SIZWE MEDICAL FUND
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APPLICATION FOR MEMBERSHIP

Please use black ink to complete all sections and return as soon as possible to ensure speedy registration.

Select Option:
- ☐ Hospital Care
- ☐ Primary Care
- ☐ Primary Care Network
- ☐ Affordable Care
- ☐ Affordable Care Network
- ☐ Full Benefit Care

FOR INTERNAL USE ONLY

Membership number:

Employer group:

SECTION 1 PERSONAL DETAILS OF PRINCIPAL MEMBER

First name(s): (as per ID)

Surname: Title: Initials:

Identity number:

Population group: ☐ African ☐ Coloured ☐ Indian ☐ White ☐ Asian

Postal address:

Code:

Physical address:

Code:

Tel (work): Cell:

Tel (home): Occupation:

Email:

SECTION 2 EMPLOYER DETAILS

Date joining fund: D D M M Y Y Y Y Date of benefit: D D M M Y Y Y Y

Income category:

Member's share of contribution: Employer's share of contribution:

Total monthly contribution: Payroll/ Employee number:

Employer/ account number:

NB: Proof of income/ salary slip to be submitted with this form.

Name: Company/ division:

Email:

Tel: Fax:

Designation:

I confirm that the applicant is employed and commenced employment on Date: D D M M Y Y Y Y

And that contributions are being deducted in accordance with the applicant's income and the eligible dependants, in terms of the appropriate contribution table. Any further changes to the employee's status will be advised to the fund within seven days.

Signature of employer: _____

Official stamp of employer

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SECTION 3 — PRINCIPAL MEMBER & DEPENDANT DETAILS (SHADED AREAS FOR OFFICE USE ONLY)

Gender codes	Marital codes		Relationship codes		
M = Male	M = Married	S = Single	S = Spouse	C = Child	O = Other
F = Female	D = Divorced	W = Widowed	P = Parent	Lp = Life partner	

IMPORTANT: New applications will not be considered unless the correct documentation is supplied. Non-compliance will result in either a delay in processing or rejection of your application. (Please complete names as stated in your identity document or birth certificate.) The main application, spouse or partner and all dependants applying for cover needs to complete this section.

NB: GREY SHADED AREAS FOR OFFICE USE ONLY

PRINCIPAL MEMBER 00

First name(s): (as per ID)

Surname: Gender: Marital status:

Identity number: Date of birth: D D M M Y Y Y Y

Waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

Condition-specific waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

SPOUSE OR PARTNER 01

First name(s): (as per ID)

Surname: Gender: Marital status:

Identity number: Date of birth: D D M M Y Y Y Y

Waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

Condition-specific waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

APPLICATION FOR MEMBERSHIP

DEPENDANT CODE 02

If there is a difference between the surname of any child dependant and the principal member please state reason

First name(s): (as per ID)

Surname: Gender: Marital status:

Identity number: Date of birth: D D M M Y Y Y Y

Waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

Condition-specific waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

DEPENDANT CODE 03

If there is a difference between the surname of any child dependant and the principal member please state reason

First name(s): (as per ID)

Surname: Gender: Marital status:

Identity number: Date of birth: D D M M Y Y Y Y

Waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

Condition-specific waiting period: Yes: No: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Reason:

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SECTION 4 PREVIOUS MEDICAL SCHEME

NOTE: Please provide full details of your membership of current and previous medical scheme(s) and termination dates (list the most recent first and provide proof by attaching your certificate/s of membership).

Name of scheme:

Membership number:

Membership duration: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Are you still a member: Yes: ☐ No: ☐

Name of scheme:

Membership number:

Membership duration: From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Are you still a member: Yes: ☐ No: ☐

Waiting period imposed? Yes: ☐ No: ☐

If yes, please indicate what waiting periods were imposed:

Late joiner penalties imposed? Yes: ☐ No: ☐

If yes, please indicate what penalties were imposed:

SECTION 5 FOR INTERNAL USE ONLY

			Number of years subject to penalty	Penalty imposed (please tick)	
Current age		Years			
Less: creditable coverage		Years	1-4 years	5%	
Less: creditable coverage		Years	5-14 years	25%	
Less: qualifying age		Years	15-24 years	50%	
Years subject to penalty		Years	25+ years	75%	

Vetted by (name):

Signature (supervisor): _____ Date of benefit: D D M M Y Y Y Y

Processed by (name):

Signature: _____ Date of benefit: D D M M Y Y Y Y

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SECTION 6 MEDICAL HISTORY: PRINCIPAL MEMBER & DEPENDANTS TO BE REGISTERED

To match the correct dependant code with the codes below, please refer to Section 3.

IMPORTANT: Please submit proof and date of treatment of pre-existing health conditions of principal member and all dependants. This means a sickness or condition for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months preceding application.

Please provide full details for any of the conditions below in the space provided and attach relevant medical reports to this form:		Mark one		Dependant number (Mark with X where applicable)					ICD-10 code	Date of last treatment
1	**Cardiovascular Conditions**	Y	N	00	01	02	03	04		
	Heart failure, hypertension, shortness of breath(angina), high blood pressure									
2	**Respiratory Conditions**	Y	N	00	01	02	03	04		
	Asthma, COPD Chronic obstructive pulmonary disease , Tuberculosis , bronchitis									
3	**Neurological Conditions**	Y	N	00	01	02	03	04		
	Stroke, epilepsy, paralysis, weakness, myasthenia gravis,									
4	**Gastro Intestinal Conditions**	Y	N	00	01	02	03	04		
	Gastric/ duodenal ulcer, liver disorder, hepatitis, hiatus hernia, gal bladder stones , pancreatitis,									
5	**Genito Urinary Condition**	Y	N	00	01	02	03	04		
	Kidney stones, prostatic hypertrophy, renal failure glomerulonephritis, STI's (including HIV)									
6	**Endocrine Conditions**	Y	N	00	01	02	03	04		
	Diabetes insipidus , thyroid disorders, Addison's disease, diabetes mellitus, osteoporosis									
7	**Blood Conditions**	Y	N	00	01	02	03	04		
	Anaemia, blood clotting problems, deep vein thrombosis, leukaemia, lymphoma									
8	**Gynaecological & Obstetric Conditions**	Y	N	00	01	02	03	04		
	Abnormal papsmear,abmormal bleeding pregnancy, miscarriage, polycystic ovarian									
9	**Mental Health Conditions**	Y	N	00	01	02	03	04		
	Depression, Dementia, Bipolar Disorder, ADHD									
10	**Musculoskeletal (back, bone, muscle pain)**	Y	N	00	01	02	03	04		
	Arthritis, sarcoidosis, fibromyalgia,ankylosing spondylitis,S-jögren's syndrome,									
11	**Tumour & Growths**	Y	N	00	01	02	03	04		
	Breast lumps, cancer, abnormal pap smear, abnormal mammogram results, prostate specific antigen (PSA)									
12	**ENT**	Y	N	00	01	02	03	04		
	Chronic otitis media, cochlear implant, sinus problems, adenoiditis, nasal surgery									
13	**Eye Conditions**	Y	N	00	01	02	03	04		
	Glaucoma, squint, blurred vision, macular degeneration, ptosis, uveitis, retinal detachment	Y	N	00	01	02	03	04		
14	Are you or any of your dependants expecting to have medical investigations or surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months?	Y	N	00	01	02	03	04		

15	Have you or any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application?	Y	N	00	01	02	03	04		
16	Have you or any of your dependants been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application?	Y	N	00	01	02	03	04		

Please provide any other relevant information:

SECTION 6 MEDICAL HISTORY: PRINCIPAL MEMBER & DEPENDANTS TO BE REGISTERED

DISCLAIMER: I will inform the Fund of any changes in my health status or the health of my dependant/s within 30 days of the change occurring from the date of application and within 90 days of the activation date.

Question no.	Name of patient	Nature and duration of complaint and full details of treatment being or expected to be received. N.B. Please specify all medication	Name and telephone number of attending doctor or hospital

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SECTION 7 GENERAL

I hereby apply to be admitted as a member of Sizwe Medical Fund, hereafter referred to as "the Fund" and agree to familiarise myself with, and abide by, its rules and regulations as amended from time to time. I am familiar with the benefits and conditions of my chosen option and hereby authorise my employer to deduct from my salary my monthly contribution as I may lawfully owe to the Fund and to remit such amounts to the Fund.

Furthermore, I understand that I will be held liable for any legal costs incurred in the recovery of any amounts owing to the Fund. I hereby authorise any doctor or other person, who may be in possession of, or hereafter acquire information concerning my health or the health of any of my dependants, to disclose this information at their reasonable discretion.

I understand that the Fund may request a medical report at its own cost when I join the Fund and that all health and personal information given to the Fund be handled confidentially by them for purposes outlined in Section 10. In the event the Fund wishes to use my, or my dependants', confidential information for purposes other than those outlined in Section 10, the Fund will require consent from me or my dependants.

I understand that the Fund may impose a general and/or condition-specific waiting period according to the Medical Schemes Act (131 of 1998) when land/or my dependants join. I understand that according to the Medical Schemes Act, I may only belong to one medical scheme at a time. I consent to all conversations between the Fund or its contacted parties and myself being recorded. I understand that application for admission to the Fund is not subject to the services of a broker, but should I appoint the below broker to manage my application, I am entitled to cancel the broker's services at any time. I hereby declare that the information in this application is true and correct and agree that any false declaration could render my application null and void. I hereby declare that the accuracy and completeness of all answers, statements and other information provided by or on behalf of me, is my responsibility.

Applicant's signature: _____ Date: D D M M Y Y Y Y

IMPORTANT: Failure to disclose all relevant and/or correct information may adversely affect the benefit available to you and your dependants.

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SECTION 8 APPOINTED BROKER DETAILS (WHERE APPLICABLE)

I authorise _____(broker's name) to act and sign all necessesary documentation on my behalf and that his/her commission will be paid on receipt of my first contribution to the Fund

To be completed by broker:

Brokerage: | Financial services provider number:

Intermediary code:

Email:

Physical address:

Code

Postal address:

Code

Tel (work): | Cell:

Intermediary code: | Date: D D M M Y Y Y Y

CMS accreditation number:

I hereby declare that I am accredited with the Council of Medical Schemes as a licensed financial service provider and have a valid contract with the Fund. I hereby declare that the information on this application form is correct and that there is no material misrepresented of any fact. In the event of material misrepresentation or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation. The applicant is familiar with the information requested in the application form and all the relevant information was provided to the applicant. The advise given to the member was impartial and in the best interest of the applicant.

Applicant's signature: _____ Broker's signature: _____

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Commission payable: _____

SECTION 9 THE FUND RESERVES THE RIGHT TO CANCEL

The fund reserves the right to cancel or suspend membership and impose restrictions on a member or dependants, on the following grounds:

a) Failure to timeously pay the monthly contributions as specified in the rules;
b) Failure to repay any debt to the fund;
c) Submission of fraudulent claims;
d) The non-disclosure of material information.

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SECTION 10 FUND DECLARATION

As Sizwe Medical Fund we are required by POPIA to explain how we obtain, use, disclose and otherwise process your information, which may include health and financial information (personal information). Sizwe Medical Fund and its administrator (Sechaba Medical Solutions (Pty) Ltd) will keep your information, including your personal information supplied to us in this application confidential. Acceptance of these terms and conditions is a requirement for activation and servicing of your medical scheme membership. You agree to us processing your personal information for the following purposes:

(a) administration of your health care option;
(b) provision of managed care services to you;
(c) providing relevant information to a contracted third party;
(d) to profile and analyse risk;
(e) for research purposes and;
(f) to comply with legislation.

Please note that we will only share your information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide your information to such third party. We may amend this notice from time to time, please check your website to inform yourself of any changes.

SECTION 11 INCOME DECLARATION AND BANKING DETAILS FOR DEBIT ORDER AUTHORITY.

BANKING DETAILS

Bank: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Branch code: ☐☐☐☐☐☐☐☐☐☐

Account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account type: ☐ Current ☐ Savings ☐ Transmission

EFT payment (payment of claims refunds directly into your bank account): Please include an original cancelled cheque (for a cheque account) or a recent original bank statement (for a savings or transmission account). Copies of cheques or bank statements cannot be accepted.

INCOME DECLARATION (COMPULSORY FOR ALL MEMBERS)

I hereby declare that my monthly income is R_____ per month.

(Substantiating proof of income must be attached and must be resubmitted to the Fund on an annual basis.)

BANKING DETAILS FOR REFUND PURPOSES

Bank: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Branch code: ☐☐☐☐☐☐☐☐☐☐

Account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account type: ☐ Current ☐ Savings ☐ Transmission

EFT payment (payment of claims refunds directly into your bank account): Please include an original cancelled cheque (for a cheque account) or a recent original bank statement (for a savings or transmission account). Copies of cheques or bank statements cannot be accepted.

CONTRIBUTION PAYMENTS

I hereby authorise that the monthly contribution, as raised by the Sizwe Medical Fund, may be withdrawn from the above-mentioned account on the 7th day of each month for the current month's membership contributions. This payment will represent the full monthly contribution payable to the Fund. I further understand that if payment is not made to the Fund on the 7th day of each month, the Fund may suspend my membership and benefits after having followed due process. I hereby declare that the information in this application is true and correct and agree that any from the Fund will cease. I hereby declare that the information in this application is true and correct and agree that any false declaration could render my application null and void.

Date of first payment: D D M M Y Y Y Y

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SECTION 12 ESSENTIAL DOCUMENTS (COMPULSORY)

Please provide the following documentation with your application	Are the relevant documents attached?			
Copy of your ID as well as your dependant	Yes		No	
Birth certificates for children (where ID is not available)	Yes		No	
Clinic cards for new born babies (within 30 days of birth to avoid waiting periods)	Yes		No	
Documentary proof in the case of adopted/foster children	Yes		No	
Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting periods)	Yes		No	
Affidavit when registering a common law spouse or partner confirming cohabitation (where applicable)	Yes		No	
Membership certification with termination dates from previous medical aids, for member and dependants (where applicable)	Yes		No	
Proof of study for dependant/s between ages 21-25 years or an affidavit proving financial dependency	Yes		No	
Dependant/s, or doctor's letter for mentally or physically disabled children	Yes		No	
Proof of taxable income (i.e., payslip, SARS ITA 34 form, etc.)	Yes		No	
Either an original cancelled cheque (for a cheque account) or an original bank statement (for a transmission or savings account) so that claims can be paid directly into your bank account	Yes		No	

Please ensure that the form is completed in full and all the necessary documents are attached with your application. Failure to submit the relevant documents will delay the processing of your membership application.