UMVUZO HEALTH

| I | D | | / | | P | A | S | S | P | O | R | T |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

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P.O. Box 1463, Faerie Glen, 0043. **T:** +27 (0) 12 845 0000 **F:** +27 (0) 86 670 0242
**Call Centre:** 0861 083 084

**www.umvuzohealth.co.za**

# MEMBER APPLICATION FORM

## A. DETAILS OF MAIN MEMBER (COMPULSORY FIELDS)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Company name | | | | | | | |
| Date of permanent employment | Y Y Y Y M M D D | Medical aid start date requested | Y Y Y Y M M D D | | | | |
| Employee number | | Pay point / Branch | | | | | |
| Option: (mark with an "X") | Ultra Affordable | | Standard | | Supreme | | Extreme | |
| *If Activator/Ultra Affordable Value is selected, kindly complete the GP nomination form* | | | | | Activator | | Ultra Affordable Value | |
| Main member name | Surname | I D / P A S S P O R T | | | | | | |
| Date of birth | Gender | Race | Email | | | | | |
| Postal / Physical address | | | | | Cell 1 | | | |
| | Code | | | | Cell 2 | | | |

## B. DETAILS OF BENEFICIARIES **Race** - **A** = African / Black, **I** = Indian/Asian **W** = White **C** = Coloured • **Gender** - **F** = Female, **M** = Male

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Spouse** | | | | | | | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |
| Email | | Cell | | | | | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |
| Email | | Cell | | | | | |
| **Adult dependants (≥21)** | | | | | | | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |
| Email | | Cell | | | | | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |
| Email | | Cell | | | | | |
| **Child dependants (<21)** | | | | | | | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |
| Name | Surname | I D / P A S S P O R T | Date of birth | Gender | Race | Relationship | |

## C. BANK DETAILS (FOR REFUND PURPOSES ONLY)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Bank name | | | | | | | |
| Branch | | Branch code | | | | | |
| Account number | | Account type (mark with an "X") | Cheque | | Savings | | |

## D. PROTECTION OF PERSONAL INFORMATION

1. The privacy and security of your personal information (which includes the personal information of your dependants) are important to Umvuzo Health Medical Scheme. The Scheme will only process personal information, which includes collecting, using, storing, sharing, analysing, automated and manual processing of such information, in accordance with its Privacy Policy, available at https://www.umvuzohealth.co.za and if the processing is permitted by law, for a legitimate interest or otherwise with your consent, if necessary.
2. Umvuzo Health Medical Scheme may require additional personal information about you and your dependants to assess your eligibility for Scheme membership, apply underwriting as permitted by the Medical Schemes Act 131, 1998 and the Umvuzo Health Medical Scheme registered rules to perform the contract between the principal member and the Scheme.
3. All conversations between you or any of your dependants and Umvuzo Health Medical Scheme, its agents or contracted parties, will be recorded and all information obtained through these conversations will form part of the records of Umvuzo Health Medical Scheme.
4. By signing this form, you authorise Umvuzo and/or its agents to obtain any information that they may require concerning you or any of your dependants (such as health information) for any purpose directly related to the medical scheme membership or which is authorised in terms of the Medical Schemes Act, the Scheme Rules or any other legislation, from any person who holds such information (such as healthcare practitioners).
5. By signing this form, you guarantee that to the extent that it may be required by law, you have the necessary authority or permission from your dependants to provide the consent, permissions and personal information on their behalf as set out in this document and as may be required from time to time by Umvuzo Health Medical Scheme.

## E. MEMBER'S UNDERTAKING

I _____ (full name)hereby declare that:

**The contents** of this document have been explained to me in a language that I understand and that all my questions have been answered satisfactorily.

**All information supplied** on this application form is, to the best of my knowledge and belief, true, correct and complete, and that I will advise the Scheme as soon as any of the information changes.

**I have read** the Privacy Policy of Umvuzo Health Medical Scheme and that I fully understand my/our rights in respect of my/our personal information processed by the Scheme, how the Scheme will process my/our information and with whom it will be shared.

**I provide** the consent below of my own free will without any undue influence from any person whatsoever.

**I have familiarised** myself with the rules, benefits and networks of the Scheme and subject myself to them.

**I understand** that I must get authorisation to visit a specialist, go to hospital, get a scan and make use of an emergency visit or any other service stipulated by the Scheme.

**I understand** the medication benefit of my selected Option and the fact that benefits can be driven by formularies, protocols and Scheme rules and that any medication outside these parameters will be for my own account.

**I hereby undertake** to comply with the management of benefits by the Authorisation Centre and the guidelines they follow and to co-operate to the best of my ability with their processes and procedures.

**I grant permission** to any provider, person or party who may be in possession of information concerning my health or that of my dependants, to divulge such information to Umvuzo Health or its duly contracted agents upon request, also after my death.

**I understand** my premium must be payed on or before the 3rd day of each month and to pay my share of accounts.

**I hereby authorise** Umvuzo Health to recover such payments from my employer, whom I authorise to deduct the amount from my salary or if I resign, from my pension and or any other money due to me and to pay this over to Umvuzo Health.

The above mechanisms may be used to cover any incurred cost should I resign from my job or terminate my Umvuzo Health Medical Scheme membership prior to such cost being recovered.

**Upon signing this document,** I understand that I am entering into a binding agreement with Umvuzo Health and that it is my responsibility to make sure that all the beneficiaries listed on this application, as well as any beneficiaries I add in future, are fully informed about all aspects of my agreement with Umvuzo Health.

**I hereby accept** the appointment that my representatives made on my behalf with regards to Healthcare Consultants and/or Brokers. I will specifically inform the Scheme in writing should I wish to revoke the appointment of the Healthcare Consultant and / or Broker.

_____ Date Y Y Y Y M M D D

Signature of applicant (main member)

_____ Date Y Y Y Y M M D D

Signature of witness (broker if applicable)

_____ _____

Signature of employer Employer stamp as verification

Medicine bag received (mark with an "X") Yes ☐ No ☐

Please note that your application will **not be processed without** the receipt of the **completed and signed** Medical Conditions Disclosure Form on page 3 and 4.

UMVUZO HEALTH

| I | D | | / | | P | A | S | S | P | O | R | T |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

**Call Centre:** 0861 083 084

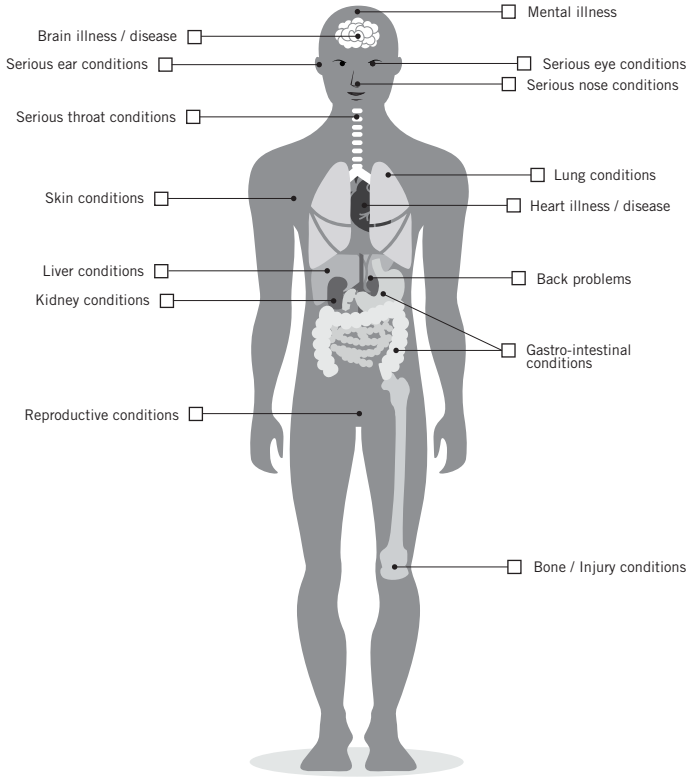
rx health

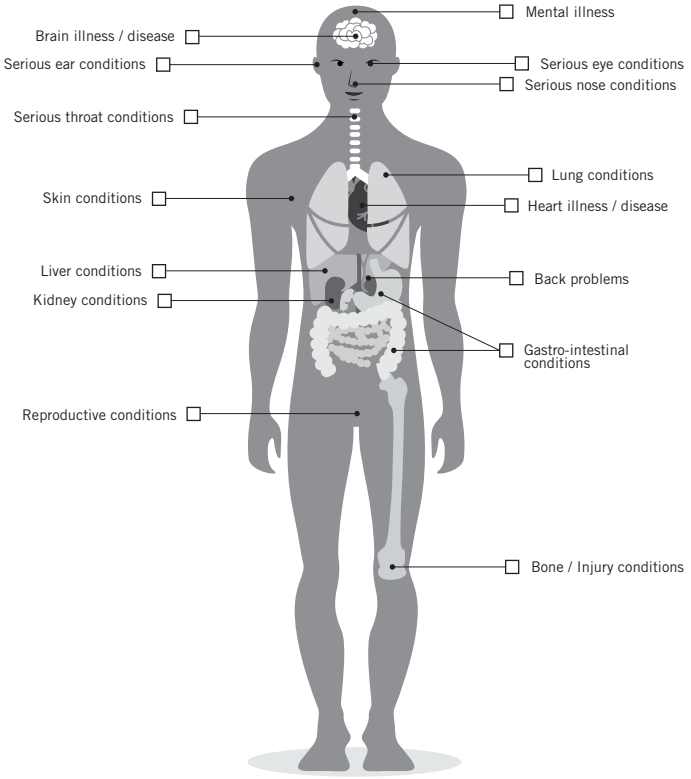
## MEDICAL CONDITIONS DISCLOSURE FORM

| Company name | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Surname | I | D | | / | | P | A | S | S | P | O | R | T |
| Contact number | | | | | | | | | | | | | | |

Have you or your dependants suffered from any of the following conditions (mark with an "X")

| MAIN MEMBER | | Spouse | | Adult dependant | |
|---|---|---|---|---|---|




| | | | |
|---|---|---|---|
| | | Name | |
| | Male | Surname | Male |
| | Female | Contact number | Female |
| Are you currently pregnant | Yes / No | | Are you currently pregnant | Yes / No | |
| | Weeks | | | Weeks | |

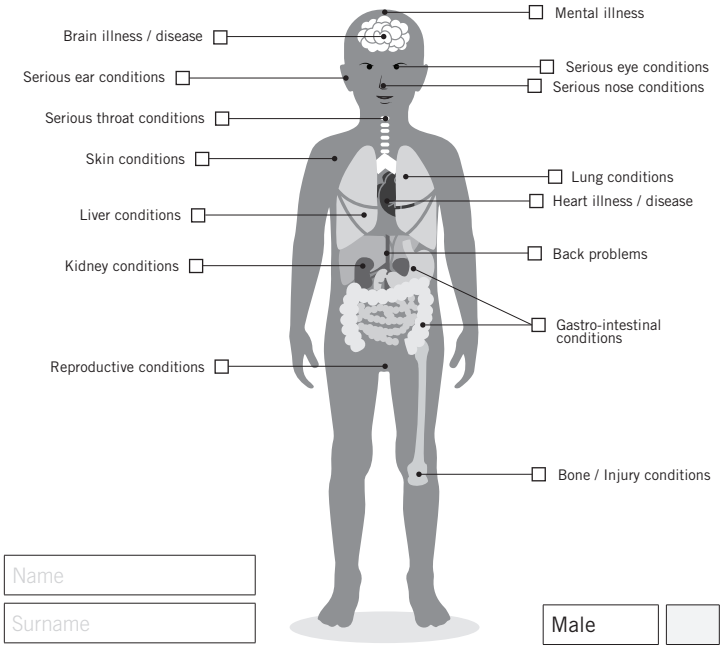
| PAST MEDICAL HISTORY (mark with an "X") | | | | PAST MEDICAL HISTORY (mark with an "X") | | | |
|---|---|---|---|---|---|---|---|
| Previous operation | | Previously hospitalised | | Previous operation | | Previously hospitalised | |
| Diabetes | | Asthma | | Diabetes | | Asthma | |
| Cancer treatment / diagnosis | | Epilepsy | | Cancer treatment / diagnosis | | Epilepsy | |
| High blood pressure | | Cholesterol | | High blood pressure | | Cholesterol | |
| HIV | | Chronic medication | | HIV | | Chronic medication | |

| DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N) | | | | | | DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Vehicle accident | | Road accident fund | | Injury on duty | | Vehicle accident | | Road accident fund | | Injury on duty | |
| Any additional information not indicated above. | | | | | | Any additional information not indicated above. | | | | | |

The Scheme and its contracted providers will only collect personal information consistent with the purpose for which it is required and will only process personal information in a manner that is adequate, relevant and not excessive in the context of the purpose for which it is processed and will take such steps as may be required to ensure that it complies with any law in respect of transfer, storage, security and use of the personal information.

**Initial**

| Adult dependant | | Child dependant | |
|---|---|---|---|



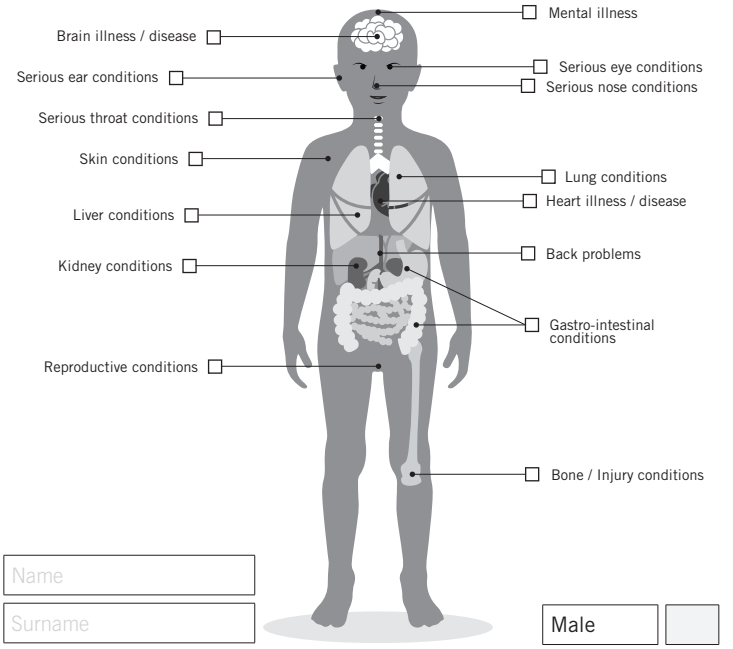

| | | | |
|---|---|---|---|
| Name | | | |
| Surname | | Male | |
| Contact number | | Female | |
| Are you currently pregnant | Yes / No | Weeks | |

| PAST MEDICAL HISTORY (mark with an "X") | | | |
|---|---|---|---|
| Previous operation | | Previously hospitalised | |
| Diabetes | | Asthma | |
| Cancer treatment / diagnosis | | Epilepsy | |
| High blood pressure | | Cholesterol | |
| HIV | | Chronic medication | |

| DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N) | | | | | |
|---|---|---|---|---|---|
| Vehicle accident | | Road accident fund | | Injury on duty | |

| Any additional information not indicated above. |
|---|

| Adult dependant | | Child dependant | |
|---|---|---|---|




| | | | |
|---|---|---|---|
| Name | | | |
| Surname | | Male | |
| Contact number | | Female | |
| Are you currently pregnant | Yes / No | Weeks | |

| PAST MEDICAL HISTORY (mark with an "X") | | | |
|---|---|---|---|
| Previous operation | | Previously hospitalised | |
| Diabetes | | Asthma | |
| Cancer treatment / diagnosis | | Epilepsy | |
| High blood pressure | | Cholesterol | |
| HIV | | Chronic medication | |

| DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N) | | | | | |
|---|---|---|---|---|---|
| Vehicle accident | | Road accident fund | | Injury on duty | |

| Any additional information not indicated above. |
|---|

## THE IMPORTANCE OF DISCLOSING YOUR HEALTH STATUS

In terms of the **registered Scheme Rules** you have a duty to **disclose** any **material information on request**. This includes the **duty** to fill out the above **health history** form **openly and honestly.**

By **disclosing your health status** in detail, we can ensure that the **clinical and financial risk** of you as **our member** and the medical scheme are **well managed.**

In terms of Section 29 of the **Medical Schemes Act**, failure to **disclose material information** gives Umvuzo Health the right to **cancel or suspend** a member's membership or that of any of **his/her dependants**.

**Full disclosure** of any health issues is vital in forging and maintaining a **good relationship with your medical scheme.**

**Disclosure will assist** you and your dependants in **gaining access to medical care and funding** - but **non-disclosure** can lead to **medical care and funding being refused.**

In order to manage risk effectively, the **Scheme holistically manages each individual member's unique healthcare funding needs** and disclosing your health status, allows us to manage your health more effectively.

I confirm that the above information is a true and correct record. I agree to notify the Scheme and its contracted providers should there be any change in my health or medical requirements.

Member signature

Date Y Y Y Y M M D D

## OFFICE USE ONLY

| | | | |
|---|---|---|---|
| Administration contact | | Processed by | Notes |
| Clinical contact | | Processed by | Notes |
| Chronic registration | | Processed by | Notes |

Email to: disclosure@umvuzohealth.co.za