



Informed Healthcare Solutions (IHS)

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FAX COVER SHEET

To:	Graham Pike of IHS	From:	
Fax:	0866 200 320	Company:	
Tel:	021 712 8866	Tel:	
Pages:		Date:	
Re:	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 0866 200 320 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

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Adult Child Title Initials

Surname (if different from principal member)

First name/s

Relationship to principal member Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name (if applicable)

ID / passport number

Tax number (if applicable)

3

Adult Child Title Initials

Surname (if different from principal member)

First name/s

Relationship to principal member Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name (if applicable)

ID / passport number

Tax number (if applicable)

4

Adult Child Title Initials

Surname (if different from principal member)

First name/s

Relationship to principal member Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name (if applicable)

ID / passport number

Tax number (if applicable)

5

Adult Child Title Initials

Surname (if different from principal member)

First name/s

Relationship to principal member Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name (if applicable)

ID / passport number

Tax number (if applicable)

Section 5 DEPENDANTS YOU WISH TO REGISTER – continued

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Adult Child Title Initials

Surname (if different from principal member)

First name/s

Relationship to principal member Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name (if applicable)

ID / passport number

Tax number (if applicable)

Section 6 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

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

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

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

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

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		

Section 8 EMPLOYER INFORMATION – This section MUST be completed and signed by your employer

If you are an employee of a Private Company, submit your Application Form to your Human Resources/Salaries Department. No Application Form will be processed without your Employer's Stamp.

Name of employer

Division number Dept. name

Bonitas pay-point code Employee number

Medical scheme start date Employment date

Dependants	Adult	Child	Non-subsidised
Total contribution	R	R	R

COMPANY STAMP

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the Scheme Rules and Plan chosen. All sections of the application form have been completed.

Employer telephone number

Employer fax number

Employer e-mail address

Name of medical scheme / salary administrator

Designation

Signature _____ Date signed

Section 9 BANK DETAILS OF PRINCIPAL MEMBER – Refund of claim and savings payments / debt order instruction Please provide the following documents:

- If Account Holder differs from that of Principal Member, an Affidavit is required.**
- Copy of the account holders ID
 - Copy of the bank statement / cancelled cheque / letter from the bank / bank letterhead confirming the account holder's details
 - Account holders signature

I instruct Medscheme to electronically collect contributions and to deposit claim and savings refunds, via the Electropay system, using the information provided below. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorise Medscheme to adjust any incorrect transactions and / or correct any electronic transfer of funds errors without prior notice.

<input type="checkbox"/> Use this account for contribution collections and refunds <input type="checkbox"/> Use this account for contribution collections only	<input type="checkbox"/> Use this account for member refunds
Bank name _____ Branch name _____ Bank branch code <input type="text"/> Type of account <input type="text"/> <input type="text"/> <input type="text"/> Name of account holder _____ Bank account number <input type="text"/>	Bank name _____ Branch name _____ Bank branch code <input type="text"/> Type of account <input type="text"/> <input type="text"/> <input type="text"/> Name of account holder _____ Bank account number <input type="text"/>
Account holder's signature _____ Date <input type="text"/>	

Section 10 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, prior to or after the acceptance of my membership by Bonitas Medical Fund, I shall promptly notify Bonitas Medical Fund 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 its 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).
21. I warrant that none of my beneficiaries are members of beneficiaries of another medical scheme.

Section 10 MEDICAL FUND ACKNOWLEDGEMENT AND DECLARATION

1. Member's/dependant's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential.
2. Member/dependant information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes.
3. The Fund has granted access, to certain persons within the organisation and its contracted third parties, to a member's/dependant's personal and health information.
4. The Fund has data security measures in place, i.e. access control to members and dependants' information to authorised individuals, disaster and data recovery plans.
5. Confidentiality agreements between the Fund, its staff and its contracted third parties who will use the medical/health/diagnosis/procedure information provided for the purpose of processing the application for membership, reimbursement of claims, determining member/dependant entitlement to benefits, risk management practises, data transfer and management, scheme administration and managed care arrangements.
6. All staff within the Fund, its administrator and third party service providers is bound by internal confidentiality agreements.
7. In the event of a breach in confidentiality, the Fund assumes responsibility and the breach will be managed according to the Fund's internal protocols.

Section 10 ACKNOWLEDGEMENT AND DECLARATION - *continued*

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 _____

Chronic Medication Management

To apply for chronic authorisation, the member, doctor or pharmacist can call Chronic Medicine Management on 0860 100 608.

Alternatively, members, doctors or pharmacists may apply for chronic medication on-line by logging onto the Medscheme website (<https://www.medscheme.co.za>)

