SAMWUMED

Real Heritage. Real People. Real Health Care.

c/o Trematon & Lascelles Streets, Athlone PO Box 134, Athlone 7760
Tel: 021 697 9000 Email: newapps@samwumed.org Website: www.samwumed.org

APPLICATION FOR MEMBERSHIP PM001

Benefit option [A] Option A [B] Option B

Joining date [D][D][M][M][Y][Y][Y][Y]

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

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

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

Name of employer Department / Directorate

Surname

First name(s)

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

Marital status [ ] Married [ ] Single [ ] Divorced [ ] Widow/er Gender [M] [F]

Postal address

Physical address

Postal code

Telephone (H) (W)

Fax Cellphone

E-mail address

Home language

Tax number

B. DEPENDANT DETAILS

	First name and surname	Identity number	Gender	Relation
1.			M F	
2.			M F	
3.			M F	
4.			M F	
5.			M F	
6.			M F	

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.

Please return this form to **newapps@samwumed.org**

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. Do you or any of your dependants suffer 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. Do you or any of your dependants suffer 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. Do you or any of your dependants suffer from muscle, bone, skin or nerve illnesses 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. Do you or any of your dependants suffer 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. Do you or any of your dependants suffer 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		

Continued overleaf ▸

C. MEDICAL HISTORY CONTINUED

6. Do you or any of your dependants suffer 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 SAMWUMEDs 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. Are you or any of your dependants pregnant? YES NO

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

   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		

CURRENT DOCTOR

Name and surname

Telephone number

How many months/years has he or she been your doctor?

Please return this form to **newapps@samwumed.org**

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D. 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 Y

2. Name of scheme

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

E . 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. 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.
10. I undertake to notify the Scheme in accordance with the Rules of the Scheme should I wish to terminate my membership.
11. I consent to the recording of all conversations between myself and the Scheme or its contracted business partners.

Applicants signature _____ Date of application D D M M Y Y Y Y

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.

Please return this form to **newapps@samwumed.org**

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F. 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.

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

Name of employer

Province

Department / Directorate

Applicants occupation

Branch

Employment date D D M M Y Y Y Y

Staff number

Postal address

Postal code

Telephone (work)

Fax (work)

Monthly Gross income **R** , .

Name of official

Position

E-mail address

Signature_____ Date D D M M Y Y Y Y

EMPLOYERS OFFICIAL STAMP

Member number

Note: Please return this form to newapps@samwumed.org

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H. SALES AND SERVICING REPRESENTATIVE DECLARATION

The Sales and Servicing representative acknowledges that they have been appointed by the applicant and that the applicant can cancel their services at any time.

The Sales and Servicing representative has a valid contract and/or is employed by the Scheme.

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

The Sales and Servicing 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 Sales and Services Representative, the Sales and Services 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 Sales and Servicing Representative

Sales and Servicing Representative code

Telephone

Fax

E-mail address

Signature _____

Date D D M M Y Y Y Y

I. 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

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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.