Informed Healthcare Solutions (IHS)

119 Main Road
Heathfield
Cape Town

Tel: +27 21 712-8866
Fax: 0866 200 320
Email: info@medicalaidcomparisons.co.za
Web: www.medicalaidcomparisons.co.za

FAX COVER SHEET

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

MEDSHIELD
medical scheme

MEDSHIELD MEMBER APPLICATION

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. All sections must be completed.

For the MediValue and MediPhila benefit options a completed MEM013 (a) or (c) Family Practitioner Nomination form is required with this form.

Selection of Benefit Option: _____

Membership number (for office use only): | | | | | | | | | | | |

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Date membership to commence: Y Y Y Y M M D D

Applicant's signature: _____ Date: Y Y Y Y M M D D

Consultant Declaration

Brokerage name: Informed Healthcare Solutions (Pty) Ltd

Agent name: Graham Pike

Agent number: | | | | | | | | | | |

DOCUMENT CHECK LIST

In order to avoid rejection of your application please provide the following documents:	PLEASE TICK
ID document copy/s for all beneficiaries (e.g. ID / Birth certificate)	
Student certifcate (child dependant age 21-28 that is studying or turning 21 in the next 3 months).	
Proof of previous medical scheme (certifcate of membership refecting an end date)	
Mem02 - Member Record Amendment (for Special Dependants: e.g. parents, foster child, niece, nephew, brother,sister, grandchild).	
Persal payslip (for persal members only)	
Stamped bank statement, stamped confirmation letter from the bank, copy of cancelled cheque, signed letter of authority for 3rd parties	
MEM013 - Family Practitioner Nomination form (only applicable to the MediValue and MediPhila benefit options	

I, _____ hereby understand that it is an offense to submit fraudulent business and I have explained Non-disclosure, General and condition specific waiting periods, Late Joiner Penalty, PMB and Pro-rating of benefits.

I further declare that I have attached all documents as per the document check list above to this application form, and that the application form is submitted to the Scheme within 14 days of the member declaration sign date.

Consultant's signature: _____ Date: Y Y Y Y M M D D

SECTION A — Personal Details (attach copy of ID)

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Postal Address:

Postal Code:

Residential Address:

Postal Code:

E-mail Address:

Telephone No. (W): (H): C O D E

Cell: Fax: C O D E

Tax Number: Basic Monthly Income:

Persal Number:

Please complete for marketing purposes:

Race: Gender: Male Female Marital Status: Single Married Divorced Widowed

SECTION B — Dependants you wish to register (attach copy of ID)

Spouse or Partner: Spouse Life Partner Divorced Spouse

Title: Initials:

First Name/s:

Surname:

Previous Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Country of Residence:

Email Address:

Race: Gender: Male Female Marital Status: Single Married Divorced Widowed

Please complete a MEM02 form for Special Dependants (e.g. Parents, Foster child, Niece, Nephew, Sibling, Grandchild).
Acceptance of dependants will in accordance with the Rules of the Scheme. Affidavits required for Special Dependants.

Dependants (attach copies of ID or Birth Certificate)

Name of Beneficiary	Surname (if different to Principal Member)	ID Number	Gender (M/F)	Relationship to Principal Member	Adult over 21	
1					Y	N
2					Y	N
3					Y	N
4					Y	N
5					Y	N
6					Y	N

SECTION C Previous Medical Aid History

Where applicable, please provide details and proof of membership of all previous medical scheme cover (membership certificates, which reflects the termination date, must be attached to this application). Failure to provide this informtion may result in underwriting being applied as per point 11 under member declaration (page 7). Where a Late Joiner Penalty has already been imposed and evidence of credible cover is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the following month. No backdate will be allowed unless evidence of previous submission is provided to the Scheme.

Name of Scheme	Membership Number	Date Joined	Date Terminated

SECTION D Medical History (yes or no)

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.
Refer to point 2 in Member Declaration.

Have you or any of you dependants sought any advice, been diagnosed with, or treated for any of the following conditions in the past 12 months?

If Yes to any of the questions, please provide full details including the date of last treatment. Should you require additional space please add an additional page to the application form.

1. Any chronic illnesses? e.g. Cardio and vascular conditions, Obstructive lung disease, Diabetes, insulin or non insulin dependent diabetes mellitus, Thyroid or other glandular or blood disorders, etc.

Y	N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

2. Skin, muscle or bone disease? e.g. Any skin rash, acne, eczema or psoriasis, multiple sclerosis, osteo or rheumatoid arthritis,osteoporosis, injury, back / neck or joint problems or replacement, fibromyalgia, prosthetic limbs, lumbago sciatica, spasms, etc.

Y	N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

3. Digestive system, stomach, liver, gall bladder or pancreas? e.g. Stomach or duodenal ulcer, GORD/heartburn, hiatus hernia, Crohn's disease, ulcerative colitis, irritable bowel syndrome, rectal bleeding, hepatitis, cirrhosis, liver failure, etc.

Y	N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

4. Psychiatric conditions? e.g. Schizophrenia, bipolar mood disorder, substance abuse, eating disorder, depression, panic attacks and / or Anxiety, ADHD or post traumatic stress disorder, etc.

Y	N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

5. Complaints of the nervous system or brain? e.g. Epilepsy, stroke, blackouts, migraine, headaches, paralysis, Parkinson's or Alzheimers. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

6. Complaints/disorder of the ear, nose, throat or eye? e.g. Defective vision, cataracts, glaucoma, eye disorders, blindness, retinitis, disorders of the cornea or wear spectacles or contact lenses, hearing loss, ear discharge, otitis media, allergies or recurrent tonsillitis, etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

7. Urinary tract, genital system or gynaecological disorders? e.g. UTI , kidney stones, kidney failure, prostatitis, sexually transmitted disease, HRT, ovarian cysts, fibroids, menstrual disorders or any abnormality of pregnancy or confinement, etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

8. Are you or any of your dependants pregnant or suspect that you are pregnant? Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

9. Malignant or benign neoplasms? e.g. cancers, malignant or non-malignant tumours/growths of any kind including removal of malignant or benign moles, etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

10. Dentistry? e.g. Specialised dentistry/maxillo-facial treatment (currently undergoing or anticipating any specialised/ orthodontic or maxillo-facial treatment), etc. Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

11. Any other medical condition not listed in question 1 - 10? Y N

Name of Beneficiary	Condition and Date Diagnosed	Currently On Treatment		Date of Last Treatment	Attending Doctor
		YES	NO		
		YES	NO		
		YES	NO		

12. Prescribed Medication

A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.
Please supply details of any prescribed medication that you, or any of your dependants, are currently taking or expect to take in the future. Your doctor or pharmacist can contact Chronic Medicine Management on 086 110 0220 to telephonically register you for chronic medication.

Question No.	Name of Beneficiary	Condition and Duration of Condition	Name of Attending Doctor	Date of Treatment

13. Surgery and Hospital Admissions

Please supply details of any surgery or HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past 12 months, and/or details of all planned surgical procedure(s) and HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future.

Name of Beneficiary	Details of Surgical /Hospital Admission	Date	Reason	Doctor	Current Condition

Immune Deficiency Status (Confidential Disclosure)

If you, or any of your dependants, have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Programme on 086 050 6080 for more information on how to join the Programme.

SECTION E Bank Details

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account.
A stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank in the name of the Principal Member is required.
Should contributions be paid by a 3rd party, a stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank together with a signed letter of authorisation from the account holder must accompany this form. For Organisations a signed letter of authorisation needs to be on a company letterhead.
NB: If contributions are not deducted by PERSAL or your employer, payment via debit order is the preferred method for the collection of contribution payment.

☐ Use this account for contribution collections and claims refunds

☐ Use this account for contribution only

Bank Name: _____

Branch Name: _____

Bank Branch Code: _____

Type of Account: Current | Transmission | Savings

Name of Account Holder: _____

Bank Account Number: _____

Date: Y Y Y Y M M D D

Signature of Account Holder: _____

☐ Use this account for claims refunds only

Bank Name: _____

Branch Name: _____

Bank Branch Code: _____

Type of Account: Current | Transmission | Savings

Name of Account Holder: _____

Bank Account Number: _____

Date: Y Y Y Y M M D D

Signature of Account Holder: _____

SECTION F Employer Information (only for Paypoints)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date: Y Y Y Y M M D D

COMPANY STAMP

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section F have been completed:

Employer's Email Address:

Employer Representative's Name:

Employer Representative's Designation:

Employer Representative Signature: _____

Date: Y Y Y Y M M D D

SECTION G Important Conditions of Membership

1. Disclaimer
   Brochures are a summarised version and do not supersede the registered Rules of the Scheme. All benefits are paid in accordance with the registered Rules of the Scheme.

2. Are all benefits available once I am a member?
   Benefits are based on a 12-month period (January to December), depending on which month you join the Scheme, your benefits will be pro-rated accordingly, i.e. should you join in March, you have 10 months' benefits available. If a benefit for the year is R1 800 you will have R1 800/12 x 10 = R1500. Waiting periods are applied to some conditions, e.g. pregnancy.

3. Do I have to wait before I can claim for benefits?
   Yes, on pre-existing conditions, e.g. a condition prior to joining the Scheme. You will receive written notification if waiting periods are imposed.

4. Will contributions increase after I become a member?
   Yes. All medical schemes increase contributions from time to time when the cost of medical, dental, hospital or other health services increase or when benefits are improved.

5. What happens when I exceed my annual benefit limits?
   You will be liable for the payment of any excess amount directly to the service provider.

6. Can I resign from the Scheme at any time?
   The Scheme requires 1 calendar month notice in writing of your intention to cancel your membership.

Member Declaration

1. I, the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree to abide by its Rules and Regulations in accordance with the provisions of the Medical Schemes Act (Act 131 of 1998) as amended. I have been informed that the Scheme Rules will be made available on request and that I am responsible to read and be bound by them.

2. I certify that all the information given is true and correct and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void and that all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me, or any person on my or my dependant's behalf, under such contracts.

3. I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

4. As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

5. Notwithstanding point 3 and 4, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

6. As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

7. I hereby authorise the Scheme, or any of its nominated representatives, to confirm my bank details.

8. Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

9. I hereby authorise and request any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my / the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my / their death, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of any nature, which may be made against them as a result of, or arising out of, the disclosure of any test results or medical information.

10. The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi which will be deemed to be my postal address unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi shall be deemed to have been received by me on the 7th day after the date of posting.

11. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

    - a 3 (three) month general waiting period in respect of all benefits;
    - a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
    - a late joiner contribution penalty.

12. Should my state of health change significantly from the date of signing this application to the date of acceptance, I will notify the Scheme in writing.

13. I hereby confirm that I am not an active beneficiary on another medical scheme.

14. I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: _____

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form is submitted to the Scheme within 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

Date: Y Y Y Y M M D D

Consent for Disclosure of Information to 3rd Party

Please complete the below should you require a nominated person to contact/make changes to your Medshield Medical Scheme membership on your behalf (i.e. a family member, attorney, etc.) - Please note that this is not complusory and merely for your convenience, should you so choose.

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Relationship to Member:

Email address:

Cellphone number:

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Relationship to Member:

Email address:

Cellphone number:

MEDSHIELD MEDICAL SCHEME

P.O. Box 4346, Randburg, 2125
www.medshield.co.za
newapplication@medshield.co.za or fax to 010 597 4710
Contact Centre: 086 000 2120
Mon - Fri 8:30 - 17:00

BANK DETAILS

Account Holder: Medshield Medical Scheme
Bank: Nedbank
Branch: Rivonia, 196905
Account number: 1969125969