SAMWUMED

Real Heritage. Real People. Real Health Care.

c/o Trematon & Lascelles Streets, Athlone.
P O Box 134, Athlone, Cape Town 7760
Tel: 0860 104 117 Email: samwumedmemberupdates@medscheme.co.za Website: www.samwumed.org WhatsApp: 060 019 3547

APPLICATION TO REGISTER DEPENDANTS PM002

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

A. PERSONAL PARTICULARS – COMPLETE BLOCKS FROM LEFT TO RIGHT, ONE LETTER PER BLOCK

Title (Dr, Mr, Mrs or Miss) Initials Membership number

Surname

First name(s)

Date of birth D D M M Y Y Y Y Identity/passport number

Cellphone (W)

Email address

Postal address

Physical address

Postal code Staff Number

Province Municipality

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widow/er Gender M F

Tax number

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.

First name and surname Identity number Gender Relation

1. M F

Physical address

Postal code

Telephone Cellphone

Email

First name and surname Identity number Gender Relation

2. M F

Physical address

Postal code

Telephone Cellphone

Email

First name and surname Identity number Gender Relation

3. M F

Physical address

Postal code

Telephone Cellphone

Email

Member number

Please return this form to **samwumedmemberupdates@medscheme.co.za**

Continued overleaf ▸

B. DEPENDANT DETAILS – CONTINUED

4.
First name and surname | Identity number | Gender M F | Relation

Physical address

Postal code

Telephone | Cellphone

5.
First name and surname | Identity number | Gender M F | Relation

Physical address

Postal code

Telephone | Cellphone

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. SPECIAL DEPENDANTS

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

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.

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D. 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. Has your dependant/s 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

   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. Has your dependant/s 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		
			YES	NO		
			YES	NO		

3. Has your dependant/s 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		
			YES	NO		
			YES	NO		

4. Has your dependant/s 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		
			YES	NO		
			YES	NO		

5. Has your dependant/s 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		
			YES	NO		
			YES	NO		

6. Has your dependant/s 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		
			YES	NO		
			YES	NO		

7. Is your dependant/s pregnant?

YES	NO

Name of beneficiary	Expected delivery date	Attending doctor

8. Has your dependant/s had surgery in the past, or are you planning to have a surgical procedure done in the next 12 months?

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		
			YES	NO		
			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

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		
			YES	NO		
			YES	NO		

E. BANKING DETAILS

Name of bank

Branch Branch code

Account in name of

Account number

Type of Account ☐ Cheque ☐ Savings ☐ Transmission ☐ Other (confirm) _____

I hereby authorise SAMWUMED to debit my bank account by no later than the last day of each month with the amount payable for the respective month. I authorise the debit of all amounts due including any arrears amounts due.

I authorise SAMWUMED to periodically adjust this deduction by any % increase as approved by the Board of Trustees. I understand that the debit hereby authorised will be reflected on my bank statement or on an accompanying voucher. I agree to pay any bank charges relating to this debit order instruction including any charges incurred as a result of this debit order being dishonoured by my Bank.

I can revoke this debit order by giving SAMWUMED thirty day's notice in writing. All payments received in terms of this authorisation will be accepted by SAMWUMED without prejudice to its rights.

F. 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 or C 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.

G. PREVIOUS MEDICAL SCHEME MEMBERSHIP

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

1. Name of scheme

Membership number From D D M M Y Y Y Y to D D M M Y Y Y

2. Name of scheme

Membership number From D D M M Y Y Y Y to D D M M Y Y Y

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.

H. MEMBER DECLARATION

1. 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.
2. I understand that confirmation of acceptance of membership is subject to the approval by the Scheme.
3. 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.
4. 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).
5. I understand that should the Board terminate my membership on this basis, the following shall apply:
   (a) I will be liable for immediate repayment to the Scheme all benefits received by or on behalf of me; and
   (b) 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;
   (c) 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;
6. 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.
7. I confirm that I am ultimately responsible for ensuring my contribution is received by the Scheme each month.
8. I confirm that I understand and I am familiar with the benefits of the Option I have selected.
9. 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.
10. 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.
11. I undertake to notify the Scheme in accordance with the Rules of the Scheme should I wish to terminate my membership.
12. I consent to the recording of all conversations between myself and the Scheme or its contracted business partners.

Applicant's signature _____ Date of application D D M M Y Y Y Y

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

Please return this form to **samwumedmemberupdates@medscheme.co.za**

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I. 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 F. 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.

Member number ☐☐☐☐☐☐☐☐☐☐☐☐☐

EMPLOYER'S OFFICIAL STAMP

01/11 L2629

J. POPIA Clause

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.

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