SAMWUMED

Real **Heritage.** Real **People.** Real **Health Care.**

c/o Trematon & Lascelles Streets, Athlone PO Box 134, Athlone 7760
Tel: 021 697 9500 Fax: 021 696 3505 Email: info@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

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

Postal code

Telephone (H) (W)

Fax Cellphone

E-mail address

Home language

Tax number

B. DEPENDANT DETAILS

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

First name and surname Identity number Gender Relation

2. [M] [F]

Physical address

Postal code

Telephone Cellphone

Member number

Continued overleaf ▸

B. DEPENDANT DETAILS – CONTINUED

First name and surname | Identity number | Gender | Relation

3. M F

Physical address

Postal code

Telephone | Cellphone

First name and surname | Identity number | Gender | Relation

4. M F

Physical address

Postal code

Telephone | Cellphone

First name and surname | Identity number | Gender | Relation

5. M F

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. 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 experienced, sought or obtained advice, treatment or counselling in respect of any 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. Have you or any of your dependants experienced, sought or obtained advice, treatment or counselling in respect of any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's 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		

Member number

C. MEDICAL HISTORY – CONTINUED

3. Have you or any of your dependants experienced, sought or obtained advice, treatment or counselling in respect of 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. Have you or any of your dependants experienced, sought or obtained advice, treatment or counselling in respect of 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. Have you or any of your dependants experienced, sought or obtained advice, treatment or counselling in respect of 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. Have you or any of your dependants experienced, sought or obtained advice, treatment or counselling in respect of 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. Are you or any of your dependants pregnant? YES NO

Name of beneficiary	Expected delivery date	Attending doctor

Member number | | | | | | | | | | | | | |

C. MEDICAL HISTORY – CONTINUED

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?

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. BANKING DETAILS

If you prefer your refund to be paid directly into your account, please complete this section. You are urged to use this facility to ensure the speedy receipt of any refunds due to you and to prevent loss of cheques through the post. Credit card accounts do not qualify.

Name of bank

Branch Branch code

Account in name of

Account number

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

NOTE: For a cheque account, please attach a cancelled or photostat copy of a cancelled cheque.

Member number

Continued overleaf ►

F. 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. I understand that confirmation of acceptance of membership is subject to the approval by the Scheme.
(2) 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.
(3) 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:
    (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) The Rules of the Scheme will not be applicable to me and I will have no right of recourse against the Scheme in terms the Rules.
(4) 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.
(5) I confirm that I understand and am familiar with the benefits of the Option I have selected.
(6) I authorise my healthcare provider or any other party who may be in possession of information concerning my or my dependant/s health to disclose such information to SAMWUMED and its business partners, provided that such information shall be kept confidential at all times. Such confidential health and personal information will only be used for purposes as outlined in this form.
(7) I undertake to inform the Scheme within 30 days of any changes in my or my dependant/s health or personal status as required by the Scheme Rules.
(8) I undertake to notify the Scheme in accordance with the Rules of the Scheme should I wish to terminate my membership.
(9) 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.

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

Please post this completed application form with copies of supporting documents to SAMWUMED, Premium Management Department, PO Box 134, Athlone 7760.

Name of employer

Province | Department

Applicant's occupation | Depot/Office

Name of employer

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

EMPLOYER'S OFFICIAL STAMP

Member number

Continued overleaf ▸

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 request the applicant's signed consent for the transfer and disclosure of health and personal information.

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. 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 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.

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