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commed
COMMUNITY MEDICAL AID SCHEME

PLEASE COMPLETE THE MEMBERSHIP APPLICATION FORM IN BLACK PEN, IN FULL AND PLEASE PRINT IN BLOCK LETTERS.
PLEASE MARK WITH AN X WHERE NECESSARY.

GROUP ☐ INDIVIDUAL ☐ BENEFIT OPTION: DE LUXE ☐ STANDARD ☐ FUNDAMENTAL ☐

If you choose Fundamental, please note: Doctor and Hospital Network (this means you may obtain treatment from a specific doctor or hospital). All beneficiaries must provide details of their provider of choice with whom they will register.

FOR OFFICE USE ONLY — SECTION A

Membership Number	Date of Application	Company Code	Inception Date/ Date of Admission	Subscription Code

MAIN APPLICANT DETAILS

Title (Mr, Ms, Mrs, Dr) ____ Male ☐ Female ☐

Surname ____

First Names ____

ID/Passport Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Country of Issue ____

E-Mail Address ____

Contact Numbers
Home ( ) ____ Work ( ) ____
Cell ( ) ____ Fax ( ) ____

Preferred Physical Address ____
____ Code ____

Postal Address
(Proof of address required) ____
____ Code ____

Marital Status
Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐

Date of Birth ____

If you have chosen Fundamental option: Doctor's Name & Surname ____

Doctor's Practice Number ____

Preferred way of communication:
Phone ☐
E-Mail ☐
SMS ☐
Pensioner ☐
Unemployed ☐

Income Tax No. (If applicable) ____

EMPLOYER DETAILS

Current Employer ____ Employee Number ____

Period of Employment ____ Occupation ____

Gross Monthly Income ____

NB. PLEASE ATTACH PROOF OF INCOME OR PENSION / AFFIDAVIT OF UNEMPLOYMENT

Physical Address ____
____ Code ____

Postal Address ____
____ Code ____

Company/Employer Stamp

Telephone Number ( )

Manager Responsible ____

Previous Employment ____

Period of Employment ____

Manager Signature _____

Initial _____

PARTNER / SPOUSE DETAILS (applicable when applying for cover)

Surname

First Names

ID/Passport Number

Country of Issue

E-Mail Address

Contact Numbers Home ( ) Work ( )

Cell ( ) Fax ( )

Preferred Physical Address

Code

Postal Address

Code

Male Female

DOB (yyyy/mm/dd)

If you have chosen Fundamental option:
Doctor's Name & Surname

Doctor's Practice Number

Preferred way of communication:

Phone
E-Mail
SMS

Pensioner
Unemployed

DEPENDANTS DETAILS (applicable when applying for cover)

	Dependant 1	Dependant 2	Dependant 3
Initials			
Name			
Surname			
Date of Birth yyyy/mm/dd			
Relationship to Main Member			
ID Number			
Gender			
Tel No.			
Cell No.			
Postal Address			
E-Mail			
If you have chosen Fundamental option:			
Doctor's Name & Surname		Doctor's Practice Number	

	Dependant 4	Dependant 5
Initials		
Name		
Surname		
Date of Birth yyyy/mm/dd		
Relationship to Main Member		
ID Number		
Gender		
Tel No.		
Cell No.		
Postal Address		
E-Mail		
If you have chosen Fundamental option:		
Doctor's Name & Surname		
Doctor's Practice Number		

IMPORTANT NOTICE

Please attach certified copies of legal documents (Birth, adoption, foster care certificate and other relevant documents)
Where the dependant is over the age of 21 years and has mental or physical impairments, please attach a medical report.
Where the dependant is a common-law wife/husband/ partner, please attach an affidavit to that effect.
Where the dependant is a full-time student, please attach proof of registration from the relevant learning institution.
No person may be enrolled with different medical schemes simultaneously.
Proof of legal liability is required for family care & support for dependant.

Initial _____

DETAILS REQUIRED IF APPLICANT BELONGED TO ANOTHER MEDICAL SCHEME

Name of Scheme 1 _____ Member Number _____

Membership Period _____ to _____

Name of Scheme 2 _____ Member Number _____

Membership Period _____ to _____

Have you contributed to a savings account on your previous medical aid? Y N

Have you ever been a COMMED member? Y N

If so, please state membership number _____

CERTIFICATE OF RESIGNATION FROM PREVIOUS SCHEME IS REQUIRED. Date of Application

_____

CERTIFICATE OF MEMBERSHIP FROM PREVIOUS SCHEME IS REQUIRED.
NB. MEMBERSHIP CARDS NOT ACCEPTABLE. Signature _____

SECTION B

MEDICAL HISTORY QUESTIONNAIRE

It is most important that the questions on the following be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit. Please advise whether you or any of your dependants suffer from, or have suffered from, or received treatment/consultation for any of the following conditions. Please ensure that you underline the appropriate condition, tick and complete the appropriate block/s.

		Yes	No	Member/Dependant
1	Any disorder of the heart e.g. Rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?			
2	High blood pressure, chronic headaches or disease of the blood vessels including cholesterol or circulatory disorder?			
3	Any respiratory or lung trouble, e.g. Asthma, bronchitis, persistent cough, tuberculosis?			
4	Any disorder of the digestive system, gall bladder or liver e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?			
5	Disease or disorder of the kidneys, bladder or reproductive organs, e.g. Albumin in urine, stones, prostates or infertility?			
6	Any nervous or mental complaint, e.g. Epilepsy, black-outs, paralysis, anxiety state of depression, alcoholism or narcotism?			
7	Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, tonsillitis and sinus problems?			
8	Disorder or disease of muscles, bones, joints, limbs, spine e.g. Rheumatism, arthritis, gout, slipped disc or other back trouble?			
9	Diabetes, acne or skin problems, sugar in urine, thyroid or other glandular or blood disorders?			
10	Cancer, growth or tumour of any kind?			
11	Any tropical disease, e.g. Bilharzia?			
12	Any other illness, disorder, operation, disability or injuries from any accident or HIV/ AIDS infection?			
13a	Any disorder of the female organs (breasts, ovaries, uterus) or any of abnormality of pregnancy or confinement, e.g. Caesarian section or miscarriage? If 'YES', state full details including dates			
13b	Are you pregnant? If 'YES', is it a multiple birth and how many months?			
14	Any special dental treatment e.g. crowns, bridges, orthodontic, etc?			
15	Any illness or physical defect likely to necessitate medical or dental treatment, e.g. headaches, lumps, pain, orthodontic work etc?			
16	Do you expect any medical or dental treatment within the next three months?			
17	Detail all medication used by applicant and dependants during the last two (2) years, as well as all Pathology and Radiology tests?			
18	Do you or your dependants have a medical condition not disclosed?			
19	Indicate whether late joiner penalties were imposed by your previous scheme?			

20	Please supply height and weight	Principal Member	Dependent 1	Dependent 2	Dependent 3
		Height:	Height:	Height:	Height:
		Weight:	Weight:	Weight:	Weight:

Initial _____

IF ANY OF THE ABOVE HAVE BEEN ANSWERED 'YES', PLEASE SUPPLY FULL DETAILS BELOW

No.	Member/ Dependant	Full details of the disorder, consulting doctor, type of medication and dosage used.	Date of Treatment	Degree of Recovery

PRACTITIONER AND/OR SPECIALIST DETAILS (you or your dependants have contacted recently)

Specialist / Pharmacy

Telephone Number — Number of years consulted

Specialist / Pharmacy

Telephone Number — Number of years consulted

Specialist / Pharmacy

Telephone Number — Number of years consulted

OFFICIAL USE ONLY

Underwriting Decision

Notes

Initial _____

SECTION C

BANKING DETAILS AND DEBIT ORDER AUTHORISATION

Account Holder

Account Number

Account Type

Banking Institution

Branch

Branch Code

I authorise COMMED to draw from my bank account (wherever it may be), the contribution in terms of the Rules of COMMED, without prejudice to the rights of COMMED. I further authorise COMMED to increase the amounts due to it, in terms of the rules, from time to time and authorise my bank to effect payment of such increased amounts upon receipt of a written notice from COMMED stating the increased amount and the date from which it is payable. This authorisation is to remain in force until I cancel it by giving written notice to COMMED. I agree that am not entitled to recover any amount drawn from my account by means of this debit order and that, should my bank/building society repay such amount to me, I will refund it immediately to COMMED. I undertake to notify COMMED immediately of any change in respect of my address or bank/building society. I acknowledge that COMMED may not cede or assign any of their right to any third party without my prior written consent and that I may not delegate any of my obligations in terms of this contract to any third party without prior written consent of the authorised party.

COMMED is hereby authorised to debit my bank/building society account with my portion of accounts paid on my behalf by COMMED.

Account Holders Name _____

Account Holders Signature _____ Date _____

BANKING DETAILS, CLAIMS PAYMENT / REFUNDS

Account Holder

Account Number

Account Type

Banking Institution

Branch

Branch Code

I hereby instruct and authorise you to pay any claim reimbursement which may accrue to me, to the credit of my account with the above mentioned bank or any other bank or branch to which I may transfer my account.

I understand the remittance advices/payment advices will be supplied to me in the normal way and that they will indicate the date on which funds will be available in my account.

I acknowledge that the party hereby authorised to effect a credit against my account may not cede or assign any of its rights to any third party without my prior written consent and that I may not delegate any of my obligations in terms of this contract/authority to any third party without written consent of the authorised party.

This authority may be cancelled by me giving you third party's notice in writing.

Account Holders Name _____

Account Holders Signature _____ Date _____

CONDITIONS OF MEMBERSHIP AND UNDERTAKING

CONTRIBUTION

Payments: Your contributions are deducted from your salary by your employer or direct from your bank account. You pay contributions monthly in advance.
Increases: All medical schemes increase contributions from time to time when the cost of medical, dental, hospital and other health services are increased, and when benefits are improved. Normally increases are effected annually.

STATE OF HEALTH AND GENERAL INFORMATION

COMMED reserves the right to impose waiting periods as defined in the Rules. Should any of these apply to you, you will be notified in writing by COMMED before commencement of membership. Please supply full details on a separate sheet of paper and attach to the application if you or your dependants have had one or more pre-existing medical condition/s during the last 12 months. (Exclude minor ailments).

Any deterioration or change in my state of health or in that of any of my dependants before the date of event to be set by COMMED for the commencement of membership or the date of acceptance of this application by COMMED or the date of receipt of the first subscription, whichever date is the latest shall entitle COMMED to reconsider the application and propose new terms of admission or declare the membership null and void in which case all moneys paid to COMMED in connection with this membership before COMMED is informed of the change, shall be forfeited and benefits paid by COMMED shall immediately be refunded to COMMED.

GENERAL INFORMATION

Resignation: (You may only resign subject to the conditions laid down in the Rules of COMMED as amended from time to time).
Membership card: The membership card is for use by the principal member and/or his dependants only.
Registration: You must register all your dependants with COMMED, unless they belong to another medical scheme. You must also notify COMMED within 30 days of any change in marital status and or dependant and or salary status that occurred since you joined COMMED.
Termination of voluntary or individual membership may require 2 months written notice and 3 months notice from companies by the scheme.

I _____ hereby make application for membership of COMMED and agree that I will be bound by the Rules of COMMED as amended from time to time.
I declare that the answers to the above questions are, to the best of my acknowledge and belief true in every respect and I agree, in the event that any of these answers are knowingly inaccurate, to forfeit all benefits from COMMED, to refund in full, grants that may have been paid on my behalf by COMMED, and to waive all claims to any subscriptions paid by me to COMMED.

My employer is hereby authorised to debit my salary with my portion of the monthly contribution required. My employer is authorised to continue thereafter to pay each month such amounts as are due until the end of the month in which COMMED is notified of my resignation.

I agree that, should any sum due to COMMED not be timeously paid by me for any reason, I shall be liable for all costs incurred by COMMED in the recovery of such a claim, including tracing charges and all fees and costs charged to COMMED by its attorneys, including collection commission.

Penalties and waiting periods may apply to late joiners. I accept that I and/or my dependants may be subjected to a general waiting period of 3 months. For any pre-exsisting condition/s within the last 12 months, a waiting period of 12 months may be applied. I acknowledge that in terms of S57(4)(i) of the Medical Scheme Act, the Board of Trustees must take all reasonable steps to protect the confidentiality of medical records concerning my state of health and in respecting the privacy of my dependants will exercise similar controls with regard to their health records. Subject to those obligations, I hereby consent to and authorise the disclosure of any such information, both to the Scheme and any other person by the provider concerned or by the Scheme itself if, in the opinion of the Scheme, there is good reason to do so.

Member Name _____ Date _____

Signature _____ Witness _____

MEMBER ACKNOWLEDGEMENT AND DECLARATION

1.1 The applicant is familiar with the conditions and benefits of the option elected, notwithstanding representation by any other party. Yes No
1.2 The contents of the information provided are true, correct and complete in every respect and any false statement in or omission from the form may lead to termination of membership or such other measures the scheme may determine in its sole discretion, subject to appeal procedures. Yes No
1.3 The applicant agrees to abide by and undertake to familiarise himself with the rules of the scheme as amended from time to time. Yes No
1.4 The applicant is aware that the medical scheme may impose general and/or condition-specific waiting periods, as provided for in the Medical Scheme Act (131 of 1998). Yes No
1.5 The applicant authorises his healthcare provider or other person who may be in possession of any information concerning his health or that of any of his dependants to disclose the information to the scheme and it's contracted third parties, provided such information shall be treated as confidential at all times. Yes No
1.6 The applicant understands that his confidential health and personal information will only be used for the purposes as outlined by the medical scheme in the medical scheme declaration (on the application form) and any deviation from this constitutes a breach of confidentiality. Yes No
1.7 In the event that the scheme wishes to use the applicant's (or his dependants) confidential information for purposes other than those outlined in the medical scheme declaration, the medical scheme is required to obtain further consent from the applicant and his/her dependants. Yes No
Yes No
1.8 It is my liability as a member for payment of monthly contributions to the scheme. Yes No
1.9 Neither the applicant nor any of his/her dependants are beneficiaries of another medical scheme.
1.10 The applicant will inform the scheme of any changes in his/her dependants' health or personal status, as required by the scheme rules, within 30 days of the change in circumstances. Yes No
1.11 The applicants consents to all conversations between himself and the scheme or its contracted parties being recorded. Yes No

Signature Applicant _____

Broker _____

BROKER DECLARATION

Broker _____ Broker Code _____

Tel: _____ Trading Address _____

Fax: _____ _____

Date _____

2.1 The applicant has appointed him/her as broker and the applicant is entitled to cancel his/her services at any time. Yes No

2.2 His/Her accreditation details and confirmation that he/she is accredited at the date of his/her signature. Yes No

2.3 He/She is licensed by the FSB in terms of the FIAS Act Yes No

2.4 He/She has provided the applicant with name, physical and postal address and telephone number. Yes No

2.5 The commission payable by member/scheme on the transaction. Yes No

2.6 He/She has a valid contract with the scheme. Yes No

2.7 There has been no material misrepresentation of any fact by him/her. Yes No

2.8 In the event of material misrepresentation or unlawful conduct, he/she undertakes to refund all monies paid in consequence of such misrepresentation or conduct. Yes No

2.9 The applicant is familiar with the information requested in the application form and all the relevant information was provided to the member. Yes No

2.10 The advice and assistance given to the applicant was impartial and in the best interests of the applicant. Yes No

2.11 The applicant has personally signed the application form. Yes No

Signature Applicant _____

Broker _____

MEDICAL SCHEME DECLARATION

3.1 A member's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential. Yes No

3.2 Member information (personal and health information) will not be used for purposes related to company business nor sold for commercial purposes. Yes No

3.3 The medical scheme has data security measure in place. The scheme will need to inform the applicant of what security is in place in a simple, clear and unambiguous manner. Yes No

3.4 The medical scheme has granted access, to certain persons within the organisation and its contracted third parties, to a beneficiaries' personal and health information. Yes No

3.5 All staff within the medical scheme and its contracted third parties is bound by internal confidentiality agreements. Yes No

3.6 The medical scheme and its contracted third parties will use medical/health/diagnosis/procedure information provided for the following purposes: processing the application of membership, reimbursement of claims, determining member entitlement to benefits and risk management practice. Yes No

3.7 The medical scheme has ensured that the confidentiality agreements have been entered into with all contracted third parties who have access to beneficiary information for the purposes of data transfer and management, scheme administration and managed care arrangements. Yes No

3.8 In the event of breach of confidentiality, the medical scheme assumes responsibility and the breach will be managed according to the scheme's internal protocol. Yes No

Signature Applicant _____

Broker _____

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