MEDSHIELD
medical scheme

GROUP TAKE-ON APPLICATION

Email: newapplication@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary. All sections must be completed.

Selection of Benefit Option: _____

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Start Date of Membership: D D M M Y Y Y Y

CONSULTANT DECLARATION

Broker Code:

DOCUMENT CHECKLIST

In order to avoid rejection of your application please provide the following documents:	Please Tick
ID copy(ies) for all beneficiaries (e.g. ID/birth certificate/passport)	
Student certificate (child dependant age 21-27 that is studying or turning 21 in the next 3 months)	
Proof of previous medical scheme (certificate of membership reflecting an end date)	
Mem02 - Member Record Amendment (for Special Dependants: e.g. parents, foster child, niece, nephew, brother, sister, grandchild)	

I, _____ hereby understand that it is an offense to submit fraudulent business and I have explained Non-disclosure, General and condition specific waiting periods, Late Joiner Penalty, PMB and proration of benefits to the applicant. I further declare that I have attached all documents as per the document checklist above to this application form, and that the application form is submitted to the Scheme within 14 days of the member declaration sign date.

Consultant Signature: _____ Date: D D M M Y Y Y Y

SECTION A PERSONAL DETAILS (attach copy of ID document)

Title: Initials:

First Names:

Surname:

ID/Passport Number:

Date of Birth: D D M M Y Y Y Y

Postal Address:

Postal Code:

Physical Address:

Postal Code:

Email Address:																				

Telephone Number (W):	C	O	D	E							
Telephone Number (H):	C	O	D	E							
Cell Number:											
Fax Number:	C	O	D	E							
Tax Number:											

Please complete for marketing purposes

Gender: (Mark with an X)	M	F	Marital Status:	Single	Married	Divorced	Widowed

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

SECTION B DEPENDANT DETAILS

Please complete a MEM02 form for special dependants (e.g. parents, foster child, niece, nephew, sibling, grandchild). Acceptance of dependants will be in accordance with the Rules of the Scheme. Affidavits are required for Special Dependants.

Dependants (attach copies of ID or birth certificate)

Dependant 1

Name of Dependant:					
Surname: (If Different to Principal Member)					
ID Number:					
Relationship to Principal Member:					
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 2

Name of Dependant:					
Surname: (If Different to Principal Member)					
ID Number:					
Relationship to Principal Member:					
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 3

Name of Dependant:						
Surname: (If Different to Principal Member)						
ID Number:						
Relationship to Principal Member:						
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 4

Name of Dependant:						
Surname: (If Different to Principal Member)						
ID Number:						
Relationship to Principal Member:						
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 5

Name of Dependant:						
Surname: (If Different to Principal Member)						
ID Number:						
Relationship to Principal Member:						
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

SECTION C FAMILY PRACTITIONER (FP) NOMINATION – MediPhila, MediValue Compact and MediPlus Compact

If you have selected MediPhila, or one of the Compact options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP). If you do not nominate a FP as per the criteria listed per option below, your application form will not be processed by the Scheme.

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediValue Compact and MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where a FP was nominated from the FP Network & Day-to-Day benefit is depleted the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION D PREVIOUS MEDICAL AID HISTORY

Where applicable, please provide details and proof of membership for all previous registered South African medical schemes you and your dependants belonged to (membership certificates, which reflects the termination date, must be attached to this application). Failure to provide this information may result in underwriting being applied as per point 9 on the member declaration (page 6). Where a Late Joiner Penalty has already been imposed and evidence of credible cover is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the following month. No backdate will be allowed unless evidence of previous submission is provided to the Scheme.

Mark with an X

Principal Member: ☐ Dependant: ☐

Name & Surname:

Name of Scheme:

Membership Number:

Date Joined: D D M M Y Y Y Y Date Terminated: D D M M Y Y Y Y

Principal Member: ☐ Dependant: ☐

Name & Surname:

Name of Scheme:

Membership Number:

Date Joined: D D M M Y Y Y Y Date Terminated: D D M M Y Y Y Y

Principal Member: ☐ Dependant: ☐

Name & Surname:

Name of Scheme:

Membership Number:

Date Joined: D D M M Y Y Y Y Date Terminated: D D M M Y Y Y Y

IMMUNE DEFICIENCY STATUS (Confidential Disclosure)

If you, or any of your dependants, have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Programme on 086 050 6080 to register on the HIV/AIDS Disease Management Programme. Failure to do so within 21 days of joining the Scheme will be considered as non-disclosure of information and may result in termination of your membership.

SECTION E BANK DETAILS

I hereby authorise Medshield Medical Scheme to pay claim refunds to the following bank account.
A stamped bank statement or cancelled cheque or a stamped confirmation letter from the bank in the name of the Principal Member is required.
Should refunds be paid to a 3rd party, a stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank together with a signed letter of authorisation from the account holder must accompany this form.

Use this account for: **Claims Refunds Only** ☐

Bank Name:	
Branch Name:	
Branch Code:	
Type of Account: (Mark with an X)	Current / Transmission / Savings
Name of Account Holder:	
Bank Account Number:	
Date:	D D M M Y Y Y Y

Signature of Account Holder: _____

SECTION F EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:	
Paypoint Code:	
Employee Payroll No.:	
Employment Date:	D D M M Y Y Y Y

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section F have been completed:

Employer's Email Address:	
Employer's Representative's Name:	
Employer's Representative's Designation:	
Date:	D D M M Y Y Y Y

Employer's Representative's Signature: _____

SECTION G MEMBER DECLARATION

All boxes must be ticked with an X as confirmation that you have read, understood and agree with the terms as stated.

1. ☐ I the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree to abide by its Rules and Regulations in accordance with the provisions of the Medical Schemes Act (Act 131 of 1998) as amended. I have been informed that the Scheme Rules will be made available on request and that I am responsible to read and be bound by them.

2. ☐ I certify that all the information given is true and correct and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void, effective from date of registration. In such event the Scheme will have the right to offset applicable costs against contributions paid and refund the difference, if any.

3. ☐ I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

4. ☐ Notwithstanding point 3, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

5. ☐ I hereby authorise the Scheme, or any of its nominated representatives, to confirm my bank details.

6. ☐ Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

7. ☐ I hereby authorise and request any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my / the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my / their death, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of any nature, which may be made against them as a result of, or arising out of, the disclosure of any test results or medical information.

8. ☐ The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi or by any agreed electronic means unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi or by any agreed electronic means shall be deemed to have been received by me on the 7th day after the date of posting.

9. ☐ I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:
   - a 3 (three) month general waiting period in respect of all benefits;
   - a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
   - a late joiner contribution penalty.

10. ☐ Should my state of health change significantly from the date of signing this application to the date of acceptance, I will notify the Scheme in writing.

11. ☐ It is illegal to be a member of more than one medical scheme at the same time. I acknowledge that it is my responsibility to resign from my existing medical scheme and agree that neither me, or any of my dependants, will be registered on both Medshield and another medical scheme simultaneously.

12. ☐ I hereby give permission, with the consent of my depedants that Medshield Medical Scheme may collect, process, store and share our personal information with the Scheme's managed care partners for the purpose of rendering medical services to me and my dependants.

13. ☐ I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: _____

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form is submitted to the Scheme within 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

Date: _____