Postal address PO Box 16148, Doornfontein, 2028
Share Call 0860 00 0048
Fax 086 608 0771
E-mail hosmedmembership@tybhealth.co.za

hosmed medical scheme care for life

MEMBERSHIP APPLICATION FORM

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

Start date		Preferred option	
Broker Code	100135 EB Solutions (PTY) Ltd		

FOR OFFICE USE ONLY

Membership no.		Company number	
Joining date		Subscription code	

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss | Initials | First name

Surname — KINDLY ATTACH COPY OF ID

Identity no.

Date of birth | Gender | Male | Female | Marital status (please mark appropriate) S M D

Employee no. | Monthly income R — KINDLY ATTACH PROOF OF INCOME (Current Payslip)

Tel no. (h) | (w) | (Cell)

Email

Residential address

Postal code

Postal address

Postal code

Name of previous medical aid scheme 1. | 2.

Period of membership 1. From | To

2. From | To — KINDLY ATTACH CERTIFICATE/S OF MEMBERSHIP Full details over last two years must be given

Preferred method of communication (please tick) Email ☐ SMS ☐ Should there be no selection made and an email address is supplied by the member, the email address will be utilised to send member communication

SECTION B: EMPLOYER DETAILS

Company

Region | Date of employment

Name | Employer signature | Designation | Date

SECTION C: DEPENDANTS DETAILS

First name	Surname	Income	Relationship (spouse, partner, daughter etc.)	Sex M/F	ID number (compulsory)	State if living with you (yes or no)
					KINDLY ATTACH COPY OF ID/ BIRTH CERTIFICATE	

Member initials _____

SECTION D: MEDICAL QUESTIONNAIRE

Do you or your depandants have, or ever had the following? If "yes" state full details below (complete all questions).				
1. Any disorder of the heart e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	No	Yes		Name
2. High blood pressure, chronic headache or disease of the blood vessels including cholesterol or circulatory disorder?	No	Yes		
3. Any respiratory or lung trouble,e.g. asthma, bronchitis, persistent cough, tuberculosis?	No	Yes		
4. Any disorder of the digestive system, gall bladder or liver e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?	No	Yes		
5. Disease or disorder of the kidneys, bladder or reproductive organs, e.g. albumin in urine, stones, prostatitis or infertility?	No	Yes		
6. Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety state or depression, alcoholism or narcotism?	No	Yes		
7. Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, tonsilitis and sinus problems?	No	Yes		
8. Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?	No	Yes		
9. Diabetes, acne or skin problems, sugar in urine, thyroid or other glandular or blood disorders?	No	Yes		
10. Cancer, growth or tumour of any kind?	No	Yes		
11. Any tropical disease, e.g. Bilharzia?	No	Yes		
12. Any other illness, disorder, operation, disability or injuries from any accident or HIV/Aids infection?	No	Yes		
13a. Any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement, e.g. Caesarian section or miscarriage? If "Yes", state full details including dates.	No	Yes		
13b. Are you now pregnant? If "Yes", how many months? _____ If "Yes" is this a multiple birth?	No	Yes		
14. Any special dental treatment, e.g. crowns, bridges, orthodontic, etc?	No	Yes		
15. Any illness or physical defect likely to necessitate medical or dental treatment, e.g. headaches, lumps, orthodontic work etc.??	No	Yes		
16. Do you expect any medical or dental treatment within the next three months?	No	Yes		
17. Do you or your dependants have a medical condition not disclosed?	No	Yes		
18. Detail all medication used by applicant and dependants during the last 2 years, as well as all Pathology and Radiology tests.				

If any of the questions on Section D have been answered "Yes", please supply details below.
If there is not enough space, please attach an additional page

No.	Patient	Date of treatment	Full details of the disorder, consulting doctor, type of medication, dosage and degree of recovery.

SECTION E: MEDICAL PRACTITIONER'S DETAILS

Please give name of the general practitioner you or any of your dependants have consulted

Name of General Practitioner			
Tel no.		Number of years consulted	
Name of Regular Pharmacist			
Tel no.		Number of years consulted	

Member initials _____

SECTION F: BANKING DETAILS FOR DEDUCTION OF MONTHLY CONTRIBUTIONS (BY DEBIT ORDER)

Account holder						
Account number		Account type (please mark appropriate)	Current		Transmission	Savings
Name of bank						
Branch						
Branch code						
Debit order run date						

I authorise Hosmed to draw from my bank account (wherever it may be), the contribution and members portion of claims due in terms of the Rules of Hosmed, without prejudice to the rights of Hosmed. I further authorise Hosmed to increase the amounts due, in terms of the rules, and authorise my bank to effect payment of such increased amounts upon receipt of a written notice from Hosmed stating the increased amount and the date from which it is payable. This authorisation is to remain in effect until I cancel it by giving written notice to Hosmed. I agree that I am not entitled to recover any amount drawn from my account by means of this debit order and that should my bank repay such amount to me, I will refund it immediately to Hosmed. I undertake to notify Hosmed immediately of any change in respect of my details. I acknowledge that Hosmed may not cede or assign any of their right to any third party without my prior consent and that I may not delegate any of my obligations in terms of the contract to any third party without prior written consent of the authorised party. Hosmed is hereby authorised to debit by bank account with my portion of accounts paid on my behalf by Hosmed.

Name _____ Signature _____ Date _____

SECTION G: BANKING DETAILS FOR REIMBURSEMENT OF CLAIMS (BY CREDIT ORDER)

Account holder						
Account number		Account type (please mark appropriate)	Current		Transmission	Savings
Name of bank						
Branch						
Branch code						

I hereby instruct and authorise you to pay any claim reimbursement which may accrue to me, to the credit of my account with the abovementioned bank or any other bank or branch to which I may transfer my account.

I understand that remittance advice/payment advices will be supplied to me in the normal way and that they will indicate the date on which funds will be available in my account.

I acknowledge that the party hereby authorised to effect a credit against my account may not cede or assign any of its rights to any third party without my prior written consent and that I may not delegate any of my obligations in terms of this contract/authority to any third party without written consent of the authorised party.

This authority may be cancelled by me giving you thirty day's notice in writing.

Name _____ Signature _____ Date _____

SECTION H: CONDITIONS OF MEMBERSHIP

MEMBERSHIP APPLICATION FORM:

I, ... hereby declare that:

(a) The information furnished herein is to the best of my knowledge and ability completely true. No relevant information has been omitted.

(b) If, after my admission to Hosmed, it is found that any statement or information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to Hosmed all payments which Hosmed may have made on my behalf and to relinquish any claim to any benefits on the part of Hosmed, should Hosmed request me to do so.

(c) Should there be any deterioration or change in my state of health or in that of any of my dependants before the date or event to be set by Hosmed for commencement of membership or the date of acceptance of this application by Hosmed or the date of receipt of the first contribution, (whichever date is the latest) or thereafter, Hosmed will be entitled to reconsider the application and purport new terms of admission or declare the membership null and void, depending on the relevant circumstances. Any sum of money paid to Hosmed in terms of this membership, before Hosmed is informed of the said change, shall be forfeited by me and any benefits paid by Hosmed on my behalf shall immediately be refunded by me to Hosmed, on the request of Hosmed.

SECTION I: UNDERTAKINGS

(d) I accept that I and/or my dependants may be subjected to a general waiting period of three months. For any pre-existing conditions within the last twelve months, a waiting period of twelve months may be applied.

(e) I accept that should any sum of money due to Hosmed not be timeously paid by me for any reason whatsoever, I shall be liable for all costs incurred by Hosmed in recovering such a claim, including tracing charges and all fees and costs charged to Hosmed by its attorneys, including collection commission or fees.

(f) I undertake to notify Hosmed within (30) thirty days of any change in my marital status and or dependant status that occurred since the commencement of my membership with Hosmed.

(g) Should I decide to resign my membership from Hosmed voluntarily, I undertake to give one month's written notice.

(h) I will call Hosmed Customer Services on 0860 00 00 48 for any pre-authorised treatment inquiries.

(i) I herewith authorise my healthcare provider to disclose information to Hosmed and its contracted third parties, provided such information is treated as confidential at all times.

(j) Should I be enrolled as a member of Hosmed, I will subject myself to the Rules of Hosmed.

SECTION J: GENERAL

(k) I irrevocably grant my permission to any physician, person or party who may be in possession of, or obtain information concerning my health, or that of my dependants, to divulge such information to Hosmed, also after my death.

(l) I confirm that I am employed by my Employer in a full time capacity and I undertake to notify Hosmed of any change in my salary structure.

(m) I undertake to pay any other amounts due to Hosmed, on default.

(n) I hereby authorise my Employer to deduct my contribution to Hosmed from any salary or any other sum of money due to Hosmed by me.

Member name

Member signature

Date

Company Stamp

FOR OFFICE USE ONLY