

## APPLICATION FOR MEMBERSHIP

PM001

Benefit option  A Option A (Savings option)  B Option B

Joining date

### FOR OFFICE USE ONLY

Membership no

Broker code

Please use black or blue ink when completing this form. Where appropriate mark your selection with an x

### Use this checklist to ensure that you have submitted all required documentation:

- Main Members ID copy
- Dependants ID copy or birth certificate (if adding dependants)
- Payslip or income clearly indicated on the form
- Membership certificate from previous medical scheme, where applicable
- Proof of disability from a medical practitioner, where required (a medical assessment report completed by a medical practitioner)
- Affidavit(s), where required
- A marriage certificate, where applicable
- Legal documents if a child is adopted/ foster where required
- Proof of registration at a recognised tertiary institution, where required

### A. MEMBER DETAILS COMPLETE BLOCKS FROM LEFT TO RIGHT, ONE LETTER PER BLOCK

Title (Dr, Mr, Mrs or Miss)	<input type="text"/>	Initials	<input type="text"/>	Staff number	<input type="text"/>	
Name of employer	<input type="text"/>	Department / Directorate	<input type="text"/>			
Surname	<input type="text"/>					
First name(s)	<input type="text"/>					
Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	Identity/passport number	<input type="text"/>	
Marital status	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widow/er	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Postal address	<input type="text"/>					
Physical address	<input type="text"/>					
	<input type="text"/>				Postal code	<input type="text"/>
Telephone	(H) <input type="text"/>	<input type="text"/>	(W) <input type="text"/>	<input type="text"/>		
Fax	<input type="text"/>	<input type="text"/>	Cellphone	<input type="text"/>	<input type="text"/>	
E-mail address	<input type="text"/>					
Home language	<input type="text"/>					
Tax number	<input type="text"/>					

Please return this form to samwumednewapps@medscheme.co.za

## B. ORDINARY DEPENDANTS DETAILS *(When registering your wife, include her maiden surname.)*

If your dependants reside at a different address from the one provided in Section A, please include it below.

1. First name and surname  Identity number  Gender  M  F Relation

Physical address   
 Postal code

Telephone   Cellphone

Email

2. First name and surname  Identity number  Gender  M  F Relation

Physical address   
 Postal code

Telephone   Cellphone

Email

3. First name and surname  Identity number  Gender  M  F Relation

Physical address   
 Postal code

Telephone   Cellphone

Email

Member number

**Note: In order to register yourself and your dependant/s, please attach copies of the following supporting documents: identity documents, marriage certificate and/or birth certificates. Sworn affidavits are required for children born outside of marriage, life partners and/or cultural marriages.**

## C. MEDICAL HISTORY

**Please note: failure to disclose medical conditions could limit and/or exclude you from receiving certain benefits. If more than three members are affected by the same condition please attach the required information to this application form on a separate sheet.**

1. Have you or any of your dependants during the past 12 months, suffered from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression, anxiety, epilepsy, and/or thyroid disorders)?

YES	NO
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If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date/frequency of treatment	Attending doctor
			YES	NO		
			YES	NO		
			YES	NO		

2. Have you or any of your dependants during the past 12 months, suffered from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohns disease, ulcerative colitis, diverticulus and /or spastic colon)?  YES  NO

If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		

- Have you or any of your dependants during the past 12 months, suffered from muscle, bone, skin or nerve illness or disorders ( e.g. back-and-neck related conditions including injury, arthritis, gout, multiple sclerosis, knee and /or hip problems)?  YES  NO

If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		

4. Have you or any of your dependants during the past 12 months, suffered from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts and/or menstrual disorders)?  YES  NO

If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		

5. Have you or any of your dependants during the past 12 months, suffered from ear, nose or throat disorders (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis and/or orthodontics)?  YES  NO

If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		

6. Have you or any of your dependants during the past 12 months, suffered from any blood disorders, immune deficiency state, HIV/Aids, cancer and/or any other life threatening illness.  YES  NO

If yes, please provide details below.

***If you or any of your dependants are living with HIV/Aids, it would be in your best interest to register on SAMWUMED's HIV Management Programme immediately, upon approval of your membership. Should you or your dependants only find out at a later stage that you are HIV-positive, please let us know as soon as possible.***

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		

7. Are you or any of your dependants pregnant?

YES	NO
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Name of beneficiary	Expected delivery date	Attending doctor

8. Have you or any of your dependants had surgery in the past, or are you planning to have a surgical procedure done in the next 12 months?

YES	NO
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If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		

9. Is there any condition or symptoms other than those listed above, for which medical advice, diagnosis, care or treatment has been recommended or received or could potentially result in a claim in the next 12 months?

YES	NO
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If yes, please provide details below.

Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			YES	NO		

#### D. BANKING DETAILS

Name of bank

Branch  Branch code

Account in name of

Account number

Type of Account  Cheque  Savings  Transmission  Other (confirm) \_\_\_\_\_

#### E. FAMILY PRACTITIONER DETAILS

	Name	Family Practitioner (FP)	Practice number	Second FP name	Practice number
Main applicant					
Spouse/partner					
Dependant*					
Dependant*					
Dependant*					

Please make sure the dependant information supplied above is the same as the dependant information in Section B of this form. If you live far away from where you work or you often need to work in different towns or provinces, you may need a second FP. Please complete the relevant section if you need a second FP allocated to you.

## F. PREVIOUS MEDICAL SCHEME MEMBERSHIP

Please give details of other medical schemes you were a member of before this application.

1. Name of scheme	<input type="text"/>																											
Membership number	<input type="text"/>										From	<input type="text"/>				to	<input type="text"/>											
2. Name of scheme	<input type="text"/>																											
Membership number	<input type="text"/>										From	<input type="text"/>				to	<input type="text"/>											

**NOTE:** Please attach proof of membership for at least two years immediately before the date of this application. A membership certificate from the scheme(s) will suffice. A membership card is unacceptable for this purpose.

## G. MEMBER DECLARATION

- I, the undersigned, hereby make application to be admitted as a member of SAMWUMED (the Scheme) and if admitted, I agree to abide by the Rules of the Scheme.
- I understand that confirmation of acceptance of membership is subject to the approval by the Scheme.
- I declare that my answers and the information supplied by me in this application, whether in my own handwriting or not, are true, correct and complete.
- I understand that should this application contain any false statement or fail to disclose any material information, the Board of Trustees of the Scheme ("the Board") may, in terms of section 29(2)(e) of the Medical Schemes Act 131 of 1998, regard my membership of the Scheme void ab *initio* (as if it never commenced).
- I understand that should the Board terminate my membership on this basis, the following shall apply:
  - I will be liable for immediate repayment to the Scheme all benefits received by or on behalf of me; and
  - All or part of the contributions paid by me to the Scheme may be retained by the Scheme to offset any costs which the Scheme has incurred on my behalf;
  - All or part of the contributions paid by me to the Scheme may be retained by the Scheme to offset any costs which the Scheme has incurred on my behalf;
- I hereby authorise my employer to deduct, from my salary/wages, any amount(s) owed to SAMWUMED and remit such amounts to the Scheme on my behalf.
- I confirm that I am ultimately responsible for ensuring my contribution is received by the Scheme each month.
- I confirm that I understand and I am familiar with the benefits of the Option I have selected.
- Repaying money owed to the Scheme  
The Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you of any amount that you must pay to the Scheme.  
If the benefit option you chose offers a Medical Savings Account, the Scheme makes money available in advance for you to use for medical expenses during the year. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme during the specific year.  
You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number **SAMWUMED** will be used. When you agree that we may recover outstanding money due to the Scheme by debit order, by signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.
- I authorise my healthcare provider, or any other party who may be in possession of information, personal or otherwise, concerning me or my dependant/s health, to disclose such information to SAMWUMED which includes disclosure to the scheme's healthcare providers, the scheme's third-party service providers, administrator, managed healthcare providers and other business partners of the scheme - provided that such information shall be kept confidential and at all times conform with SAMWUMED's policy on Access to Information and Protection of Personal Information. Such confidential health and personal information will only be used for purposes as outlined in this form.
- I undertake to notify the Scheme in accordance with the Rules of the Scheme should I wish to terminate my membership.
- I consent to the recording of all conversations between myself and the Scheme or its contracted business partners.

Applicants signature \_\_\_\_\_ Date of application

Please select the racial category (Race) with which you most closely identify, by placing an "X" in the appropriate box.

Black  White  Coloured  Asian

Please indicate how you wish the Scheme to communicate with you:  SMS  Email  Post

**Please submit this application to your HR for approval before sending to the Scheme.**

**H. SCHEME DECLARATION**

SAMWUMED confirms that all health or personal information concerning the applicant and his or her dependant/s will be kept confidential and will only be used in execution of the scheme, and its official business partners' business.

SAMWUMED has a formal Access to Information and Protection of Personal Information Policy, which is available on the scheme's website at WWW.SAMWUMED.ORG.

SAMWUMED confirms that the Applicant has consented to the processing of his/her and his/her dependants' personal and health information for purposes of this application and the scheme and its business partners' official business. The Applicant is referred to his/her consent in paragraph E. above.

The Scheme will endeavour to obtain further consent from the applicant should confidential health and personal information be used for purposes other than those outlined in this application.

**I. EMPLOYER NAME AND POSTAL ADDRESS OF DEPARTMENT RESPONSIBLE FOR PAYMENT OF CONTRIBUTIONS**

Name of employer

Province  Department / Directorate

Applicants occupation  Branch

Employment date  Staff number

Postal address

Postal code

Telephone (work)  Fax (work)

Monthly Gross income R  ,  .

Name of official  Position

E-mail address

Signature \_\_\_\_\_ Date



Member number

**Note: Please return this form to [samwumednewapps@medscheme.co.za](mailto:samwumednewapps@medscheme.co.za)**

## J. SCHEME REPRESENTATIVE DECLARATION

The Scheme Representative acknowledges that they have been appointed by the applicant and that the applicant can cancel their services at any time.

The Scheme Representative has a valid contract and/or is employed by the Scheme.

The Scheme Representative is duly accredited by both the Council for Medical Schemes and the Financial Services Conduct Authority to provide this service to the applicant.

The Scheme Representative is remunerated by the Scheme as provided for by the Medical Schemes Act, 31 of 1998, and its Regulations.

The Scheme Representative confirms that there has been no misrepresentation of fact. Should there be misrepresentation or unlawful conduct, the representative undertakes to refund all monies paid as a consequence of such misconduct.

In the event of misrepresentation or any other unlawful or unprofessional conduct by the Scheme Representative, the Scheme Representative acknowledges that he/she will be open disciplinary procedures by both SAMWUMED, the Council for Medical Schemes and the Financial Services Conduct Authority to criminal prosecution where applicable.

Name of Scheme Representative	<input type="text"/>		
Scheme Representative code	<input type="text"/>		
Telephone	<input type="text"/>	Fax	<input type="text"/>
E-mail address	<input type="text"/>		

Signature \_\_\_\_\_

Date

**1.1. The purposes for which your Personal and Health Information will be processed, collected and stored by the Scheme (SAMWUMED), administrator, managed healthcare organization and contracted third parties are as follows:**

- 1.1.1. Assessing the risk to be covered by the Scheme.
- 1.1.2. To verify the accuracy, correctness, completeness of any information provided (or not) to the Scheme in the course of processing an application for membership or a benefit for processing a claim.
- 1.1.3. The performance of administration services and relevant managed healthcare services and the enforcement of related contractual rights and obligations flowing from your membership.
- 1.1.4. To facilitate the recovery of third-party liability claims from third parties for any possible past and future claims for damages, and for all treatments paid for by the Scheme on behalf of a guilty third party.
- 1.1.5. To enable you to access and use the website and mobile application, including the regular development on the website and mobile application, marketing of Scheme products and to activate and pre populate the website and mobile application.
- 1.1.6. Collect from and store all Personal and Health Information relating to your diagnosis, treatment and care at any healthcare establishment or facility and by any healthcare service provider.
- 1.1.7. The prevention and risk management initiatives of the Scheme were established to deal with fraud, waste, and abuse of your healthcare benefit in accordance with your option.
- 1.1.8. The Scheme has endeavored to ensure that reasonable measures are taken as it pertains to the storage of your personal and healthcare information, as well as information in transit, and that it complies with all statutory requirements and internal Privacy and Data Protection Policies.
- 1.1.9. The Scheme's PAIA Manual, Customer Privacy Notice and the POPIA Policy are available on the Scheme's website for members to access alternatively members can request same at the Scheme head office.
- 1.1.10. The PAIA Manual is an important document for members to be aware of as members will require this manual in order to provide us with consent to provide them with their records.