MEDSHIELD
medical scheme

MEMBER HEALTH DECLARATION

Email: newapplication@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. All sections must be completed in full.
Leave one block between words.

Mark with an X:

New Member application (complete medical history for all beneficiaries): ☐

Registration of Dependant (complete medical history only for new dependants): ☐

I, _____ the undersigned,
ID number _____ am aware 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 to as 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.

SECTION A MEDICAL HISTORY (yes or no)

To be completed by each applicant in respect of himself/herself and all his/her dependants. All questions must be answered with a "Yes" or "No".

All conditions, symptoms and or disorders have to be declared, no matter how insignificant they may seem. Incomplete, inaccurate information or information that is withheld may result in the termination of your membership effective from date of registration.

If additional space is required, please complete a separate sheet of paper and attach it to the application.

1. Have you or any of your dependants sought advice, been diagnosed or treated for any condition within the past 12 months? Y ☐ N ☐

Name of Beneficiary:				
Condition:				
Date Diagnosed:		Currently On Treatment:	Y ☐	N ☐
Date of Last Treatment:				
Attending Doctor:				

Any additional information:

2. Do you, or any of your dependants take chronic medication or are you expecting to take medication on an ongoing basis? Y ☐ N ☐

Name of Beneficiary:				
Condition:				
Date Diagnosed:		Currently On Treatment:	Y ☐	N ☐
Date of Last Treatment:				
Attending Doctor:				

A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.
Your doctor or pharmacist can contact Chronic Medicine Management on 086 000 2120 to telephonically register you for chronic medication.
Any additional information:

3. Have you or any of your dependants been admitted to hospital or undergone any procedure (other than routine medical or dental treatment) in the past 12 months? Y N

Name of Beneficiary:			
Condition:			
Date Diagnosed:		Currently On Treatment:	Y N
Date of Last Treatment:			
Attending Doctor:			
Any additional information:			

4. Are you or any of your dependants planning or reasonably expecting to be hospitalised or to have a procedure or treatment in the next 12 months - including pregnancy? Y N

Name of Beneficiary:			
Condition:			
Date Diagnosed:		Currently On Treatment:	Y N
Date of Last Treatment:			
Attending Doctor:			
Any additional information:			

5. Are there any other conditions or symptoms not mentioned above for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months that you would like to disclose? Y N

Name of Beneficiary:			
Condition:			
Date Diagnosed:		Currently On Treatment:	Y N
Date of Last Treatment:			
Attending Doctor:			
Any additional information:			

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.

Medshield Medical Scheme requires that this form is submitted to the Scheme within 14 days of the member sign date below.

Consultant Signature: _____ Date: _____

Member Signature: _____ Date: _____