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: samwumednewapps@medscheme.co.za Website: www.samwumed.org WhatsApp: 060 019 3547

APPLICATION FOR MEMBERSHIP

PM001

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

Joining date

FOR OFFICE USE ONLY

Membership no

Broker code

Please use black or blue ink when completing this form. Write in clear block letters in the spaces provided. Where appropriate, mark your selection with an X.

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

- ☐ Main Member's ID copy
- ☐ Dependant's ID copy or birth certificate or, preferably, ID copy or birth certificate for each dependant
- ☐ 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 or in foster care, where required
- ☐ Proof of registration at a recognised tertiary institution, where required

Special Dependant Checklist

- ☐ ID (if over 18 years)
- ☐ Birth certificate
- ☐ Adoption papers (for adopted children)
- ☐ Common-law spouse affidavit
- ☐ Proof of study at a recognised tertiary institution (if younger than 28 years)

Please return this form to samwumednewapps@medscheme.co.za or upload a scanned PDF copy of this form together with required documentation by using the Application Form Upload Tool, located at: https://forms.samwumed.org/form/application-form-upload-tool or by scanning the QR Code below:

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

Title (Dr, Mr, Mrs or Miss) | Initials | Staff number

Surname

First name(s)

Date of birth | Identity/passport number

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widow/er | Gender

Postal address

Physical address

Postal code

PAXI address
(Your nearest PEP Store)

Telephone (H) | (W)

Fax | Cellphone

E-mail address

Home language

Tax number

B 1. ORDINARY DEPENDANTS' DETAILS *(i.e. spouse, biological and legally adopted child/children, etc.)*

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.

Physical address

Postal code

Telephone | Cellphone

Email

First name and surname | Identity number | Gender | Relation

2.

Physical address

Postal code

Telephone | Cellphone

Email

First name and surname | Identity number | Gender | Relation

3.

Physical address

Postal code

Telephone | Cellphone

Email

Continued overleaf ▸

First name and surname | Identity number | Gender | Relation

4.

Physical address

Postal code

Telephone | Cellphone

Email

First name and surname | Identity number | Gender | Relation

5.

Physical address

Postal code

Telephone | Cellphone

Email

First name and surname | Identity number | Gender | Relation

6.

Physical address

Postal code

Telephone | Cellphone

Email

B 2. SPECIAL DEPENDANTS' DETAILS *(Nieces, Siblings, mother-in-law, father-in-law, grandparents.)*

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.

Physical address

Postal code

Telephone | Cellphone

Email

First name and surname | Identity number | Gender | Relation

2.

Physical address

Postal code

Telephone | Cellphone

Email

First name and surname | Identity number | Gender | Relation

3.

Physical address

Postal code

Telephone | Cellphone

Email

Continued overleaf ▸

First name and surname | Identity number | Gender | Relation

4.

Physical address

Postal code

Telephone | Cellphone

Email

First name and surname | Identity number | Gender | Relation

5.

Physical address

Postal code

Telephone | Cellphone

Email

B 3. SPECIAL DEPENDANT DECLARATION - SECTION 3

I, _____
(full name of Main Member)

holder of Identity Number _____

and Membership Number _____,

hereby declare and confirm that:

I apply for the registration of _____
(full name of proposed dependant)

Identity Number/Date of Birth: _____

as a special dependant on my SAMWUMED membership.

The proposed dependant is my:

Parent

Parent-in-law

Grandchild

The proposed dependant is financially dependent on me for support, and I confirm that the dependency is bona fide.

Where the proposed dependant is my grandchild, I confirm that the proposed dependant is not a member of, or registered as a dependant of a member of, any other medical scheme.

I acknowledge that I am liable for the full contribution payable in respect of the proposed dependant in accordance with the Rules of the Scheme.

I confirm that the information provided in this declaration and all supporting documentation submitted in connection with the application is true, accurate and complete.

I acknowledge and agree that SAMWUMED may require an affidavit and/or other evidence for purposes of assessing and verifying the proposed dependant's eligibility for registration and the bona fide nature of the financial dependency.

I acknowledge that the Scheme reserves the right to review the dependant's eligibility category annually and may request updated information or supporting documentation for this purpose.

I acknowledge that any false, misleading, inaccurate or incomplete information may result in the rejection of the application, the termination of the dependant's registration, the recovery of any benefits or amounts incorrectly paid, and/or such further action as may be permitted in terms of the Rules of the Scheme and applicable legislation.

I make this declaration voluntarily and confirm that I understand its contents.

Signed at: _____

On this: _____ day of _____ 20_____

Signature of Main Member: _____

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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

   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		
			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, Crohn's disease, ulcerative colitis, diverticulitis 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/frequency of treatment	Attending doctor
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		

3. 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/frequency of treatment	Attending doctor
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		

Continued overleaf ▸

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/frequency of treatment	Attending doctor
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			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/frequency of treatment	Attending doctor
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			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 by calling 0860 100 646/email: afa@afadm.co.za

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		
			YES	NO		
			YES	NO		
			YES	NO		

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C. MEDICAL HISTORY (continued)

7. Are you or any of your dependants pregnant? YES | NO

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		
			YES	NO		
			YES	NO		
			YES	NO		

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

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		
			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/frequency of treatment	Attending doctor
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			YES	NO		
			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) _____

Continued overleaf

E. GENERAL PRACTITIONER (GP) DETAILS

	Member Name	First GP Name	Practice Number	Second GP name	Practice Number
Main applicant					
Spouse/partner					
Dependant 1					
Dependant 2					
Dependant 3					

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 GP. Please complete the relevant section if you need a second GP 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

Membership number From to

2. Name of scheme

Membership number From to

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

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). Before the Scheme makes a final decision where information supplied in this application is believed to be false, incomplete or misleading, the affected applicant or member will be given a reasonable opportunity to respond.

   The applicant or member will be informed of the Scheme's internal complaints and dispute resolution process. If the matter remains unresolved after the Scheme's internal process has been followed, the member may refer the complaint or dispute to the Council for Medical Schemes.

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;
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.

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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/dependants' health information 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. The Scheme may record conversations with members for record-keeping and related Scheme purposes. Recordings will be kept in accordance with applicable law and the Scheme's approved record-retention requirements. Access to recordings will be limited to authorised employees and service providers who require access to perform their duties and to other people where access is required or permitted by law. A member may request access to a recording containing their personal information in accordance with POPIA, PAIA and the Scheme's access to information process
13. The Scheme will keep personal information for as long as it is required for the purpose for which it was collected, or for any period required or permitted by applicable law and the Scheme's approved record-retention requirements. Personal information may continue to be kept after a member leaves the Scheme where this is necessary to meet the Scheme's legal, regulatory and record-keeping obligations. Once the applicable retention period has ended, the information will be securely destroyed, deleted or de-identified, unless its continued retention is required or permitted by law.
14. I hereby authorise and consent for my employer's Human Resources department and/or payroll administrator to disclose and share my personal information with SAMWUMED and, where applicable, other medical schemes for purposes of processing, administering, verifying, and maintaining my medical scheme membership and related employee benefits. Such information may include, but is not limited to: my membership certificate, employee number, payroll information, remuneration details, tax number, contact details and any other information reasonably required for the administration of my medical scheme membership.
15. I acknowledge and consent that my employer's HR department may provide the aforementioned information to SAMWUMED for the purposes of membership registration, contribution administration, verification of eligibility, claims-related administration where applicable and compliance with legal and regulatory requirements. I further understand that such information will be processed in accordance with applicable data protection and privacy laws.

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

1. 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, the Scheme and its official business partners in conducting their business.
2. 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.
3. 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 G. above.
4. 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.

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

Name of employer			
Province		Department / Directorate	
Applicant's 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

EMPLOYER'S OFFICIAL STAMP

Please return this form to samwumednewapps@medscheme.co.za or upload a scanned PDF copy of this form together with required documentation by using the Application Form Upload Tool, located at: https://forms.samwumed.org/form/application-form-upload-tool or by scanning the QR Code below:

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J. SCHEME REPRESENTATIVE DECLARATION

1. The Scheme Representative acknowledges that they have been appointed by the applicant and that the applicant can cancel their services at any time.
2. The Scheme Representative has a valid contract and/or is employed by the Scheme.
3. 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.
4. The Scheme Representative is remunerated by the Scheme as provided for by the Medical Schemes Act 131 of 1998, and its Regulations.
5. 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.
6. 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 subject to disciplinary procedures by SAMWUMED and/ or the relavant regulatory authority, and to criminal prosecution where applicable.
7. The Scheme Representative acknowledges that any unlawful, fraudulent or unprofessional conduct may be reported to the relevant law enforcement authorities and may result in criminal prosecution, where applicable.

Name of Scheme Representative	
Scheme Representative code	
Telephone	Fax
E-mail address	

Signature _____ Date

K. 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 and 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. To perform 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 Scheme's website and mobile application platform, including the regular development of the website and mobile application, for marketing of Scheme products and to activate and pre-populate the website, and mobile application or other Scheme communication platform.

1.1.6. To 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. To undertake the prevention and risk management initiatives of the Scheme which have been established to deal with fraud, waste, and abuse of your healthcare benefit in accordance with your option.

1.2 The Scheme has endeavoured to ensure that reasonable measures are taken in respect 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.

1.3 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.

1.4 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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