIGNATURE OF APPLICANT

DATE OF SIGNATURE (YEAR/MONTH/DAY) YYYY MM DD

SIGNATURE OF WITNESS

DATE OF SIGNATURE (YEAR/MONTH/DAY) YYYY MM DD