4216-11/15

my medihelp application form 2014

Enquiries: 086 0100 678
Fax: 012 336 9540 **Email:** medihelp@medihelp.co.za
Postal address: PO Box 26004, ARCADIA, 0007

medihelp
medical scheme

MSP CONSULTANTS
TEL: 011 462 8361
FAX: 086 679 5053

For office use only								
Membership number								
		M	H					

How to complete this form:

1. Please complete in print, using black ink, and e-mail, fax or post the form to Medihelp.
2. Please complete all sections in full and sign the application form. Note the following at section 5:
2.1 If you apply for membership of Medihelp Plus and the Dimension range, complete item 5.1
2.2 If you apply for membership of the Necesse benefit option, complete item 5.2 and 5.4
2.3 If you apply for membership of the Unify benefit option, complete item 5.3 and 5.4
3. Never sign a blank application form.

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1. date from when membership is required

y y y y m m 0 1

2. details of applicant (person who requests membership)

ID/passport No. | Title: Mr | Mrs | Ms | Other (specify)

A copy of your passport must be attached if you use your passport number.

Surname | Initials

First names | Gender: Male | Female

Nickname

Marital status: Married in community of property | Married out of community of property | Single | Divorced | Widow | Widower | Other (specify)

Date of birth (y y y y m m d d) | Date of marriage (y y y y m m d d)

Income tax number | Language: Afrikaans | English

3. contact details of applicant

Postal address | Tel: (W) Code | No.

Tel: (H) Code | No.

Code | Fax Code | No.

Residential address | Cell Number

E-mail address

Code

May Medihelp use your/your dependants' personal details to determine the quality of our service? Yes | No

4. details of employer

NB: Complete only in the following cases:
- **If your employer pays your subscription in full or in part to Medihelp.**
- **If you own a business and your subscription will be paid by the business.**
- **Pensioners who are subsidised by their former employers must also complete this section.**
- **If your subscription is paid by debit order by your employer, section 7 must also be completed.**

Name of employer

Contact person responsible for the account: Tel: Code | No.

Title: Mr | Mrs | Ms | Other (specify) | Initials | Surname

E-mail address of contact person

Postal address of employer

Code

Branch code/Employer group No.

Payroll number

Appointment date | Appointment: Permanent | Temporary

Pay area

Office stamp of employer

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5. choice of benefit option (choose only one benefit option by marking an "X" at 5.1, 5.2 or 5.3)

5.1 dimension range and medihelp plus benefit option

Dimension Prime 1	Dimension Prime 1 (Network)	Dimension Prime 2	Dimension Prime 2 (Network)
Dimension Prime 3	Dimension Prime 3 (Network)	Dimension Elite	Medihelp Plus

5.2 network option: necesse

Necesse

5.3 network option: unify

NB: **The primary care services for this benefit option are rendered exclusively by healthcare providers in the Uitenhage, Despatch, Kirkwood and Port Elizabeth areas in the Eastern Cape.**

Unify

Please indicate your choice of medical network service provider by completing the practice number of each service provider below. If section 6 of this application form is not completed, your choice of service providers will also be applicable to your dependants.

General practitioner	Dentist	Optometrist
Practice number	Practice number	Practice number

5.4 gross monthly income – only necesse or unify

Gross monthly income of applicant		Occupation of applicant	
Gross monthly income of spouse/partner		Occupation of spouse/partner	

For the purpose of the Necesse and Unify benefit options, "monthly income" means the gross monthly income before any deductions.

Only applicants whose monthly income is **less than the highest income category** need to provide proof of income. Should the applicant not receive an income and another person pay the subscription on behalf of the applicant or an allowance to the applicant, proof of income of the person paying the subscription/allowance must be provided.

Acceptable proof of income

Income from investments:
This income must be declared by all individuals, if applicable, and includes interest, dividends and rental income.
- Letter from an auditor/accountant/income tax adviser
- Latest tax assessment – ITA34
- IT3(a) and the past **three** months' bank statements*
- Rental income – the rental agreement and past **three** months' bank statements*

Income from full-time employment:
Gross monthly income includes all forms of remuneration, such as basic salary, overtime, commission, bonuses, allowances, fringe benefits and one-off payments.
- The past **three** months' official pay slips
- The latest tax assessment – ITA34
- IRP5 of the previous tax year
- Past **three** months' commission and bank statements*

Pensioners: (Pension, annuity)
- The latest tax assessment – ITA34
- The past **three** months' pension payment advices and additional proof

Own business: (Income from vocation/profession, total income from business, irregular income)
- The latest tax assessment – ITA34
- Letter from an auditor/accountant/income tax adviser

Unemployed:
Individuals who receive no income from a vocation/profession/business, who are unemployed or receive an allowance.
- Income of the person paying the subscription/allowance
- UIF payments

* Please note: Only official bank statements on which the account holder's initials and surname are indicated, are acceptable. Please indicate clearly on the bank statements which payment(s) refer to your income.

Employer groups:
- Any proof of income applicable to individuals as indicated above

Full-time students (members WITHOUT dependants):
- A notice or letter on an official letterhead from the tertiary institution where you are registered as a full-time student
- A copy of your student card for the current year

Important:
- If no acceptable proof of income can be provided, your subscription will be calculated according to the highest income category.
- Medihelp can require additional proof other than the above.

6. details of dependants you wish to register

The following dependants of an applicant may be registered:

- Spouse/partner.
- Father/mother/brothers/sisters/grandchildren of the **applicant** (**PLEASE NOTE:** the dependants of the spouse/partner cannot be registered as dependants of the applicant, and grandchildren of the applicant pay the same subscription as that of a spouse, unless legally adopted).
- Dependent natural children (of the applicant and spouse/partner).
- Dependent stepchildren (of the applicant and spouse/partner).
- Adopted children/foster children/children in temporary safe care/children born in terms of a surrogate motherhood agreement (of the applicant and spouse/partner). Official proof of the Court/clerk of the Court/appointed social worker must be provided in terms of the set criteria determined by Medihelp – foster children and children in temporary safe care may be registered as dependants only up to the age of 21 years in terms of legislation.
- In the case of dependants who are not South African citizens, a copy of their passport must be submitted with the completed application form.

Dependant (spouse/partner)

Surname

First names in full

Nickname

ID/passport number

Gender Male Female

Date of birth y y y y m m d d

Cell number

Relationship to applicant

Dependant

Surname

First names in full

Nickname

ID/passport number

Gender Male Female

Date of birth y y y y m m d d

Relationship to applicant

Dependant

Surname

First names in full

Nickname

ID/passport number

Gender Male Female

Date of birth y y y y m m d d

Relationship to applicant

Dependant

Surname

First names in full

Nickname

ID/passport number

Gender Male Female

Date of birth y y y y m m d d

Relationship to applicant

Unify only – choice of service provider: indicate practice number

Surname	Nickname	General practitioner	Dentist	Optometrist
		Practice number	Practice number	Practice number
		Practice number	Practice number	Practice number
		Practice number	Practice number	Practice number
		Practice number	Practice number	Practice number

7. banking details

*I/my employer hereby authorise/s Medihelp to recover the applicable monthly subscriptions payable by *me/my employer as my authorised agent to Medihelp by debit order from *my/my employer as my authorised agent's bank account monthly on the first workday of each month as from the date of enrolment. I further authorise Medihelp to increase or decrease the subscriptions, should it be necessary, and recover the amended amount, or any subscriptions in arrears, from *my/my employer as my authorised agent's bank account.
(*Delete where not applicable)

☐ 1. Use this account for **all transactions**

☐ 2. Use this account only for the recovery of subscriptions
NB: If you select this option, please complete your banking details for refunding claims in the table on the right.

Bank	
Branch	
Branch code	
Type of account	Savings / Cheque / Transmission
Name of account holder	
Account number	

☐ Use this account for claims refunds only
NB: If you selected number 2 on the left, please complete these banking details

Bank	
Branch	
Branch code	
Type of account	Savings / Cheque / Transmission
Name of account holder	
Account number	

If only one bank account number is provided, this account will be used both for the recovery of subscriptions and for refunding credits.

Signature of account holder

Signature of authorised official of the employer
(If your subscription is paid by your employer)

8. previous/current membership of medical scheme(s)

8.1 Has this application been necessitated by a change in employment which resulted in the cancellation of your membership of a previous medical scheme? (Not applicable to pensioners who belong to closed schemes.)

Yes / No Who was the member of the previous scheme? Name and surname

8.2 **Please provide details of ALL the medical schemes where you and your dependants are currently, or have previously been, enrolled:**

NB:
- The date joined and the date ended are important to place you in the correct enrolment category.
- Indicate "current" if your membership of the existing scheme is still active.
- Ensure that the dates of your membership at the different schemes do not overlap.

Name of medical scheme*	Name and surname*	Membership number	Date joined*	Date ended*

*This information is compulsory. If not completed, your application for membership cannot be finalised.

8. previous/current membership of medical scheme(s) (continued)

8.3 Did your or your dependants' previous medical scheme apply any late-joiner penalty?

Yes	No

If "Yes", please provide the following details:

Name of applicant/dependant	Late-joiner penalty			
	5%	25%	50%	75%
	5%	25%	50%	75%
	5%	25%	50%	75%

8.4 Did your or your dependants' previous medical scheme apply any condition-specific waiting period and was it still active at the time of termination of membership? (The treatment of a specific condition was excluded from benefits for a certain period.)

Yes	No

If "Yes", please provide the following details:

Name of applicant/dependant	Condition-specific waiting period (CSW)	End date of CSW							
		y	y	y	y	m	m	d	d
		y	y	y	y	m	m	d	d
		y	y	y	y	m	m	d	d

If the space provided is insufficient, please provide additional information on a separate page.

9. medical questionnaire

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **If the space provided is insufficient, please provide additional information on a separate page.**

NB: Has ANY person indicated on this application form EVER suffered from or received treatment/consulted a doctor for any of the following medical conditions, illnesses or disorders AT ANY TIME? (Disorder includes affection or condition of illness.)

Mark with an "X"

1. Any disorder of or previous treatment of the neurological system (brain, spinal cord, epilepsy, tremors, paralysis, weakness, stroke, etc.)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

2. Any disorder of or previous treatment of the musculo-skeletal system (joints, back, bones, rheumatism, spinal column, muscle weakness, osteoporosis, gout, arthritis, etc.)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

3. Any disorder of or previous treatment of the stomach, intestines, liver or other abdominal organ (heartburn, ulcer, infection, jaundice, irritable bowel syndrome, haemorrhoids, etc.)?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

9. medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Has ANY person indicated on this application form **EVER** suffered from or received treatment/consulted a doctor for any of the following medical conditions, illnesses or disorders **AT ANY TIME?** (Disorder includes affection or condition of illness.)

Mark with an "X"

4. Any disorder of or previous treatment of the kidneys, bladder, or genital organs (kidney stones, infections, dialysis, malformations, etc.)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

5. Is any female beneficiary indicated in this application currently pregnant or is pregnancy suspected? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

6. Any lung disorder (asthma, infections, breathing problems, emphysema, etc.) or previous treatment of the respiratory system? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

7. Any disorder of or previous treatment of the heart or circulatory system (high blood pressure, chest pain, pacemaker, coronary artery disease, etc.)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

8. Does any beneficiary suffer from diabetes or elevated blood sugar? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

9. Does any beneficiary suffer from high cholesterol? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

9. medical questionnaire (continued)

- All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.
- If the space provided is insufficient, please provide additional information on a separate page.

NB: Has ANY person indicated on this application form EVER suffered from or received treatment/consulted a doctor for any of the following medical conditions, illnesses or disorders AT ANY TIME? (Disorder includes affection or condition of illness.)

Mark with an "X"

10. Does any beneficiary suffer from haemophilia (blood clotting disorder)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

11. Any dental procedures already approved but not yet begun, currently in process or already completed? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

12. Any type of cancer (leukaemia, lymphoma, tissue-specific cancers, etc.)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

13. Any psychiatric or mental health condition or previous hospitalisation for depression, stress, panic attacks, etc.? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

14. Any eye disorder or previous surgery/hospitalisation for defective vision, cataracts, glaucoma, retinitis, etc.? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

15. Hernias of any nature (break in the abdominal wall, hiatus hernia, etc.)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

9. medical questionnaire (continued)

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **If the space provided is insufficient, please provide additional information on a separate page.**

NB: Has ANY person indicated on this application form EVER suffered from or received treatment/consulted a doctor for any of the following medical conditions, illnesses or disorders AT ANY TIME? (Disorder includes affection or condition of illness.)

Mark with an "X"

16. Any other metabolic or congenital disorders (porphyria, lactose intolerance, vitamin D deficiency, etc.)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

17. Any substance dependency (alcohol, drugs, anabolic steroids, etc.)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

18. Any disorder of the ears/nose/throat (ear discharge, recurrent infection, tonsillitis, sinusitis, etc.)? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

19. Any gynaecological disorder or previous treatment for gynaecological conditions, irregular menstrual cycles and/or excessive menstrual bleeding/miscarriages? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

20. If you are **HIV positive or have Aids**, you must phone Medihelp on **086 090 6090** within 21 days from your enrolment date to register on Medihelp's HIV/Aids programme. Should you fail to adhere to this condition, it will be considered as the non-disclosure of information which may result in the termination of your membership. On receipt of this request, Medihelp will determine whether underwriting conditions will be applied, and if this is the case, you will receive an amended "proof of membership" document.

21. Has any person indicated in this application ever been diagnosed with, treated or managed for any condition or disorder not mentioned in the medical questionnaire, or has he/she consulted a medical practitioner for any condition or disorder not mentioned in this questionnaire? | Yes | No |

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

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9. medical questionnaire (continued)

- **All questions must be answered with a "Yes" or "No". If "Yes", please provide full details. Incomplete, inaccurate information or information which is withheld may result in the termination of your membership.**
- **If the space provided is insufficient, please provide additional information on a separate page.**

NB: Has ANY person indicated on this application form EVER suffered from or received treatment/consulted a doctor for any of the following medical conditions, illnesses or disorders AT ANY TIME? (Disorder includes affection or condition of illness.)

Mark with an "X"

22. Does any person indicated in this application plan or anticipate any medical test/examination/operation/hospitalisation and/or treatment or is he/she awaiting test results in respect of any conditions or disorders? Also state whether any person has already been scheduled for any of the above.

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

23. Do you/your dependants use any medicine on a regular basis not already mentioned above (including medicine bought without prescription)? If "Yes", please indicate the medicine as well as the condition.

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

24. Does any beneficiary suffer from any other chronic disease(s) not already mentioned above?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

25. Any abnormalities in the results of previous medical tests/examinations not already mentioned above?

Yes	No

Name(s) of patient(s)	Specify illness/condition/ disorder in full	Date of diagnosis	Last date of follow-up consultation, tests or treatment	Indicate treatment, therapy and/or medicine used during the past 12 months

Please note that this medical questionnaire does not constitute an application to register or authorise chronic medicine/PMB services/ planned procedures/treatment for benefits. Should you need to obtain authorisation for chronic medicine, please phone MEDICHRON, Medihelp's medicine management division, on 086 0100 678 once your membership of Medihelp has been finalised, to obtain an application form for chronic medicine benefits. Alternatively, you can download an application form from the Medihelp website at www.medihelp.co.za.

10. conditions of membership and declaration by applicant

Medihelp confirms that –

1. your and your registered dependants' personal and medical information will be treated confidentially and will not be sold to a third party or used for commercial or related purposes;
2. security measures have been implemented to protect your data and that Medihelp staff and contracted parties have access to your data to process and pay claims, among other things, and that they have signed a confidentiality agreement in terms of which they undertake not to disclose your personal information to any unauthorised parties;
3. your personal information will only be used for purposes such as processing your application for membership, paying your medical claims, determining whether you are entitled to benefits, managing risks, and for any communication purposes;
4. the Scheme will accept liability for any breach of confidence and will manage such occurrences in accordance with its internal policy; and

10. conditions of membership and declaration by applicant (continued)

5. should you make use of a Medihelp accredited broker house service then relevant membership information will be made available to the broker house in order to render a service to you, and any authorised person of the broker house may instruct Medihelp to change any of your personal information except for banking details, unless you instruct Medihelp otherwise.

Your responsibilities as a member of Medihelp:

1. I will ensure that I know all the provisions of Medihelp's Rules and will read all the correspondence from Medihelp, such as newsletters and statements, and I will study my benefit guide and familiarise myself with the coverage offered by the benefit option that I have chosen.

2. I undertake to abide by the Rules, as amended from time to time, as available at www.medihelp.co.za, and not to submit any fraudulent claims or commit any fraudulent acts.

3. I declare that the information provided in this application for membership is accurate and complete. I understand that any false declaration or omission of information may result in the termination of my membership and that of my registered dependant(s) or any other measures which Medihelp, in its sole discretion, may decide to take, subject to appeal procedures. I undertake to notify Medihelp in writing should there be any changes in my health status or that of my dependants after my application for membership has been submitted but prior to my membership commencement date. I confirm that the residential address stated on page 1 is the address that I choose for the purpose of serving any legal documentation. I undertake to notify Medihelp in writing should there be any future changes in my personal details and/or banking details.

4. I confirm that neither my dependant(s) nor I will be registered as beneficiaries of another registered medical scheme on the date on which I request membership of Medihelp.

5. I take note that the monthly subscription fees will be due on the first day of the calendar month in which I am enrolled as a member, and on the first day of every subsequent calendar month. Should my employer, as my authorised agent, undertake to pay my subscriptions to Medihelp, I give permission to my employer to deduct the amount payable to Medihelp from my salary and pay such amount over to Medihelp. I am also responsible for repaying any debt outstanding on my medical savings account should I terminate my membership of Medihelp.

6. I confirm that I am responsible for giving advance notice of termination of membership, and that neither my dependant(s) nor I will be registered as beneficiaries of another registered medical scheme while still being members of Medihelp.

Medihelp's rights as a medical scheme:

7. I am aware that a 3-month general and/or a 12-month condition-specific waiting period and a late-joiner penalty may be imposed on my membership and that of my registered dependant(s) in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998). Medihelp may finalise my membership without issuing a document containing the conditions of my membership in the event that no waiting period and/or late-joiner penalty is imposed.

8. I am also aware that Medihelp may restrict benefits to be granted and limit amounts/tariffs to be paid in respect of particular services, for example by enforcing co-payments and exclusions.

9. Medihelp's Rules may provide for various interventions designed to promote cost-effectiveness and appropriateness of services, such as preauthorisation and making use of designated service providers.

10. Medihelp may also restrict interchanges between benefit options to the beginning of a year, and require a notice period as set out in the Rules.

11. Medihelp may refuse to pay a claim that is submitted after the period as prescribed in the Rules.

12. I am further aware that my membership may be suspended should I not fully pay my contributions or debt for a period of a month, and that my membership may be terminated should I be in arrears for a period of two (2) months, and that my account will be handed over for collection.

13. I am aware that Medihelp may increase its subscriptions annually at the beginning of the year.

Protection of information:

14. I hereby give permission, and declare that I have obtained the consent of all my dependants, that –

    14.1 Medihelp may enquire about my health status or that of my dependant(s) at any medical doctor or any person who is in possession of such information, and give permission for the doctor or person concerned to make such information available to Medihelp and its contracted third parties;

    14.2 my dependants may enquire about my personal and medical information and that of any of my dependants at Medihelp's disposal;

10. conditions of membership and declaration by applicant (continued)

14.3 a broker in service of a Medihelp accredited broker house, should I make such appointment and use their service, may have access to my personal and medical information and that of any of my registered dependants at Medihelp's disposal, and that such broker or an authorised person of the broker house may instruct Medihelp to change any of my personal information except for my banking details and may sign the acceptance document containing the conditions of membership on my behalf; and

14.4 Medihelp may disclose my and my dependants' medical and personal information to medical service providers for the purpose of delivering medical services to my dependants and I and to pay for such services.

15. I understand that the information contemplated in paragraph 14 will only be used for the purposes as set out in Medihelp's confidentiality statement (on this application form) and that any deviation will be regarded as a breach of confidence. Should Medihelp wish to use the information for any other purpose, Medihelp must first obtain my approval.

16. I agree that all my telephone conversations and/or that of my dependant(s) with Medihelp and/or its contracted third parties may be recorded.

17. I agree that Medihelp may, for the purpose of considering my application for membership or conducting underwriting or risk assessments or considering a claim for medical expenses, request information about me and my dependant(s) from medical practitioners, financial advisers, credit bureaus, industry regulatory bodies or employers.

18. I further consent, and declare that I have obtained the consent of all my dependants, that Medihelp may provide any credit bureau or credit providers industry association with any information about my/my dependants' consumer credit record, including and not limited to information about my/my dependants' credit history, financial history, personal information and judgment or default history.

Signature of applicant

In your capacity as | Member | Guardian | Curator |

Date | y | y | y | y | m | m | d | d |

Should you be applying on behalf of another person as **guardian or curator**, please complete the following:

ID/passport No. | | | | | | | | | | | | | |

Title | Mr | Mrs | Ms | Other (specify) |

A copy of you passport/ID document, as well as the document confirming your appointment as guardian/curator, must accompany this application.

First names | | Surname | |

Tel: Code | | No. | | Fax: Code | | No. | |

Cell number | |

11. undertaking and declaration by broker

NB: If this section is not completed in full by the broker, no commission will be paid.

I declare that –

1. the applicant has appointed me as his/her broker and is entitled to cancel my services at any time;
2. I have a signed a valid contract with my Medihelp accredited broker house; and
3. the applicant has signed the application in person.

I take note that the broker/brokerage/broker house indemnifies Medihelp against any non-adherence to the legal requirements as quoted above.

Name of broker house | | Broker house code | A | | | | | Broker code | | | | |

Name and surname of broker

CONSULTANTS

MSP CONS
AO609
1383

Tel: Code | | No.: 011 462 8361 | Fax: Code | | No. | X: 086 679 5053 |

E-mail address

Signature of broker

Lead reference number | | | | | | | | | | | | | | |

Date | y | y | y | y | m | m | d | d |

In case of a dispute, the registered Rules of Medihelp will apply.

IVISP CON$ULTANTS
THL: 01 1 4fi2 8g61
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