

FREEDOM OF ASSOCIATION APPLICATION

PM022

Benefit option A Option A 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) Initials Staff number

Name of employer Department / Directorate

Surname

First name(s)

Date of birth Identity/passport number

Marital status Married Single Divorced Widow/er Gender M F

Please select the racial category (Race) with which you most clearly identify Black White Coloured Asian

Postal Address

Postal code

Physical Address

Postal code

Telephone (H) (W)

Fax Cellphone

E-mail address

Home language

Tax number

Please Indicate how you wish the scheme to communicate with you SMS Email Post

Please return this form to newapps@samwumed.org

B. DEPENDANT DETAILS

	First name and surname	Identity number	Gender	Relation
1.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>

Member number

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

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

Name of employer	<input type="text"/>		
Province	<input type="text"/>	Department / Directorate	<input type="text"/>
Applicant's occupation	<input type="text"/>	Depot/Office	<input type="text"/>
Employment date	<input type="text"/>	Staff number	<input type="text"/>
Postal address	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Telephone (work)	<input type="text"/>	Fax (work)	<input type="text"/>
Monthly Gross income	R <input type="text"/>		
Name of official	<input type="text"/>	Position	<input type="text"/>
E-mail address	<input type="text"/>		

Signature _____ Date

EMPLOYER'S OFFICIAL STAMP

D. 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 confirm that I understand and I am familiar with the benefits of the Option I have selected.
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
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Please submit this application to your HR for approval before sending to the Scheme.

E. 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.

E. 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	<input type="text"/>		
Sales and Servicing Representative code	<input type="text"/>		
Telephone	<input type="text"/>	Fax	<input type="text"/>
E-mail address	<input type="text"/>		

Signature _____

Date