Be Smart. **Keep it Simple.**

KeyHealth MEDICAL SCHEME

86 Koranna Avenue Doringkloof Centurion 0157 | PO Box 14145 Lyttelton 0140 | Application Enquiries: 0860 873 628 | Fax: 086 605 0656

Application for Membership

Instructions:

1. Please complete every section below in full. If not applicable, please write N/A in the appropriate field.
2. The Medical Schemes Act requires that a copy of the Principal Member and all Dependants' identity documents must be attached.
3. Any incomplete or illegible information will result in further enquiries, which could delay your application for membership.
4. Membership is subject to the conditions, exclusions or limitations of benefits in accordance with the Medical Schemes Act and/or Scheme Rules.
5. Since the Scheme's contract is with the Principal Member, the application form is to be completed by and signed on behalf of all the Dependants, by the Principal Member.
6. A certificate(s) of membership, confirming previous medical scheme coverage, must be attached. This is obtainable from previous medical scheme(s).
7. Applicants may not make use of medical services, to be paid for by the Scheme, until such time as WRITTEN CONFIRMATION OF MEMBERSHIP has been received.

Section 1: Option Choice

Important note: The Principal Member may make an option change only as from 1 January of each year

- Essence Option ☐
- Origin Option ☐
- Equilibrium Option ☐
- Silver Option ☐
- Gold Option ☐
- Platinum Option ☐

I request the Scheme to register me and my dependants from 0 1 – M M – 2 0 Y Y

Section 2: Principal Member Personal Details (attach copy of ID / Passport)

Title | Initials | First name

Surname

ID number (Y Y M M D D) Gender: Male ☐ Female ☐

Race: African/Black (A) ☐ Coloured (C) ☐ White (W) ☐ Indian/Asian (I) ☐ Unknown (U) ☐

Passport number | Marital status

Residential address

Postal code

Postal address (if different)

Postal code

Telephone - home (code - number) | Cellphone number

Telephone - work (code - number) | Fax - work (code - number)

E-mail address

Language preference: English ☐ Afrikaans ☐

Section 2.1: Spouse / Partner Personal Details (attach copy of ID / Passport if applying for membership)

Title | Initials | First name

Surname

Previous surname

ID number (Y Y M M D D) Gender: Male ☐ Female ☐

Race: African/Black (A) ☐ Coloured (C) ☐ White (W) ☐ Indian/Asian (I) ☐ Unknown (U) ☐

Passport number | Country of origin

Country of residence

Relationship to Principal Member

Cellphone number

E-mail Address

Section 2.2: Dependants Personal Details (attach copies of ID / Passport or Birth Certificate)

First name	Surname, if different from Principal Member	ID No./Passport No.	Race	Gender (M/F)	Relationship to Principal Member	Contact details (if applicable)
1.			Please select			
2.			Please select			
3.			Please select			
4.			Please select			

***An Applicant may be requested by the Scheme to confirm relationship to Principal Member.**

Section 3: Financial Advisor / Broker

Name: ATFIN CONSULTING (PTY) LTD

Broker Code: 312 000 000 | Accreditation Number: ORG 2825

Telephone number (code - number): 0210071623

Email Address: applications@atfin.com

I _____ **(Principal Member), declare that, I am aware of the appointment of the abovementioned Financial Adviser/Broker and that;**

1. I give my broker access to my and my dependant(s) membership information with the Scheme in order to be of service to me;
2. This appointment was made voluntarily by me and can be cancelled at any time;
3. This appointment will entitle me to receive certain services from my Financial Advisor/Broker and that this was explained to my satisfaction.

Principal Member Signature | **Date** D D – M M – 2 0 Y Y

Financial Advisor Signature | **Date** D D – M M – 2 0 Y Y

Section 4: Banking Details for Payment of Contributions

Bank account holder	**KeyHealth Medical Scheme**
Name of financial institution	**ABSA**
Account number	**6 000 000 12**
Account type	**Cheque**
Branch code	**632005**
Reference	**Kindly use your membership number as reference**

Please fax proof of payment to 0860 111 390

Section 5: Method of Contribution Payments

Method of payment: Debit order ☐ Electronic Funds Transfer (EFT) ☐

***Please note that no credit card banking details will be accepted**

Section 5.1: Contribution Collection and Claims Reimbursements

Please indicate the choice of monthly debit order deduction date: 02 ☐ 07 ☐ 26 ☐ Last day of month ☐

☐ Use this account for **contribution collections** and **claims reimbursements**

☐ Use this account for **contribution collections** only

Name of account holder _____

_____

Name of financial institution _____

Bank Branch code

Type of Account Please select

Bank account number

***Please note that no credit card banking details will be accepted**

Account Holder Signature

Date D D – M M – 2 0 Y Y

☐ Use this account for **claims reimbursements** only

Name of account holder _____

_____

Name of financial institution _____

Bank Branch code

Type of Account Please select

Bank account number

***Please note that no credit card banking details will be accepted**

Account Holder Signature

Date D D – M M – 2 0 Y Y

Assignment

I hereby acknowledge that the party hereby authorise to effect the drawing(s) against my account may not cede or assign any of its rights to any third party without my consent and that I may not delegate any of my obligations in terms of ths contract/authority to any third party without prior written consent of the authorised party.

Note: Attach a copy of a cancelled cheque/ a recent bank statement/an official bank letter for bank identification purposes. (Current accounts only.)

Account Holder Signature

Date D D – M M – 2 0 Y Y

If a company account is to be debited:

- I warrant that the Principal Member, referred to in this application, is an employee of the organisation.
- KeyHealth may bill the employer for the amount due for this member in the same manner as for other members that the organisation employs.

Name

Position in company

Authorised signatory

Date D D – M M – 2 0 Y Y

Section 6: Employer Information - To be completed by employer

Company Name

Existing group number

Employee number

Business telephone number (code - number)

Date of employment D D – M M – Y Y Y Y

Principal Member's occupation

SIGNATURE AND STAMP OF EMPLOYER

DESIGNATION

Date D D – M M – 2 0 Y Y

Section 7: Previous Medical Scheme Information

Attach certificate of previous medical scheme(s), if applicable. Should additional space be required, copy this section and attach it to this application. **Please list previous medical scheme details below for all Beneficiaries.**

Name of member	Name of scheme	Member number	Date joined	Date terminated / or current

1. Are you changing your medical scheme due to a change in your employment, if yes please provide proof of change of employment and certificate of membership. (Closed Schemes members only) Yes ☐ No ☐

2. Have you, your Spouse / Partner or any of your Dependants ever had a waiting period, pre-existing condition, exclusion or a late joiner penalty? If Yes, please attach previous membership certificate(s) (if available). Yes ☐ No ☐

Section 7.1: Medical Details Questionnaire

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership.
The Scheme may, within the first twelve (12) months of membership initiate a possible non-disclosure investigation for any major medical services (e.g. hospitalisation).

All questions must be answered with either 'Yes' or 'No'. If the answer to any question is 'Yes', please provide full details. If more space is required, please include additional pages.

7.1.1 Have you or any of your dependants suffered from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, headaches, Systemic Lupus Erythematosus (SLE) depression, anxiety, epilepsy, and/ or thyroid disorders)? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.2 Have you or any of your dependants suffered 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 applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.3 Have you or any of your dependants suffered from muscle, bone, joints, skin or nerve illnesses or disorders (e.g.back and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, motor neuron disease, osteoporosis, dermatitis)? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.4 Have you or any of your dependants suffered from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts, irregular menstrual cycle / abnormal (irrespective of severity) menstrual bleeding)? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.5 Have you or any of your dependants suffered from eye, ear, nose, mouth (teeth or gums) or throat disorders (e.g. glaucoma, cataracts, sinusitis, visual disorders, deafness, rhinitis, orthodontics) If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

Section 7.1: Medical Details Questionnaire - Continued

7.1.6 Have you or any of your dependants suffered from any blood disorders, cancer (either benign or malignant)? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.7 Are you or any of your dependants pregnant or planning a pregnancy within the next 12 months? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.8 Were you or any of your dependants hospitalised or had surgery in the past (including but not limited to pacemaker, VP shunt, joint replacements)? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.9 Are you or any of your dependants planning any hospitalisation or surgery within the next 12 months? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.10 Is there any other condition or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim (including planned procedures, paraplegia, quadriplegia and birth defects)? If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.11 Have you or any of your dependants experienced any symptoms, how insignificant it might seem, that have not yet been treated or diagnosed? If yes, provide details. Yes ☐ No ☐

Section 7.2: GP Nomination - Essence Option Only

Members on the Essence Option are required to nominate a General Practitioner (GP) in respect of the treatment of chronic conditions. Please note that a GP nomination is required for each beneficiary.

First name of Beneficiary	Surname, if different from Principal Member	GP Name	Practice Name	Practice number
1.				
2.				
3.				
4.				
5.				
6.				

Section 7.3: HIV/Aids

Failure to disclose a pre-existing condition as stipulated, could limit and/or exclude certain benefits or result in termination of membership. If you and/or any of your Dependants are living with HIV/Aids and would prefer not to disclose your and/or their HIV-status on this form due to confidentiality, you may wait until you have received your membership number; please then dial **0860 50 60 80** in order to notify the Scheme that you and/or any of your Dependants are living with HIV/Aids. This information must be disclosed to KeyHealth within 7 days of your official entry onto KeyHealth.

Section 8: Declarations

Section 8.1: Medical Scheme Declaration

KeyHealth Medical Scheme confirms that:

8.1.1 A member's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential;
8.1.2 Member information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes;
8.1.3 The Medical Scheme has data security measures in place including anti-virus security, prevention of unauthorized access to members detail, eliminating unauthorized e-mails, web-mails and access controls for signing on to the computer system;
8.1.4 The Medical Scheme has granted access, to certain persons within the organisation and its contracted third parties, to a beneficiarie's personal and health information. This is for the facilitation of normal business processes;
8.1.5 All KeyHealth employees and its contracted third parties is bound by internal confidentiality agreements;
8.1.6 The Medical Scheme and its contracted third parties will use the medical health/diagnosis/procedure information for the following purposes: processing the application for membership; re-imbursement of claims, determining member entitlement to benefits, and risk management practices. Risk management practices include: hospital risk management, disease risk management and medicine risk management;
8.1.7 The Medical Scheme has ensured that confidentiality agreements have been entered into with all contracted third parties who have access to beneficiary information for the purposes of data transfer and management, Scheme administration and managed care arrangements;
8.1.8 In the event of a breach in confidentiality, the Medical Scheme assumes responsibility and the breach will be managed according to the Scheme's internal protocols.

Section 8.2: Financial Declaration

8.2.1 I hereby instruct and authorise the Scheme to draw against my bank indicated in this application form (or any other bank or branch to which I may transfer my account) the amount necessary for payment of my monthly contribution due in respect of the abovementioned membership on the selected deduction date as indicated in Section 3.1 each and every month and continuing until termination of our agreement or until cancelled by me in writing. All such withdrawals from my bank account by the Scheme shall be treated as though they had been signed by me personally.
8.2.2 I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher.
8.2.3 I agree to pay any bank charges relating to this debit order instruction.
8.2.4 This authority may be cancelled by me giving you thirty days notice in writing, but I understand that I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my bank (whichever it is or will be).

Section 8.3: Declaration by Principal Member

PLEASE NOTE

8.3.1 Acceptance of this application is at the discretion of the Scheme and shall be subjected to such conditions as the Scheme may determine in its rules from time to time.
8.3.2 The Scheme reserves the right to call for such additional information on the income, where applicable, and health of the applicant and/or Dependants.
8.3.3 With specific reference to and acknowledgement of the detail contained in the Medical Details section, failure to disclose pertinent information or to supply false information could lead to the termination of membership or such other measures as the Scheme may determine in its sole discretion, and the applicant's attention is specifically drawn to Article 66 of the Medical Scheme Act, Act No. 131 of 1998.

8.3.4.1. I declare that

8.3.4.1.1. the contents of this application, and any other documents which may be required in support thereof, are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and should there be any change in state of health or illness suffered by myself or any of my registered dependants from the date of signing this application form and the date of inception on the Scheme, notification of such change will be provided to the Scheme in writing with full details of such condition/ailment;
8.3.4.1.2. none of the applicants are registered with another medical scheme;
8.3.4.1.3. I expressly authorise any healthcare service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to the Scheme, or its contracted service providers, on request, also after the death or termination of membership of any of us. I expressly grant the Scheme the right to access our personal information as and when necessary;
8.3.4.1.4. I expressly authorise the Scheme, to the extent that it may be required by law, to process, which includes the collection, usage and storage of, our personal information, comprising amongst others our demographic, health and biometric information, contact details as well as information related to any suspected fraudulent behaviour by me or any of my dependants, and which information has been supplied by us to the Scheme or which the Scheme may lawfully collect from any third party, for the purposes specified above;
8.3.4.1.5. I consent to the recording of all conversations between myself or any of my dependants and the Scheme or any of its contracted service providers and agree that all information so obtained as well as all other information about us may form part of the records of the Scheme, which records may be retained for as long as it is required in terms of the Rules or applicable legislation, for historical, statistical or research purposes, subject to the requirements of the law, or for any other lawful purpose;
8.3.4.1.6 I understand that my dependants and I must ensure that the Scheme is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of our application for membership, underwriting, the administration of our membership, the calculation of contributions, the processing of claims, payment of benefits, communication by the Scheme with us, and other purposes relevant to our membership as stipulated above;
8.3.4.1.7. I understand that my dependants and I may have access to our personal information held by the Scheme and may request that the Scheme to correct any inaccurate information subject to the provisions of applicable legislation;
8.3.4.1.8 I authorise the Scheme to deal with my dependants and I electronically and treat electronic communication (such as e-mail, fax, telephone, or communication through the Scheme's digital app) as being the same as written authority and confirmation. I agree further that, where I choose to use electronic methods to transact with the Scheme, we will carry the risk of such use;
8.3.4.1.9 I guarantee that, to the extent that it may be required by law, I have the necessary authority from my dependants to provide the consent and permissions contained in this application and to receive communication from the Scheme on their behalf regarding any matter related to their membership and medical scheme cover, including relevant health information.

Section 8.3: Declaration by Principal Member - Continued

8.3.4.2. further accept that

8.3.4.2.1. my statements and answers in this application form shall form the basis of the proposed membership;
8.3.4.2.2. if I omit any pertinent information or make any false statement in my application, the Scheme may decline the application, or if membership has already been granted, terminate my or my dependants' membership, or impose such appropriate sanctions as it may determine in its sole discretion;
8.3.4.2.3. I will be responsible for all monthly contributions for the applicants and for any other amounts legally due to the Scheme, which may be incurred by them, and that such amounts may be recovered from me retrospectively;
8.3.4.2.4. I will be responsible for informing the Scheme of any changes to any of my dependants and their income, where applicable, within 30 days and for obtaining confirmation of those changes, in writing, from the Scheme.
8.3.4.2.5. All conversations between myself and the Scheme or its contracted parties may be recorded.
8.3.4.2.6. The terms and conditions issued in respect of this application are valid for 30 days from the signature date.

8.3.4.3. authorise

8.3.4.3.1. the Scheme to obtain and disclose any medical information it may require in order to consider and process this application for membership, and, during my period of membership, to obtain as it may require, disclose and utilise any information concerning my own and my dependants medical history;
8.3.4.3.2. where applicable, my employer to pay to the Scheme any portion of the monthly contribution due by me, by deduction from my salary, and any amount in arrears by way of double deduction from my salary, until fully recovered;
8.3.4.3.3. the Scheme to register me and my dependants' membership.

8.3.4.4. state that

8.3.4.4.1. I am familiar with the conditions and benefits of the option selected, notwithstanding representation by any other party;
8.3.4.4.2. I undertake to abide by the latest Rules of the Scheme as amended from time to time.
8.3.4.4.3. I am of sound mind, memory and understanding.
8.3.4.4.4. I understand that the Scheme may impose general and/or conditions specific waiting periods, as provided for in the Medical Schemes Act 131 of 1998;
8.3.4.4.5. I fully understand the implications of moving from one scheme to another;
8.3.4.4.6. Admission to the Scheme is not subject to the services of a broker being employed;
8.3.4.4.7. I understand the role of my broker (if applicable).

This authorisation will remain valid until cancelled in terms of the Rules of the Scheme.

Signature of Principal Member		**Print Name and Surname of Principal Member**	

Date D D – M M – 2 0 Y Y