

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.

Please note: Copies of ID/Passport numbers must be provided for the principal member as well as all beneficiaries. Should this be outstanding, your application cannot be processed.

X Selection of Benefit Option: _____

Membership number: (for office use only):

Date membership to commence:

Applicant's signature: _____ Date:

Consultant Declaration

Brokerage name:

Healthcare consultant:

Agent name:

Agent number:

I, Peter Pyburn hereby understand that it is an offence to submit fraudulent business and have explained the following to the prospective member:

Non-disclosure General and condition specific waiting periods Pro-rating of benefits Late Joiner Penalty

Consultant's signature:  _____ Date:

Where applicable, please provide details and proof of membership of all previous medical schemes cover. (Membership certificates, which reflects the termination date, must be attached to this application). Failure to provide this information may result in underwriting being applied as per point 11 under Member Declaration (page 7).

Name of Scheme	Membership Number	Date Joined	Date Terminated

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, 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		

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		

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		

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		

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													
		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													
		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													
		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													
		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													
		YES	NO													

10. Dentistry? e.g. Specialised dentistry/maxillo-facial treatment (currently undergoing or anticipating any specialised/ orthodontic or maxillofacial 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													
		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													
		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 MHRS on 086 010 0608 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	Surgical Procedure/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 Program on 086 050 6080 for more information on how to join the Programme.

X SECTION E Mediphila only (Select GP from network)

Name of Beneficiary	Name of Doctor	Practice Number
1		
2		
3		
4		
5		
6		
7		
8		

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 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: _____ X

Principal Member Signature: _____ X

Date:

Y	Y	Y	Y	M	M	D	D
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