Thank you for your wise decision to join Resolution Health Medical Aid**.** Once accepted you will can be secure in the knowledge that you are a member of one of the finest medical aid schemes currently on offer. I can get you accepted in around 7 days. Cover begins the 1st of a month that is when your debit runs.

RESOLUTION PLAN

Page 1 – NAME and ID NUMBER

Page 2 - SECTION A and B - Your and dependent details. SIGN

Page 3 - SECTION C - Your contact details.

Page 3 - SECTION D - Any previous medical aid membership.

PLEASE GET CERTIFICATES FROM THE MEDICAL AIDS OR ATTACH AN AFFIDAVIT SHOWING MEDICAL AIDS AND DATES.

Page 3 - SECTION E - Select your plan and start date - SIGN

Page 4 - SECTION F - GP DETAILS (if any) (COMPLETE NOMINATION FOR FOUNDATION)

Page 4 - SECTION G - Medical question to answer YES or NO. Please give as much information as possible - use extra page if need be. (ESPECIALLY IF YOU ARE PREGNANT)
PLEASE ANSWER EVEN FOR COLDS AND FLU CONSULTATIONS!

Page 5/6 - SECTION G/H - Medical question to answer YES or NO.

Page 6/7 - SECTION I, J and K - Debit order details SIGN

Page 7 - SECTION L - DECLARATION SIGN and DATE

Page 8 - SECTION N - Intermediary details SIGN <u>ON RIGHT AS APPLICANT</u>

PLEASE NOTE - YOU MUST RETURN ALL PAGES OR THE APPLICATION CANNOT BE PROCESSED!
COPY OF EVERY PERSON'S ID - PROOF OF PAST MEDICAL AID MEMBERSHIP (if applicable)
FAX to 0866 688 122 or scan and email

I will process it and advise you of its progress.

Your admission pack (sent to you with membership confirmation) will provide all the details you will need.

If you have any queries, please call me.

PETER

Resolution Health Medical Scheme

2017 MEMBERSHIP APPLICATION FORM

Name & surname

X ID number

This application form must be received at the Scheme within one month following the date on which it was signed. Failure to do so will result in this application being null and void. Incomplete application forms will not be accepted.

FOR OFFICE USE ONLY

Member number

Group reference number

Region

Date of commencement

D D M M Y Y Y Y

Applicable option

- **Hospital**
- **Progressive Flex**
- **Progressive Flex Plus**
- **Millennium**
- **Millennium Select**
- **Supreme**
- **Foundation**

Income category

- Region EDO
- R0 - R4 600
- R4 601 - R7 100
- R7 101 – R9 700
- R9 701+

Underwriting decision:

Authorisation:

Name

Signature

Date:

D D M M Y Y Y Y

CATEGORY	A	B	C
COPY ☐	ORIGINAL ☐		
NO WAITING PERIOD	☐	☐	☐
3 MONTH WAITING PERIOD	☐	☐	☐
TWELVE MONTH WAITING PERIOD	☐	☐	☐
PMB PAYMENT YES ☐	NO ☐		
POST MEMBERSHIP GUIDE YES ☐	NO ☐		
LATE JOINER PENALTY	☐	☐	☐
MEMBERSHIP PACK TO UNDERWRITING			
Signature	Resolution Health Medical Scheme		

A. DETAILS OF APPLICANT (Note: Please complete all sections in **BLACK** and attach copy of SA ID document / Passport)

X Surname | Title

First name(s) *(in full)* | Initials

ID number | Date of birth D D M M Y Y Y Y | Gender M F

Race: Black | Coloured | White | Asian or Indian | Other

Passport number | Income Tax number

Employer name

Employee number | Branch

Occupation full details

Date of employment D D M M Y Y Y Y | Language

B. FAMILY MEMBERS TO BE INCLUDED (Note: Please attach copies of SA ID document / Passport:)

X 1) Dependant children or other members of immediate family in respect of whom the member is liable for care and support

	1	2
Dependant type	Spouse / Partner / Dependant 1	Dependant 2
Surname		
First name(s) *(in full)*		
Initials	Title / Gender M F	Title / Gender M F
ID number		
Passport number		
Email		
Contact No.		
Date of birth	D D M M Y Y Y Y / Age	D D M M Y Y Y Y / Age
Relationship to applicant	Married / Disabled / Full-time student	Married / Disabled / Full-time student
	Is your dependant financially dependent on you? Y N	Is your dependant financially dependent on you? Y N
	Does your dependant earn an income? Y N	Does your dependant earn an income? Y N
	If yes, what is the monthly income?	If yes, what is the monthly income?

	3	4
Dependant type	Spouse / Partner / Dependant 3	Spouse / Partner / Dependant 4
Surname		
First name(s) *(in full)*		
Initials	Title / Gender M F	Title / Gender M F
ID number		
Passport number		
Email		
Contact No.		
Date of birth	D D M M Y Y Y Y / Age	D D M M Y Y Y Y / Age
Relationship to applicant	Married / Disabled / Full-time student	Married / Disabled / Full-time student
	Is your dependant financially dependent on you? Y N	Is your dependant financially dependent on you? Y N
	Does your dependant earn an income? Y N	Does your dependant earn an income? Y N
	If yes, what is the monthly income?	If yes, what is the monthly income?

A dependant who is self-supporting (i.e. earning more than the maximum social pension) will have to enrol as a principal member.

C. CONTACT DETAILS

X Residential address | Postal address

Code | Code

Telephone (W) | Cell | Cell

Telephone (H) | Fax

Email address

SMS correspondence YES NO | Email statement YES NO | Email newsletter YES NO

D. DETAILS OF PREVIOUS MEMBERSHIP - APPLICANT

X **(Should membership certificates not be attached at time of submission, waiting periods may be imposed)**

Name of scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Name of scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Proof attached YES NO

Have you ever been declined, or had late joiner penalties, exclusions or waiting periods imposed by a medical scheme? YES NO

If yes please provide details: ___

DETAILS OF PREVIOUS MEMBERSHIP - SPOUSE / PARTNER

(Should membership certificates not be attached at time of submission, waiting periods may be imposed)

Name of scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Name of scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Proof attached YES NO

Have you ever been declined, or had late joiner penalties, exclusions or waiting periods imposed by a medical scheme? YES NO

If yes please provide details: ___

E. PLAN AND PRODUCT SELECTION (Please indicate with an X where applicable)

X Only complete this section if plan selection was not made at employer group level on the Employer Application form or if your employer has allowed you to override the group level selection.

☐ Hospital ☐ Progressive Flex ☐ Progressive Flex Plus ☐ Millennium ☐ Millennium Select ☐ Supreme

☐ Foundation

Income category ☐ Region EDO ☐ R0 - R4 600 ☐ R4 601 - R7 100 ☐ R7 101 – R9 700 ☐ R9 701+

Proof of income on the Foundation option is the combined household family income. Find attached to my application (please tick the appropriate box):

☐ Latest income tax return ☐ Commission / fee statement (submit 3 months statements)

☐ Latest salary advice ☐ Auditor / accountant's letter ☐ Bank statements (submit 3 months statements)

The following documents are mandatory for Pensioner Principal members:

- Bank Statement for the last 3 months (mandatory)
- Grinrod Bank Statement or the last 3 months (mandatory)
- Pension Fund Statement for the last 3 month (mandatory)
- Signed letter of undertaking (mandatory)
- Latest income tax returns if the member is not registered, a letter from SARS is required.

The following documents of mandatory for Adult dependents

- Bank Statement for the last 3 months (mandatory)
- Grinrod Bank Statement for the last 3 months (mandatory)
- Pension Fund Statement for the last 3 months (mandatory)
- Latest income for tax return. If the member is not registered a letter from SARS is required.

Should no proof of income be attached, you will be placed in the highest income bracket. Proof of income must be submitted annually before December each year. Members with registered Adult Dependants must complete the Household Income Verification form and submit proof of income as per the form's specifications.

REFERENCE & CREDIT BUREAU CONSENT

I/We hereby consent to you or your administrator/s making enquiries to my/our credit records and references with any credit reference agency or any third party to confirm the details provided. I confirm that this consent shall apply in every respect to every director, shareholder, member and/or associate of the applicant. I/We irrevocable authorise Resolution Health Medical Scheme or their administrator to obtain from any person any information that Resolution Health Medical Scheme requires to assess the information contained in this application.

Signed at ___ on this ___ day of ___ / ___

X SIGNATURE

Signature of Applicant

E. PLAN AND PRODUCT SELECTION (Continues)

Requested date of commencement of membership | D | D | M | M | Y | Y | Y | Y | NOTE: SUBJECT TO UNDERWRITING

Did your intermediary supply you with a Membership Guide? **YES** **NO**

If answered "no", please indicate to which address we should post a Member Guide: **Residential** **Postal**

F. DETAILS OF CURRENT MEDICAL PRACTITIONER

1

Name of principal member's doctor

Telephone | Date of first consult D D M M Y Y Y Y

2

Name of dependant/s' doctor

Telephone | Date of first consult D D M M Y Y Y Y

NOTE: Please ensure that above details are correct and completed in full as this may delay application and authorisation processes.

DETAILS FOR NOMINATION OF MEDICAL PRACTITIONER – FOUNDATION PLAN ONLY

Dependant type	1 Principal member	2 Spouse / Partner / Dependant 1
Name of practice or name and surname of doctor:		
Tel number:		
Practice number:		
Region:		
Suburb:		

Dependant type	3 Dependant 2	4 Dependant 3
Name of practice or name and surname of doctor:		
Tel number:		
Practice number:		
Region:		
Suburb:		

G. SPECIFIC HEALTH QUESTIONS

X State whether you or any of your dependants have ever suffered from, been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including, but not limited to:

1. Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia, clotting disorders	YES	NO
2. Cancer, growths, abscess or tumours of any kind, whether benign or malignant	YES	NO
3. Cardiovascular (heart and blood vessels) disorders e.g. congenital heart conditions, chest pain, coronary artery disease / ischaemic heart disease, high blood pressure, valvular disease, arrythmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever, shortness of breath, palpitations, angina, deep vein thrombosis, pulmonary embolism, atheorsclerosis lymphatics	YES	NO
4. Ear, nose and throat disorders e.g. hearing / speech impairment, ear infections, sinus problems, nasal / throat surgery, ear discharge, hoarseness, mouth disorders, tonsils, adenoids, grommets, previous nasal injuries, upper airway infections, cleft lip / palate, epistaxis, hayfever / rhinitis, blocked nose	YES	NO
5. Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities, sugar in urine, nutritional disorders, metabolic syndrome, hypo / hyperglycaemic coma	YES	NO
6. Eye related disorders e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts, lens implants, infections, refractive and laser surgery, short or far sightedness, pterygium	YES	NO
7. Gastro-intestinal disorders e.g. recurrent indigestion, heartburn, reflux, ulcers, bowel disorders, gallbladder disorders, liver disorders and pancreas disorders, hiatus hernia, piles, anal fissures, rectal bleeding, ulcerative colitis or have you or any of your dependants, ever had a gastroscopy or colonoscopy, spleen disorders, Crohn's disease	YES	NO
8a. Gynaecological and obstetrical disorders e.g. ectopic pregnancy, caesarean section, fibroids, endometriosis, menstrual irregularities, abnormal papsmear, receiving hormone treatment, vaginal bleeding, laparoscopic surgery, dilatation and curettage, miscarriages, pregnancy related problems, cysts, infertility, breast disorders	YES	NO

8b. Pregnancy - expected date of delivery D D M M Y Y Y Y	YES	NO
9. Male genitourinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system	YES	NO
10. Musculoskeletal disorders e.g. osteo-arthritis, rheumatoid arthritis, back problems, gout, osteoporosis, all joint problems e.g. knee, shoulder, bones, limbs, spine, fractures, carpel tunnel syndrome, bunion, spondylosis, hernia, kyphosis / scoliosis	YES	NO
11. Neurological disorders e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue, headache, migraine, polio, paralysis, Guillian-Barre, meningitis, Parkinson's disease, Alzheimer disease, dementia	YES	NO
12. Psychological disorders e.g. insomnia, anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit disorder, post traumatic stress, schizophrenia, bi-polar disorders, mood swings, attempted suicide, anorexia / bulimia nervosa	YES	NO
13. Renal (kidney) disorders e.g. blood in the urine, urinary tract stones, recurrent infections, kidney failure, bladder problems, dialysis, Addisons disease, nephritis	YES	NO
14. Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema or cigarette smoking related disorders, tuberculosis, persistent cough, allergies, chronic obstructive pulmonary disease, pneumoconiosis	YES	NO
15. Skin disorders e.g. eczema, psoriasis, melanoma, skin cancer, burns, acne, scars, keloids, growths, warts, ingrown toe nails	YES	NO
16. State whether you or any of your dependants, have received medical advice or treatment for any infectious and tropical disease e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitis, bilharzia, malaria, cholera	YES	NO
17. Do you or any of your dependants have any birth defects or hereditary disorders?	YES	NO
18. Have you or any of your dependants ever sought counselling or treatment for HIV or AIDS related infections or ever tested positive for HIV or AIDS?	YES	NO
19. Have you or any of your dependants ever been diagnosed and / or treated for an immune system problem?	YES	NO
20. Previous injuries and trauma including sports injuries?	YES	NO
21. Have you or any of your dependants ever been told to improve your adherence to medical treatment?	YES	NO
22. Have you ever required rehabilitation following an event i.e. stroke or motor vehicle accident?	YES	NO

If "yes" answered to any of the questions above, please supply full details below

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current condition

If the space provided is insufficient please complete addendum.

Addendum attached YES NO

SURGERY AND HOSPITAL ADMISSIONS

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

Applicant	Surgical procedure / Hospital admission	Date	Reason	Doctor	Current condition

CHRONIC MEDICATION

1. Please supply details of any chronic medication (prescribed medicines used continuously for more than 3(three) months) currently prescribed for you or any of your dependants.
2. Do you or any of your dependants expect chronic medication to be prescribed in the next 12 months? YES NO

   If so please supply details below.

Applicant	Prescribed medication	Medical condition	Date started / to be started

H. GENERAL HEALTH QUESTIONS

Question		
1. Do you or any of your dependants expect to receive any treatment in the next 12 months and do you or your dependants expect to be, or are currently, hospitalised?	YES	NO
2. Has any close blood relative (excluding dependants named in this application form) ever been diagnosed with heart disease, high blood pressure, high cholesterol, diabetes or any other hereditary disease?	YES	NO
3. Do you or any of your dependants have incomplete dental treatment plans, dental implants, orthodontic treatment, dentures, wisdom teeth problems or do you or currently receive, or expect to receive, dental treatment in the next 12 months?	YES	NO
4. Are you or any of your dependants currently involved in any third party or WCA claim that may include medical treatment? If so please provide below FULL details of injuries, surgery and investigative procedures for which claims will be, or have been, lodged.	YES	NO
5. Do you or any of your dependants smoke or receive medical advice to reduce the quantity of tobacco used? If so, specify whether cigarettes, cigars or a pipe is / were smoked and how many are / were smoked per day.	YES	NO
6. Do you or any of your dependants consume alcohol? If so, specify what type of alcohol and quantity consumed per week.	YES	NO
7. Have you or any of your dependants ever received medical advice, counselling or treatment to reduce alcohol consumption for alcohol abuse or alcoholism?	YES	NO
8. Do you or any of your dependants use stimulants, any illegal drug substances or have ever been treated for illegal drug substance abuse or addiction?	YES	NO
9. Investigations and / or specialised treatment (in and out of hospital) a. Are you or any of your dependants currently undergoing, or expect to undergo investigations for any medical condition and / or symptoms not yet diagnosed?	YES	NO
b. Are you or any of your dependants currently receiving or expect to receive specialised treatment (i.e. chemotherapy, radiotherapy, bone marrow transplant, mechanical ventilation, oxygen therapy, dialysis, psychotherapy or counselling)?	YES	NO
10. In the past 2 years, have you or any of your dependants had any x-rays, electrocardiogram or other examinations, including genetic testing or tumour markers, operations or hospitalisations?	YES	NO

If yes answered to any of the questions above, please supply full details below.

Question	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and consulting doctor's details)

If the space provided is insufficient, please attach additional information to this application.

HEIGHT AND WEIGHT

Applicant	Initials	Height cm	Weight kg
Spouse / Partner / Dependant 1	Initials	Height cm	Weight kg
Dependant 2	Initials	Height cm	Weight kg
Dependant 3	Initials	Height cm	Weight kg
Dependant 4	Initials	Height cm	Weight kg

N.B. Any misrepresentation or non-disclosure of medical material or factual information will render all benefits granted by the Scheme null and void. In addition, any payment made due to such actions will be recovered from the member by the Scheme.

I. PAYMENT METHOD

Payment Method: Debit order | Persal | Via employer

J. CONTRIBUTION COLLECTION DETAILS

K. CLAIM REIMBURSEMENT DETAILS

X Claim refunds can only be paid by direct credit to your bank account. All claims will be reimbursed at Scheme rate, unless otherwise indicated.

	J. Contribution collection	K. Claim reimbursement
Name of bank		
Account type	Cheque / Transmission / Savings	Cheque / Transmission / Savings
Name of account holder		
Account number		
Branch		
Branch code		

Monthly debit order: 1st | 5th

Resolution Health Medical Scheme ("the Scheme") is hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted, and similarly I authorise my bank to debit my account with amounts drawn against it by the Scheme.

I understand that the withdrawals hereby authorised will be processed by computer through a system known as Nedbank / Debit Order / Multidata and I also understand that the details of each withdrawal will be printed on my bank statement or on an accompanying voucher.

I agree to pay any bank charges relating to this, Nedbank / Debit Order / Multidata, instruction.

The authority may be cancelled by myself giving the Scheme / Agility Health (Pty) Ltd thirty (30) days notice in writing, sent by prepaid registered post, but I understand that I shall not be entitled to any refund of amounts which the Scheme has withdrawn while this authority was in force if such amounts were legally owning to the Scheme. Receipt of this instruction by the Scheme / Agility Africa (Pty) Ltd shall be regarded as receipt thereof by my bank.

I further agree to advise the Scheme / Agility Africa (Pty) Ltd in writing of any changes which may occur.

X **Signature of Account Holder** SIGNATURE

L. MEMBER ACKNOWLEDGEMENT AND DECLARATION

General

1. *I, the undersigned applicant:*

1.1 Hereby apply for myself and my dependants to be registered on the Resolution Medical Scheme ("the Scheme") and agree to abide by and undertake to familiarise myself with the Rules of the Scheme;

1.2 Warrant that 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 the state of health or change in personal status by myself or any of my dependants from the date of signing this application form and the date of inception of the membership, notification of such change will be provided to the Scheme immediately upon occurrence of the change, in writing with full details of such condition / ailment as soon as I become aware of the circumstances. Such notification is to include all available medical reports relating to any health conditions in order to enable the Scheme to investigate the circumstances causing and/or contributing to such change;

1.3 Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null and void and all contributions paid shall be forfeited;

1.4 Understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary, including the result of such medical examinations and tests that they may require me or my dependants to undertake;

1.5 Consent to the Scheme addressing any requests for information, tests or examinations directly to any dependants of mine over the age of 18, with the same legal consequences as if the request had been addressed to me in my capacity as a member;

1.6 Acknowledge that it is my responsibility as a member to ensure that claims are submitted within the 4 month submission period (Rule 15.2).

1.7 Acknowledge that it is my responsibility as a member to ensure that the monthly contribution is received by the Scheme in terms of the rules of the Scheme;

1.8 Acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any contribution is not paid on the due date; and

1.9 Undertake to inform the Scheme within One (1) calendar month should the situation regarding the dependency of any of my dependants change (Rule 7.2.1).

1.10 Am familiar with and have full knowledge of the irrefutable conditions and benefits of the option elected, notwithstanding misrepresentation by any other party;

1.11 That neither myself or my dependants are dependants of another medical scheme;

1.12 Hereby consent to all conversations between myself, the Scheme or any party being recorded;

1.13 Understand, acknowledge and accept that I may be contacted by the Scheme's panel of attorneys in order to verify the possibility of claims being recovered from third parties. I understand that I will not be liable for any costs herein and that any costs are deductable from the successful proceeds of any action.

1.14 Understand that by recovering from third parties I will contribute to the overall financial sustainability of the Scheme.

Authority

2. Accepting that I am curtailing my and my dependants right to privacy, but in order to facilitate the assessment of the risk and the consideration of any claim, I irrevocably authorise:

2.1 The Scheme / Panel of attorneys, whom I hereby so authorise and direct to give, any information which the Scheme deems necessary.

2.2 I further authorise and instruct the Scheme and any hospital concerned to give any information relating to myself and my dependants to the Medical Case Managers and/or Managed Care Organisation and their personnel appointed by the Scheme, for the purposes of ensuring that the members of the Scheme receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources. I also consent to the processing of the information herein for purposes of marketing of value added or similar products and services.

2.3 I understand and accept that the above authorisation constitutes a partial waiver of my and my dependants right to privacy.

3. *declare that:*

3.1 I am liable for his/her family care.

3.2 Dependant children or other members of immediate family in respect of whom the member is liable for care and support.

3.3 My dependant(s) is/are not in receipt of remuneration of more than the maximum social pension per month.

3.4 My dependant(s) is/are not a member(s) or dependant(s) of another medical scheme.

4. By their signature hereto any of my dependants who have reached or are over the age of 18 declare themselves bound to the above terms

Termination

4. On termination of my membership of the Scheme:

4.1 One (1) calendar month written notice (Rule 12.2.1)

Signed at ____________________ on this __________ day of ____________ / ________

X SIGNATURE

Signature of Applicant

M. INTERMEDIARY DECLARATION

1. *I, the undersigned hereby confirm that:*

1.1 The appointed intermediary is accredited at date of signing the application form

1.2 The appointed intermediary is licensed by the FSB in terms of the FAIS Act

1.3 The appointed intermediary has made his / her name, physical, postal address and contact number available

1.4 I am aware of commission payable by the Scheme on this transaction to the appointed intermediary

1.5 The appointed intermediary is contractually bound to the Scheme

1.6 There has been no material misrepresentation of facts by the appointed intermediary and that, in such an event, the appointed intermediary undertakes to refund all monies paid to the Scheme

1.7 I have been given all the relevant information with regards to the application information to the appointed intermediary

1.8 The advice given to me by the appointed intermediary was in my best interest and unprejudiced

N. INTERMEDIARY DETAILS

Name of Brokerage: Peter J Pyburn

Brokerage code: J 1 6 0 6 0 0

Address: P O B o x 1 0 6 8

F o u r w a y s Code: 2 0 5 5

Consultant / Agent sub-code:

Full name of consultant / agent:

Telephone number: 0 8 3 3 7 7 8 8 9 3

Email address: p e t e r @ p e t e r p y b u r n . c o . z a

Fax number: 01 8 6 6 6 8 8 1 2 2

Signature of Broker | Signature of Consultant | Signature of Applicant

O. SCHEME DECLARATION

1. *We hereby confirm that:*

1.1 The applicant and his / her dependant's personal and medical information (obtained from healthcare providers with applicant's consent) will be kept confidential

1.2 Both personal and medical information obtained will not be used or sold commercially

1.3 Data security measures are in place

1.4 Staff of RHMS as well as its contracted third parties are bound by confidentiality agreements

1.5 The Scheme and its contracted third parties use application information for the processing of the application, re-imbursement of claims to determine benefits and access levels of care in respect of managed healthcare principles

1.6 The Scheme's contractual agreements ensure the confidentiality of data management, Scheme administration and managed health care agreements

1.7 Should the Scheme assume responsibility for breach in confidentiality, the management thereof will be in accordance to Scheme rules and protocols

Signed at ______________________ on this __________ day of ____________ / __________

SIGNATURE

Signature on behalf of Scheme

WHAT TO EXPECT WITH YOUR APPLICATION:

Upon receipt of the application:

1. We capture and check your details
2. If any details are missing, you will be contacted in writing or telephonically
3. We will advise you or your intermediary in writing, SMS or via an E-mail to inform you of your acceptance to join Resolution Health Medical Scheme

This correspondence may contain certain conditions:

1. You sign these terms of acceptance to confirm that you accept any waiting period/s or late joiner penalties (if we apply any) and return it to us
2. You will receive a membership pack in the post
3. This will contain details about your plan selection to get you started

If you do not hear from us 7 (seven) days after submission, please contact your financial advisor or call us on 0861 796 6400.