



Informed Healthcare Solutions (IHS)

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Heathfield
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Fax: 0866 200 320
Email: info@medicalaidcomparisons.co.za
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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:	Spectramed 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

MEMBER APPLICATION FORM

(TO BE COMPLETED IN BLACK INK)



• NATIONAL ACTION LINE: 0861 497 497 • NATIONAL FAX LINE: 0861 492 492 • DEDICATED FAX LINE: 086 506 0226 •
• NATIONAL POSTAL ADDRESS: Private Bag X1 Gardenview 2047 •

SPECTRAMED Reg No: 1141

Version 1/2012

1. USE BY INTERMEDIARY/PRODUCT SPECIALIST ORDER TO APPLICANT (FOR OFFICE USE ONLY)

INTERMEDIARY HOUSE NAME **Informed Healthcare Solutions (Pty) Ltd**

INTERMEDIARY ACCREDITATION NO. **ORG104**

INTERMEDIARY CODE **00428**

SIGNATURE

DATE OF SIGNATURE (YEAR/MONTH/DAY)

YYYY

MM

DD

DATE OF COMMENCEMENT (YEAR/MONTH/DAY)

YYYY

MM

DD

PRODUCT SPECIALIST NAME **Graham**

PRODUCT SPECIALIST SURNAME **Pike**

PRODUCT SPECIALIST CODE

SIGNATURE

DATE OF SIGNATURE (YEAR/MONTH/DAY)

YYYY

MM

DD

DATE OF COMMENCEMENT (YEAR/MONTH/DAY)

YYYY

MM

DD

2. EMPLOYER INFORMATION

NAME OF EMPLOYER

MEMBER TO BE REGISTERED AS PART OF EMPLOYER GROUP

YES

NO

PAYPOINT CODE

GROUP CODE

3. HOW DID YOU HEAR ABOUT SPECTRAMED?

PRINT MEDIA

TELEVISION

RADIO

FRIEND / FAMILY MEMBER

INTERNET

INTERMEDIARY

4. OPTION SELECTION

BENEFIT OPTION CHOSEN

COBALT

AZURE

CAPRI

CYAN

AQUA

INITIAL

5. PRINCIPAL MEMBER PERSONAL DETAILS

TITLE	<input type="text"/>	FIRST NAME	<input type="text"/>	SURNAME	<input type="text"/>
INITIALS	<input type="text"/>	ID/PASSPORT NO.	<input type="text"/>	DATE OF BIRTH (YEAR/MONTH/DAY)	<input type="text" value="YYYY"/> <input type="text" value="MM"/> <input type="text" value="DD"/>
DO YOU GRANT SPECTRAMED PERMISSION TO PERFORM ID VERIFICATION ON ALL RELATED PARTIES?				<input type="button" value="YES"/>	<input type="button" value="NO"/>
GENDER	<input type="text"/>	PREVIOUS SURNAME IF APPLICABLE	<input type="text"/>		
TAX NO.	<input type="text"/>	COUNTRY OF RESIDENCE	<input type="text"/>		
RISK EQUALISATION FUND NO.	<input type="text"/>				
MARITAL STATUS	<input type="button" value="SINGLE"/>	<input type="button" value="MARRIED"/>	<input type="button" value="DIVORCED"/>	<input type="button" value="WIDOWED"/>	<input type="button" value="CO-HABITING"/>
HOME LANGUAGE	<input type="button" value="ENGLISH"/>	<input type="button" value="ZULU"/>	<input type="button" value="XHOSA"/>	<input type="button" value="AFRIKAANS"/>	<input type="button" value="OTHER"/>

6. CONTACT DETAILS OF PRINCIPAL MEMBER

ADDRESSES	POSTAL ADDRESS	RESIDENTIAL/PHYSICAL ADDRESS
BUILDING NAME & NO.	<input type="text"/>	<input type="text"/>
STREET ADDRESS/ BOX NO.	<input type="text"/>	<input type="text"/>
SUBURB	<input type="text"/>	<input type="text"/>
TOWN/CITY	<input type="text"/>	<input type="text"/>
PROVINCE	<input type="text"/>	<input type="text"/>
AREA CODE	<input type="text"/>	<input type="text"/>

CONTACT DETAILS	
WORK TEL. NO.	<input type="text"/>
CELLULAR NO.	<input type="text"/>
FAX NO.	<input type="text"/>
HOME TEL. NO.	<input type="text"/>
EMAIL	<input type="text"/>

CAN SPECTRAMED CONTACT YOU VIA SMS?	<input type="button" value="YES"/>	<input type="button" value="NO"/>
PREFERRED CORRESPONDENCE CHANNEL?	<input type="button" value="POSTAL"/>	<input type="button" value="EMAIL"/>

INITIAL

7. DEPENDANT DETAILS

SPOUSE

TITLE FIRST NAME/S SURNAME

GENDER DATE OF BIRTH (YEAR/MONTH/DAY)

PREVIOUS SURNAME

I.D. NUMBER CONTACT NO. SPOUSE

DEPENDANTS

* REFER TO DISCLOSURE FORM

FIRST NAME/S

SURNAME DATE OF BIRTH (YEAR/MONTH/DAY)

I.D. NUMBER GENDER

* REFER TO DISCLOSURE FORM

FIRST NAME/S

SURNAME DATE OF BIRTH (YEAR/MONTH/DAY)

I.D. NUMBER GENDER

* REFER TO DISCLOSURE FORM

FIRST NAME/S

SURNAME DATE OF BIRTH (YEAR/MONTH/DAY)

I.D. NUMBER GENDER

* REFER TO DISCLOSURE FORM

FIRST NAME/S

SURNAME DATE OF BIRTH (YEAR/MONTH/DAY)

I.D. NUMBER GENDER

INITIAL

8. INCOME (from all sources) please note: for SPECTRA Azure and SPECTRA Cyan only

GROSS MONTHLY SALARY

PRINCIPAL MEMBER SPOUSE

PAID

Contributions will be calculated on the higher of the two gross monthly incomes. In absence of proof you will be defaulted to the highest income bracket

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

PLEASE NOTE: Billing of contributions is done in or in on the 1st calendar day of every month. Contributions will be paid no later than the 4th day of the same 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

CONFIRMATION OF AUTHORISED SIGNATORY

I, the undersigned, authorise **SPECTRAMED** to debit my account monthly for the medical aid contribution

NAME ID NUMBER

AUTHORISED SIGNATURE (Mandated Account Holder)

USE THE ABOVE ACCOUNT FOR CLAIMS REFUNDS Should the banking details provided not be that of the principal member, please state account holder's relationship with principal member, e.g. spouse, sibling, etc.

RELATIONSHIP

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. Please state whether these documents are attached

BANK NAME BRANCH NAME

ACCOUNT HOLDER BRANCH CODE

ACCOUNT NUMBER

TYPE OF ACCOUNT AUTHORIZED SIGNATURE (Mandated Account Holder)

INITIAL

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)
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	YYYY/MM/DD	YYYY/MM/DD
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	YYYY/MM/DD	YYYY/MM/DD
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	YYYY/MM/DD	YYYY/MM/DD
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	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)
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	YYYY/MM/DD	YYYY/MM/DD
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	YYYY/MM/DD	YYYY/MM/DD
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	YYYY/MM/DD	YYYY/MM/DD
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	YYYY/MM/DD	YYYY/MM/DD
<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	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.

INITIAL

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)

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:
					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

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:
					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

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:
					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

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:
					YYYY/MM/DD	NAME: TEL:

INITIAL

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		
			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		
			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		
			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		
			YES	NO	YYYY/MM/DD	NAME: TEL:
			YES	NO	YYYY/MM/DD	NAME: TEL:

INITIAL

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:
					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:
					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:
					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:
					YYYY/MM/DD	NAME: TEL:

INITIAL

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:
					YYYY/MM/DD	NAME: TEL:

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

Alcoholism, Drug Dependency 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:
					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:
					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)	
		NAME:	TEL:
	YYYY/MM/DD		
	YYYY/MM/DD		

INITIAL

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		NAME:	TEL:
					YYYY/MM/DD		
					YYYY/MM/DD		

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		NAME:	TEL:
					YYYY/MM/DD		
					YYYY/MM/DD		

INITIAL

QUESTION 22: Participate in hazardous sports, hobbies or pursuits

Including, but not limited to:
Skydiving, Bungee 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
PRINCIPAL MEMBER	<input type="text"/>	<input type="text"/>	<input type="text"/>
ADULT DEPENDANT	<input type="text"/>	<input type="text"/>	<input type="text"/>
DEPENDANT 2	<input type="text"/>	<input type="text"/>	<input type="text"/>

	YEAR	MONTH	DAY
SPOUSE	<input type="text"/>	<input type="text"/>	<input type="text"/>
DEPENDANT 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
DEPENDANT 3	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

- YES NO COPY OF ID DOCUMENT OR BIRTH CERTIFICATE OR PASSPORT FOR PRINCIPAL MEMBER AND/OR SPOUSE, PARTNER OR ADULT DEPENDANTS
- YES NO COPY OF LATEST SALARY ADVICE/COPY OF CANCELLED CHEQUE/BANK STATEMENT WITH ACCOUNT DETAILS OR LAST 3 MONTHS' BANK STATEMENTS OR 12 MONTHS' COMMISSION STATEMENTS OR COPY OF LATEST TAX ASSESSMENT FOR APPLICANT AND FOR SPOUSE / PARTNER MUST BE ATTACHED
- 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) <input type="checkbox"/> YES <input type="checkbox"/> NO	SPOUSE OR PARTNER	MARRIAGE CERTIFICATE OR AFFIDAVIT/ DISCLOSURE CONFIRMING CO-HABITATION
b) <input type="checkbox"/> YES <input type="checkbox"/> NO	NEWBORN	BIRTH CERTIFICATE OR HOSPITAL CONFIRMATION OF BIRTH
c) <input type="checkbox"/> YES <input type="checkbox"/> NO	ADULT DEPENDANT (EX-SPOUSE)	ORDER OF THE COURT OR DIVORCE CERTIFICATE
d) <input type="checkbox"/> YES <input type="checkbox"/> NO	MINOR DEPENDANT - ADOPTED OR CUSTODIANSHIP AWARDED FOR WHOM MEMBERSHIP IS APPLIED	ORIGINAL ADOPTION CERTIFICATE OR ORIGINAL CERTIFIED COPY OF COURT DOCUMENT AWARDED CUSTODY
e) <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDANTS STUDYING FULL-TIME BETWEEN THE AGES OF 21 - 25 FOR WHOM MEMBERSHIP IS APPLIED	STUDENT CERTIFICATE FROM REGISTERED INSTITUTION (A student card is not accepted)
f) <input type="checkbox"/> YES <input type="checkbox"/> NO	DEPENDANT OVER THE AGE OF 21 NOT STUDYING FOR WHOM MEMBERSHIP IS APPLIED	COPY OF ID DOCUMENT, FULL WRITTEN MOTIVATION AND ORIGINAL AFFIDAVIT/DISCLOSURE OF DEPENDANCE
g) <input type="checkbox"/> YES <input type="checkbox"/> NO	HANDICAPPED ADULT DEPENDANT FOR WHOM MEMBERSHIP IS APPLIED	DOCTOR'S REPORT SUPPORTING APPLICATION
h) <input type="checkbox"/> YES <input type="checkbox"/> NO	CUSTOMARY OR TRADITIONAL UNION	ORIGINAL AFFIDAVIT/DISCLOSURE CERTIFYING EXISTENCE OF RELATIONSHIP AND DURATION
i) <input type="checkbox"/> YES <input type="checkbox"/> 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) <input type="checkbox"/> YES <input type="checkbox"/> 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) <input type="checkbox"/> YES <input type="checkbox"/> 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/DISCLOSURE CERTIFYING CO-HABITATION OR FINANCIAL RESPONSIBILITY FOR THE DEPENDANT

INITIAL

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 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 complete this 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 email 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 by the **4th day of the month**.
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**

**SIGNATURE
OF WITNESS**

DATE OF SIGNATURE
(YEAR/MONTH/DAY)

YYYY

MM

DD

DATE OF SIGNATURE
(YEAR/MONTH/DAY)

YYYY

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