

HEALTHCARE BROKER APPLICATION FORM

How to complete this form:

1. Please complete in black ink. Print clearly using capital letters.
2. Supporting documents as per Section E must be provided. Should this be outstanding, your application cannot be processed.
3. Section D does not apply to representatives.
4. Please cross applicable boxes.
5. Submit this completed form and supporting documents to **commissions@medshield.co.za** or fax 010 597 4709.
6. Ensure the FSP and/or key individual is authorised for financial product: Health Service Benefit.
7. Representatives must complete their application form(s).

I am applying as a (mark with an X):

Company

7

Representative

7

SECTION A

BROKER HOUSE DETAILS

Broker House Name:

Broker House Code:

SECTION B

HEALTHCARE BROKER INFORMATION

Registered Business Name/
Representative Name:

Trading Name:

Company Registration Number:

FSP Licence Number:

VAT Number:

Identity/Passport Number:
(key individual/representative)

Business Type:

CMS Accreditation Number
(key individual/representative)

CMS Accreditation Number
(organisation)

Owner's Name and Surname:

Owner's Identity Number:

[illegible]

SECTION C

GENERAL INFORMATION

Number of years experience in healthcare consulting and marketing?

7

Target Market:

Individuals

1

Corporates

1

Number of Active Scheme Contracts:

[illegible]

SECTION D

OFFICE CONTACT DETAILS

Postal Address (office):

[illegible]

Postal Code:

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

[illegible]

BANK DETAILS

- a) I am the account holder of the bank details provided and I hereby authorise Medshield Medical Scheme to pay refunds to the above bank via the ACB system using the information provided.
- b) We understand that Medshield Medical Scheme may dispute any erroneous transaction, and shall be authorised to reverse or rectify any erroneous transaction, subject to prior written confirmation being issued to Medshield.
- c) I understand that Medshield Medical Scheme will rely upon the facts set out herein for the accurate loading of bank details.

[illegible]

Bank Account Number:

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

YOUR DOCUMENTS CHECK LIST (Please mark boxes with an X when attached)

| | |
|--|--|
| | A complete broker application form |
| | Company Registration Certificate, if applicable |
| | Company Registration Certificate, if applicable |
| | Financial Sector Conduct Authority certificate |
| | Identity Document of the key individual |
| | Letterhead with contact details |
| | Membership growth business plan |
| | The key individual's Council for Medical Schemes accreditation certificate |
| | VAT Registration Certificate, if applicable |

| | |
|--|---|
| | A complete broker application form |
| | Council for Medical Schemes accreditation certificate |
| | Identity Document of the key individual |
| | Membership growth business plan |

An application by a **Company or Close Corporation** must include:

- | | |
|--------------------------|--|
| <input type="checkbox"/> | A complete broker application form |
| <input type="checkbox"/> | Cancelled cheque or bank statement with a bank stamp or letter with a bank stamp |
| <input type="checkbox"/> | Company Registration Certificate, if applicable |
| <input type="checkbox"/> | Financial Sector Conduct Authority certificate |
| <input type="checkbox"/> | Identity Document of the key individual |
| <input type="checkbox"/> | Membership growth business plan |
| <input type="checkbox"/> | Letterhead with contact details |
| <input type="checkbox"/> | The key individual's Council for Medical Schemes accreditation certificate |
| <input type="checkbox"/> | VAT Registration Certificate, if applicable |

| SECTION G | FOR ADMINISTRATIVE USE ONLY |
|-------------------------|-----------------------------|
| Broker Consultant Name: | |
| Broker Code: | |
| Broker House Code: | |
| Comments: | |
| | |

HEALTHCARE BROKER MEMBER SERVICE LEVEL AGREEMENT

The minimum level of services to be provided by a healthcare broker to a member:

1. The healthcare broker shall use his/her best endeavours to interpret and apply the rules of the , that the healthcare broker introduced to the member, to suit the member's individual situation and explain to the member upon request the aspects of those product rules about which the member may be uncertain or ignorant.
2. The healthcare broker shall advise the member, after analysing the member's particular and specific needs in relation to cover, which of the options is most suited to meet those needs considering the member's financial status and individual circumstances.
3. The healthcare broker shall at all times facilitate the relationship between the member and the product to which the healthcare broker has referred the member, and shall:
 - Use their best endeavours to resolve any problem which the member experiences with their dealings with Medshield Medical Scheme promptly and efficiently;
 - Use their best endeavours to advise and assist the member in gauging the impact on and relevance to the member of any proposed or actual change in the rules of the product;
 - Make themselves available to attend at least two (2) meetings per year (not more than a 6 month interval), at the request of the member, between the member and representatives of Medshield Medical Scheme or its administrators to provide expert advice and support to the member in the course of the meeting.
4. The healthcare broker shall return a member's telephone call, email or facsimile message within 3 days from the date of the member's correspondence unless the healthcare broker is on vacation or is physically or otherwise incapacitated in which case the call, email or facsimile message shall be returned within three (3) days of the healthcare broker's return to work or to capacity.

Accepted and signed at: _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Signature of Applicant: _____

Full Name:

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

Does the Key Individual on this application require a separate broker code (apart from the broker house broker code)?

☐

HEALTHCARE BROKER HONESTY & INTEGRITY DECLARATION

I, _____ hereby confirm that:

1. I have not within a period of five years preceding this date been found guilty of any civil or criminal proceedings by a court of law (whether in the Republic or elsewhere) of having acted fraudulently, dishonestly, unprofessionally, dishonourably or in breach of a fiduciary duty;
2. I have not within a period of five years preceding this date been denied membership by any professional or financial services industry body (whether in the Republic or elsewhere) on account of an act of dishonesty, negligence, incompetence or mismanagement, sufficiently serious to impugn the honesty and integrity of the Financial Services Provider (FSP);
3. I have not within a period of five years preceding this date been found guilty by any professional or financial services industry body (whether in the Republic or elsewhere) recognised by the Financial Sector Conduct Authority (FSCA) of an act of dishonesty, negligence, incompetence or mismanagement, sufficiently serious to impugn the honesty and integrity of the FSP;
4. I have not within a period of five years preceding this date had my authorisation to carry on business refused, suspended or withdrawn by any professional or financial services industry body (whether in the Republic or elsewhere), on account of an act dishonesty, negligence, incompetence or mismanagement, sufficiently serious to impugn the honesty and integrity of the FSP;
5. I have not within a period of five years preceding this date, had any licence granted to me by a professional or financial services industry body (whether in the Republic or elsewhere) suspended or withdrawn by such body on account of an act of dishonesty, negligence, incompetence or mismanagement, sufficiently serious to impugn the honesty and integrity of the FSP;
6. I have not at any time prior to this date been disqualified or prohibited by any account of law (whether in the Republic or elsewhere) from taking part in the management of any company or other statutorily created, recognised or regulated body, irrespective whether such disqualification has since been lifted or not.
7. I am not insolvent and I have not been disqualified from marketing in the financial service industry for any reason whatsoever.
8. I agree with the the correctness of the information submitted and I authorise Medshield Medical Scheme to verify the details contained in this application and I hold harmless any person in respect of any adverse statement or information about me.
9. I will conduct myself in all matters relative to, or in any way connected with, my appointment and conduct as a healthcare broker to bring credit to the financial service healthcare industry.
10. I agree to the terms and conditions within the contract and submit to the general code of conduct for financial services providers as promulgated under the Financial Advisory and Intermediary Services Act (FAIS Act) (Act 37 of 2002) as amended as well as the Financial Sector Regulation Act (Act 9 of 2017) as amended.
11. I agree that this application is subject to a background check to ensure compliance with the fit and proper requirements as per FAIS Act as amended.

Accepted and signed at: _____

Date:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Signature of Applicant: _____

Full Name:

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|