

Applying to become a member of MEDiPOS Medical Scheme



Contact us

Tel: 0860 100 078 • PO Box 652509, Benmore 2010 • www.medipos.co.za

Thank you for deciding to join MEDiPOS Medical Scheme. This document is an application form for membership.

It also contains some rules for membership. Please make sure you read and understand these rules.

Who we are

MEDiPOS Medical Scheme (also known as the "Scheme"), registration number 1548, is a not-for-profit organisation registered with the Council for Medical Schemes and is the medical scheme that you are applying to become a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the Administrator and managed care organisation for MEDiPOS and takes care of the administration of your membership.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly or complete it electronically by typing into the fields below.
2. Read and understand the Terms and Conditions for membership (section 10).
3. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
4. Main applicant to sign and date any changes.
5. It is imperative that all sections of this application be completed in full. Failing to do this may cause a delay in the processing of this application, as the incomplete form will be returned to your employer.
6. Once completed, please return to your human resources department.
7. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

Once you send us your application form, this is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will send you a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely accepted. This date may differ from the date on which you sign the application form.
- You will then get a membership pack in the post.

When you sign this application, you confirm that you have read and understood the Terms and Conditions (section 10 of this form) for membership, as well as the Privacy Statement and agree to them.

I consent to my spouse and/or adult dependant acting on my behalf and providing my personal information, including health information, to Discovery Health for the purpose of my application to join MEDiPOS Medical Scheme.

Yes No

1. About yourself (main applicant)

When do you want your cover to start?	<input type="text"/>								
Title	<input type="text"/>	Initials		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>								
First names (as per identity document)	<input type="text"/>								
ID or passport number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Race	African <input type="checkbox"/>	Coloured <input type="checkbox"/>	Indian/Asian <input type="checkbox"/>	White <input type="checkbox"/>	Other <input type="checkbox"/>	Do not want to disclose <input type="checkbox"/>			
<i>You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.</i>									
Marital status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>					
Tax number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Number of dependants	<input type="text"/>
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone (W)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				

Email

Physical address

Unit/Suite number Complex name

Street number Street name

Suburb

City Postal code

Postal address (Post collected from post box, suite or private bag)

PO Box Private Bag Box number

Suite PostNet Suite Number

Suburb

City Postal code

2. About your spouse or partner (only complete if applying for cover)

Title Initials

Surname

First name(s)

Previous or maiden name

ID or passport number

Gender M F Date of birth

Race African Coloured Indian / Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member Spouse Partner Legally married (Include marriage certificate if legally married)

Telephone (H) Telephone (W)

Cellphone

Email

Partnership declaration

In the event that you are not legally married and unable to produce a marriage certificate, we require that you complete the below section fully.

Registration of a PARTNER is subject to the following definition as defined in the rules of the Scheme:

“Partner” is a person with whom the member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

We hereby declare that we are in a long-term, committed relationship that is akin to a marriage and that we reside together at the same residence.

We understand that by signing this declaration we agree to inform the Scheme of any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that, should the information provided regarding our relationship or residency be false in any way, the Scheme reserves the right to terminate both our memberships. Should the below section not be signed and dated by both parties, the application process will be halted until such time as the section has been duly signed and dated by both parties.

Signature of main applicant Date

Original signature required

Signature of partner Date

Original signature required

3. About your dependants (if applying for cover)

Dependant 1

Title Initials

Surname

First names (according to identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child, stepchild. Please give us legal proof of the relationship.)

If over 18 years provide cellphone number

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A full-time or part-time student? Yes No

If the dependant is disabled, please confirm type of disability Permanent Temporary

Dependant 2

Title Initials

Surname

First names (according to identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child, stepchild. Please give us legal proof of the relationship.)

If over 18 years provide cellphone number

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A full-time or part-time student? Yes No

If the dependant is disabled, please confirm type of disability Permanent Temporary

Dependant 3

Title Initials

Surname

First names (according to identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (For example mother or child. Where your child is not your biological child, please state your relationship, for example adopted child, stepchild. Please give us legal proof of the relationship.)

If over 18 years provide cellphone number

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A full-time or part-time student? Yes No

If the dependant is disabled, please confirm type of disability Permanent Temporary

Are you applying for more than 3 dependants? Yes No

Note: If you are applying for more than 3 dependants, please add the details on a separate page.

Dependant classification and proof required

Definition of Dependant	Documentation required
Spouse	Marriage certificate or affidavit for customary/common law marriage
Natural child	ID, birth certificate (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Natural child with different surname to main member	ID, birth certificate, affidavit (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Stepchild	ID, birth certificate, affidavit (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Adopted child	ID, full birth certificate, legal proof of adoption (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Disabled dependant	(If > 21) Medical report from treating doctor / specialist or proof of disability pension
Traditional/polygamous spouse	ID, affidavit/certificate of customary union
Parents/siblings of main member	ID, affidavit of financial dependency, proof of income
Common-law partner/same gender partner	ID, affidavit

4. Please select your benefit option

Please indicate with an X the option required: Option A Option B Option B Classic Option C

Personal Medical Savings Account only on Option B. Select payment method.

MEDiPOS Medical Scheme offers members on Option B two options to have their claims paid from their Personal Medical Savings Account (PMSA). This option is available to you on registration and every year on 01 January.

Please tick which method you would like to be paid from your PMSA

Automatically pay my claims at Cost (paid in full)

This would mean that should the Scheme receive your claim, we will automatically pay your claim from your PMSA if there is a short payment (or co-payment), rejection or if your benefits have been exceeded.

Do not pay any of my claims from my PMSA without my permission

This would mean, you would have to contact the Administrator to have your claims paid from your PMSA, should there be a short payment, rejection or if your benefits have been exceeded.

5. Your claims refund banking details

9.1 Please note: We cannot accept credit card account details. We no longer issue cheques, if no details are provided it will impact your claims payment. If we are paying a third party bank account, the main member must insert the ID number of the third party.

Name of bank

Branch name Branch code - -

Account number Type of account Cheque/Transmission/Transaction Savings

Account holder

Account holder contact number

Account holder email address

If we are refunding a third-party bank account, the main member must insert the ID or passport number of the third-party.

ID number of third party

If the third party bank account is a Joint account Company account Trust account

Please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

According to Payments Association of South Africa (PASA) debit order mandate requirements, you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system.

If you wish to update any contact details please visit www.discovery.co.za

We will debit your account on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Discovery Health will collect that amount in the interim, upon activation . Once your account is paid up to date, you may change your debit order date to a variable debit order date by contacting us on **0860 99 88 77**.

9.2 Your claims refund

Can we use the same account provided for contributions to make any payments to you (e.g., claims payments, refunds of overpayments)? Yes No

If you do not want to use the same banking details for your contributions and claims refunds, please give us the details you would like to use:

Please note: We cannot accept credit card account details. We no longer issue cheques, if no details are provided it will impact your claims payment. If we are paying a third party bank account, the main member must insert the ID number of the third party.

Name of bank			
Branch name		Branch code	<input type="text"/> - <input type="text"/> - <input type="text"/>
Account number	<input type="text"/>	Type of account	Cheque/Transmission/Transaction <input type="checkbox"/> Savings <input type="checkbox"/>
Account holder			
Physical address			
Unit/Suite number	<input type="text"/>	Complex name	
Street number	<input type="text"/>	Street name	
Suburb			
City		Postal code	<input type="text"/>
Account holder contact number	<input type="text"/>		
Account holder email address			

If we are refunding a third-party bank account, the main member must insert the ID or passport number of the third-party.

If third party bank details, please insert the third party ID number

If the third party bank account is a Joint account Company account Trust account

Please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded and authorize MEDiPOS to contact the account holder provided above to verify payments made or received, if necessary.

Signature of account holder

Date

Signature of main applicant

Date

6. Previous medical scheme details (please give us proof in the form of a membership certificate)

Please give us the details of all registered South African medical schemes that you and your dependants previously belonged to. **We may use the information on the membership certificate to determine if we can apply waiting periods. However, it is still the applicant's obligation to disclose any and all relevant information as required above.**

Were all your dependants on the same medical scheme? Yes No

If you and your dependants belonged to different medical schemes, please complete them below:

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	

7. Moving from another medical scheme

Please make sure that you have completed section 6.

7.1. I confirm that all people named on this application:

7.1.1. have not had a break in membership of more than 90 days since resigning from the previous South African medical scheme, and

Yes No

7.1.2. are currently or have been members of a South African medical scheme for at least the past 24 months

Yes No

If you answered yes to the above questions, please answer the questions in 7.2.

If you answer no to any question in 7.1, you must complete all the medical questions in section 8.

7.2. For any person named on this application form:

7.2.1. have they been admitted to hospital in the 12 months before this application?

Yes No

7.2.2. are they currently taking regular, ongoing medicine and/or treatment of a medical condition or symptom?

Yes No

7.2.3. are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment/investigations in the next 12 months?

Yes No

If you answered yes to any questions in 7.2, we will apply a three-month general waiting period to your application and you do not have to complete Section 8.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules. If you feel that a three-month general waiting period should not be applied and you want to give us more information, please complete section 8.

8. Your health questions

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customised information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve the Scheme's financial modelling, to assist the Scheme to better assess and mitigate its risk and other beneficial uses.

A condition-specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a 12-month period ending on the date on which this application is considered to be fully and properly made.

You must tell us in writing if any of the information you gave, in your application for membership, changes between the day you sign this form and the day your membership starts. This includes information about your health and the health of those you apply for.

The main applicant, spouse or partner and all dependant/s applying for cover need to complete section 8.

Have you or **any dependant** in this application ever experienced, been investigated, treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders.

Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Scheme requiring that you undergo a medical examination, at the Scheme's cost. Should that medical examination reveal a current health condition, waiting periods may apply in respect of such current condition.

Please take note that if you have any disorder, symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 8.18 below. Indication of existing medical conditions on this application does not automatically enrol you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Scheme's disease management enrolment, visit www.medipos.co.za.

Please answer ALL questions by ticking "Yes" or "No". If you answered 'Yes', please provide full details in the sections provided.

8.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast

Yes No

Example: skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abscess, abnormal mammogram result, any autoimmune conditions, any congenital conditions, any other abnormal cancer-screening or diagnostic test result/s or other skin conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.2 Heart and circulation conditions

Yes No

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, deep vein thrombosis, pulmonary embolus, and varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.3 Gynaecological and obstetrics conditions

Yes No

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed period, ovarian cyst, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.4 Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or having difficulty falling pregnant?

Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.5 Mental healthYes No

Example: mood disorders (like depression and bipolar disorders), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling, any autoimmune conditions, any congenital conditions and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.6 Metabolic or endocrine conditionsYes No

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, overweight, obesity, metabolic disorders, Conn's syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.7 Abdominal conditionsYes No

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colorectal symptoms/conditions, Crohn's disease, ulcerative colitis, diverticulitis, irritable bowel syndrome (IBS), hemorrhoids, long-standing constipation/diarrhea, ascites (fluid in the abdomen) any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.8 Brain and nerve conditionsYes No

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt), intellectual disability, CVA, bleeding on the brain, constipation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.9 Breathing and respiratory conditionsYes No

Example: asthma, ventilator, oxygen therapy, CPAP, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease/chronic cough > 3-months, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.10 Musculoskeletal (back, bone, injury and muscle pain)Yes No

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis and internal insertion of surgical implants, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.11 Kidney or urinary conditions including current or past dialysisYes No

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.12 Blood conditionsYes No

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.13 Eye conditionsYes No

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.14 Ear, nose and throat (ENT) and dentistry conditionsYes No

Example: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.15 Male urogenital conditionsYes No

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), undescended testes, phimosis, urinary incontinence, retention, infertility, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.16 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/been in casualty in the last 12 months?Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.17 Have you or any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical provider, in the last 12 months before this application?Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

8.18 Have you or any of your dependants ever been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side-effects, not mentioned in the questions above, in the last 12 months before this application?Yes No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 100 078** within seven working days from the date we activate your MEDiPOS membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme. The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before we start paying for any general or specific medical conditions. A 12-month condition-specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. If you do not let us know about you or your dependant's HIV status within seven days of your membership being active, we may end your membership.

9. MEDiPOS Medical Scheme Privacy Statement 2026

When you engage with MEDiPOS Medical Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants, beneficiaries and life assureds, where applicable. To view and read our Privacy Statement, please follow this link: <https://www.medipos.co.za/wcm/medical-schemes/medipos/assets/privacy-statement.pdf>

Signed at (town or city)

on

D	D	M	M	Y	Y	Y	Y
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Signature of main member

10. Terms and Conditions applicable to MEDiPOS Medical Scheme membership

Definitions

The Scheme refers to MEDiPOS Medical Scheme, registration number 1548, registered with the Council for Medical Schemes. **Administrator** refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed healthcare organisation for and a subsidiary of the Discovery Group.

10.1. Scheme rules for membership

The rules of the Scheme record your rights and responsibilities for your membership of MEDiPOS Medical Scheme. They may change from time to time. You may ask us for a copy of these rules at any time or view them on www.medipos.co.za.

When you sign this application, you confirm that you have read and understood the terms and conditions and you agree that you and those on your membership will be bound by these and the Scheme Rules.

Please speak to the Administrator if there is anything you do not understand.

10.2. Who you are applying for

You may apply to join MEDiPOS Medical Scheme on your own or together with other people – your spouse, /partner, your children and people who are financially dependent on you as defined in the Scheme rules. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. We might ask you to give us proof of financial means or responsibility. You may be called the principal member or main member in our future communications to you.

10.3. Acting for others

You confirm you have the right to act for others. By signing this document, you confirm that:

- You have the right to act for those on your membership in any matter relating to membership
- You have received permission from your spouse/partner and any dependant(s) over 18 to act for them in any matter relating to their membership.

10.4. Giving and getting information

You must give true, correct and complete information

To consider your application for membership, the Scheme must learn more about you and those you apply for. Information about you and those on your membership must be true, correct, and complete. This includes the details you have given in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application.

Your legal address

The Scheme or Administrator will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Scheme and Administrator may record telephone calls

The Scheme and Administrator may record telephone conversations with you and with those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including healthcare providers, contracted service providers, credit bureaus or industry regulatory bodies (“relevant sources”) and further process such information to conduct risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse.

We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct, and complete. You give your permission that the Scheme and Administrator may get any information that is relevant to your application from your employer.

Tell the Scheme or Administrator immediately if your information changes

You must inform the Scheme or Administrator in writing if any of the information you gave in your application for membership changes between the day you signed the document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership

The Scheme may cancel your membership if you and those you apply for:

- do not give us information that later turns out to be relevant to your application
- give us any information that is not true, correct and complete;
- do not tell us about any relevant changes (including about your health and the health of those on your membership) between the day you sign this document, and the day cover starts.

Providing false information may lead to criminal charges being brought against you. You will also have to pay any amount owing to the Scheme as a result of this cancellation.

10.5. The Scheme might not pay for certain expenses immediately after you become a member

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will advise if any waiting periods apply to your membership and the membership of those you apply for. Please speak to the Administrator with regard to any waiting periods applicable to your membership.

10.6. You must ensure contributions are paid on time

As the main member of the Scheme even if your contributions will be paid via your employer, you are responsible for ensuring that your full contributions and the full contributions of those on your membership are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time with prior notification.

10.7. Repaying money owed to the Scheme

The Scheme has the right at any time to collect from you any amount that you owe. We will notify you if there is any amount that you owe to the Scheme.

Signature of main member

Date

D	D	M	M	Y	Y	Y	Y
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11. Third-Party Bank Details - Annexure A

Banking details for a third party

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
 - State that the account can be used
 - State the membership details (including the membership or policy numbers) for which the bank account will be used
 - Include the details of the signatory
 - Be dated and signed by an authorised person on behalf of the company
 - A copy of the company's certificate of registration.
 - A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

Proof of account (bank statement or bank letter not older than three months)

- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
 - Show the trustees
 - Be dated and signed by an authorised person on behalf of the trust
 - Contain the membership or policy numbers
 - A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.

12. Your employment details

Region/Paypoint number	<input type="text"/>	Gross monthly income R	<input type="text"/>
Region/Paypoint name	<input type="text"/>	Date of employment	<input type="text"/>
Personnel number	<input type="text"/>	Group	SAPO <input type="checkbox"/> DOCEX <input type="checkbox"/> Post bank <input type="checkbox"/>
Employment type	Permanent staff <input type="checkbox"/> Pensioner <input type="checkbox"/>		
Registration date	<input type="text"/>		

13. Official Employer Stamp

STAMP

This section must be completed by an authorised official, only if applicant is a permanent staff member, after thorough scrutiny.

Signature	<input type="text"/>
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Date	<input type="text"/>
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