SIZWE
MEDICAL FUND

APPLICATION FOR MEMBERSHIP

PLEASE USE BLACK INK TO COMPLETE ALL SECTIONS AND RETURN AS SOON AS POSSIBLE TO ENSURE SPEEDY REGISTRATION.

Please indicate your option choice by ticking the appropriate box:

MEDICAL FUND OPTIONS

☐ Hospital Care ☐ Savings Care ☐ Primary Care ☐ Affordable Care ☐ Full Benefit Care

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Medical aid number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Employer code: ☐☐☐☐☐☐☐☐

SECTION 1 PERSONAL DETAILS OF PRINCIPAL MEMBER

Title: ____________ Surname: ____________

First names: ____________ Initials: ____________

ID number: ____________

Postal address: ____________ Postal code: ____________

Physical address: ____________ Postal code: ____________

Email address: ____________ Occupation: ____________

Telephone (H): ( )____________ (W): ( )____________ (C): ____________

RACE: ____________ PREFERRED METHOD OF COMMUNICATION: ☐ SMS ☐ Email ☐ Post

SECTION 2 EMPLOYER DETAILS

Date joining the Fund: DD / MM / YYYY Date of benefit: DD / MM / YYYY

Income category: ____________ Payroll number: ____________

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

Employer or Account number: ____________

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

We confirm that the applicant is employed and commenced employment on (date): DD / MM / YYYY

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

Company/division: ____________ Name: ____________

Designation: ____________ Email contact: ____________

Date: DD / MM / YYYY Telephone: ____________ Fax: ____________

OFFICIAL STAMP OF EMPLOYER

FOR OFFICE USE

Total monthly contribution: ____________

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SECTION 3 PRINCIPAL MEMBER AND DEPENDENT DETAILS (SHADED AREAS FOR OFFICE USE ONLY)

Marital codes
M = Married
S = Single
D = Divorced
W = Widowed

Gender codes
M = Male
F = Female

Relationship codes
S = Spouse
C = Child
P = Parent
LP = Life partner

Important: New applications will not be considered unless the correct documentation is supplied. Non-compliance will result in either a delay in processing or rejection of your application. (Please complete names as stated in your identity document or birth certificate.

NB: Shaded areas for **office use only**	Surname	First name	Date of birth	Gender	Marital status	Relationship	ID number
Principal member 00			DD/MM/YY			N/A	
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 01			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 02			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 03			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Dep. code 04			DD/MM/YY				
If there is a difference between the surname of any child dependant and the principal member, please state reason:							
Waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							
Condition-specific waiting period		YES / NO	From	DD/MM/YY	To	DD/MM/YY	
Reason							

Note: Child Dependants who are aged between 21 and 24 years, who are either full time students or financially dependent on their parents, must provide proof thereof.(Full-time students, please submit a confirmation letter from your registered institution; financially dependent child dependants please submit an affidavit).

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SECTION 4 PREVIOUS MEDICAL SCHEME

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

Name of scheme: ______________________________

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership from: DD / MM / YYYY to DD / MM / YYYY

Are you still a member: ☐ Yes ☐ No

Name of scheme ______________________________

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Membership from: DD / MM / YYYY to DD / MM / YYYY

Are you still a member: ☐ Yes ☐ No

Did you contribute to a savings account? ☐ Yes ☐ No

If yes, please indicate what percentage you paid towards savings: _______ %

Waiting period imposed? ☐ Yes ☐ No

If yes, please indicate what waiting periods were imposed: ______________________________

Late joiner penalties imposed? ☐ Yes ☐ No

If yes, please indicate what penalties were imposed: ______________________________

SECTION 5 FOR INTERNAL USE ONLY

			Number of years subject to penalty	Penalty imposed (please tick)	
Current age	☐	years			
Less: creditable coverage	☐	years	1-4 years	5%	☐
= Number of years not covered	☐	years	5-14 years	25%	☐
Less: qualifying age	☐	years	15-24 years	50%	☐
Years subject to penalty	☐	years	25+ years	75%	☐

Vetted by (name): ______________________________

Signature (supervisor): ______________________ Date: DD / MM / YYYY

Processed by (name): ______________________________

Signature: ______________________ Date: DD / MM / YYYY

SECTION 6 MEDICAL HISTORY OF PRINCIPAL MEMBER AND DEPENDANTS TO BE REGISTERED

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

IMPORTANT: Please submit proof and date of treatment of pre-existing health conditions of principal member and all dependants. This means a sickness or condition for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months preceding application. Please ask your treating doctor to help you to provide the relevant ICD-10 code for your condition.

Please provide full details for any of the conditions below in the space provided and attach relevant medical reports to this form:

Condition	Mark one		Dependant number				ICD-10 code
1. Blood disorder e.g. anaemia, bleeding disorders haemophilia, clothing disorders?	Y	N	1	2	3	4	
2. Cancer, growths, abscess or tumours of any kind, whether begin or malignant. Cardiovascular (heart and blood vessels) disorders e.g. congenital heart conditions, chest pain, coronary artery disease/ischaemic heart disease, high blood pressure, valvular disease?	Y	N	1	2	3	4	
3. Arrthmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever shortness of breathe, palpitation, angina, deep vein thrombosis, and pulmonary embolism atherosclerosis lymphatic's. Ear nose and throat disorders e.g. hearing/speech impairment, ear infections, sinus problems nasal/throat surgery ear discharge, hoarseness, mouth disorder, tonsils, adenoids, and grommets?	Y	N	1	2	3	4	
4. Previous nasal injuries, upper airway infections cleft lip/palate, epistaxis, and hay fever/rhinitis blocked nose?	Y	N	1	2	3	4	

Question							
5. Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities sugar in urine, nutritional disorders metabolic syndrome, hypo / hyperglycaemic coma?	Y	N	1	2	3	4	
6. Eye related disorders e.g. glaucoma, blindness, eye surgery retinitis pigmentosa cataracts, ten implants, infections, refractive and laser surgery, short so far sightedness, pterygium. Gastro-Intestinal disoders e.g recurrent indigestion, heartburn, reflux, ulcers, bowel disoders, gallbladder disoders, liver disorders and pancreas disorders hiatus hermia, piles, and anal fissures.	Y	N	1	2	3	4	
7. Rectal bleeding, ulcerative colitis or have you or any of your dependants ever had a gastroscopy or colonoscopy, spleen disorders, crohn's disease.	Y	N	1	2	3	4	
8a. Gynaecological and obstetrical disorders e.g. ectopic pregnancy, caesarean section, fibroids endometriosis, menstrual irregularities, abnormal papsmear, receiving hormone treatment, vaginal bleeding, laparoscopic surgery, dilatation and curettage, miscarriages, pregnancy related problems, cysts, infertility, breast disorders.	Y	N	1	2	3	4	
8b. Pregnancy – expected date of delivery.	Y	N	1	2	3	4	
9. Male genito-urinary system e.g. testes, prostate abnormalities of the penis, scrotum, reproductive system.	Y	N	1	2	3	4	
10. Musculo- skeletal disorders e.g. osteo – arthiritis, rheumatoid arthritis, back problems, gout, osteoporosis, all joint problems e.g knee, shoulder, bones, limbs, spine, fractures, carpel tunnel syndrome, bunion, spondylosis, hernia, kyphosis.	Y	N	1	2	3	4	
11. Neurological disorders e.g. epilepsy, muscular wealness, stroke, brain or spinal cord disorders chronic fatrigue, headache, migraine, polio, paralysis, `guillian-Barre, meningitis, Parkinson's Disease, Alzheimer Diesease, dementia.	Y	N	1	2	3	4	
12. Psychological disorders e.g. `insomnia, anxiety, depression, stress, panic attracts, alcohol or drug dependency, attention deficit disorder, post traumatic stress, schizophrenia, bi-polar disorders, mood swings, attempted suicide, anorexia/bulimia nervosa.	Y	N	1	2	3	4	
13. Renal (kidney) disorders e.g. blood in the urine, urinary tract stones, recurrent infections, kidney failure, bladder problems, dialysis, Addison's Diseases, nephrilis.	Y	N	1	2	3	4	
14. Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema or cigarette smoking related disorders, tuberculosis, persistent cough allergies, chronic obstructive pulmonary disease, pneumoconiosis.	Y	N	1	2	3	4	
15. Skin disorders e.g. eczema psoriasis melanoma, skin cancer, burns, acne, scars, keloids, growths, warts, and ingrown toe nails?	Y	N	1	2	3	4	
16. State whether you or any of your dependants have received medical advice or treatment for any infectious and tropical disease e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitis, bilharzia, malaria, cholera.	Y	N	1	2	3	4	
17. Do you or any of your dependants have any birth defects or hereditary disorders?	Y	N	1	2	3	4	
18. Have you or any of your dependants ever sought counselling or treatment for HIV or AIDS related infections or ever tested positive for HIV or AIDS?	Y	N	1	2	3	4	
19. Have you or any of your dependants ever been diagnosed and/or treated for an immune system problem?	Y	N	1	2	3	4	
20. Previous injuries and trauma including sports injuries?	Y	N	1	2	3	4	
21. Have you or any of your dependants ever been told to improve your adherence to medical treatment?	Y	N	1	2	3	4	
22. Have you ever required rehabilitation following an event i.e stroke or motor vehicle accident?	Y	N	1	2	3	4	
23. Do you or any of your dependants expect to receive any treatment in the next 12 months and do you or your dependants' expect to be, or are currently hospitalised?	Y	N	1	2	3	4	
24. Has any close blood relative (excluding dependant's named in this application form) ever been diagnosed with heart disease, high blood pressure, high cholesterol, diabetes or any other hereditary disease?	Y	N	1	2	3	4	
25. Do you or any of your dependants have incomplete dental treatment plans, dental implants orthodontic treatment, dentures, wisdom teeth problems or do you or any of your dependants currently receive, or expect to receive dental treatment in next 12 months?	Y	N	1	2	3	4	
26. Are you or any of your dependants currently involved in any third party claim or WCA claim that may include medical treatment? If so please provide below, FULL details of injuries, surgery, investigative procedures for which claims will be or have been lodged?	Y	N	1	2	3	4	
27. Do you or any of your dependants smoke, or did you or any of your dependant's receive medical advice to reduce the quantity of tobacco used? If so, specify whether cigarettes, cigars or a pipe and how many are or were smoked per day?	Y	N	1	2	3	4	
28. Do you or any of your dependants consume alcohol? If so, specify what type of alcohol and quantity consumed per week?	Y	N	1	2	3	4	
29. Have you or any of your dependants ever received medical advice, counselling or treatment to reduce alcohol consumption for alcohol abuse or alcoholism?	Y	N	1	2	3	4	
30. Do you or any of your dependants use stimulants any illegal drug substances, or ever been treated for illegal drug substance abuse or addiction?	Y	N	1	2	3	4	
31a. Investigations and/or specialised treatment in and out of hospital. a. Are you or any of your dependants currently undergoing, or expect to undergo investigations for any medical condition and/or symptoms not yet diagnosed?	Y	N	1	2	3	4	
31b. Investigations and/or specialised treatment in and out of hospital. b. Are you or any of your dependants currently receiving or expect to receive specialised treatment (i.e. chemotherapy, radiotherapy or counselling)?	Y	N	1	2	3	4	
32. In the past 2 years, have you or any of your dependants had any x-rays, electrocardiogram or other examinations including generic testing, or tumour markers, operations or been hospitalised?	Y	N	1	2	3	4	

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SECTION 7 GENERAL

I hereby apply to be admitted as a member of Sizwe Medical Fund, hereafter referred to as "the Fund" and agree to familiarise myself with, and abide by, its rules and regulations as amended from time to time. I am familiar with the benefits and conditions of my chosen option and hereby authorise my employer to deduct from my salary my monthly contribution as I may lawfully owe to the Fund and to remit such amounts to the Fund. Furthermore, I understand that I will be held liable for any legal costs incurred in the recovery of any amounts owing to the Fund. I hereby authorise any doctor or other person, who may be in possession of, or hereafter acquire information concerning my health or the health of any of my dependants, to disclose this information at their reasonable discretion. I understand that the Fund may request a medical report at its own cost when I join the Fund and that all health and personal information given to the Fund be handled confidentially by them for purposes outlined in Section 10. In the event the Fund wishes to use my, or my dependants', confidential information for purposes other than those outlined in Section 10, the Fund will require consent from me or my dependants. I understand that the Fund may impose a general and/or condition-specific waiting period according to the Medical Schemes Act (131 of 1998) when I and/or my dependants join. I understand that according to the Medical Schemes Act, I may only belong to one medical scheme at a time. I consent to all conversations between the Fund or its contracted parties and myself being recorded. I understand that application for admission to the Fund is not subject to the services of a broker, but should I appoint the below broker to manage my application, I am entitled to cancel the broker's services at any time. I hereby declare that the information in this application is true and correct and agree that any false declaration could render my application null and void. I hereby declare that the accuracy and completeness of all answers, statements and other information provided by or on behalf of me, is my responsibility.

Applicant's signature: ____________________ Date: DD / MM / YYYY

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

SECTION 8 APPOINTED BROKER DETAILS (WHERE APPLICABLE)

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

To be completed by broker:

Brokerage: ____________________ Financial Services Provider number ____________________

Intermediary code: ____________________ Email ____________________

Tel: ( ) ____________________ Cell: ____________________ Date: DD / MM / YYYY

Physical address: ____________________

____________________ Postal code: ____________________

Postal address: ____________________

____________________ Postal code: ____________________

CMS accreditation number: ____________________

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

Applicant's signature: ____________________ Broker's signature: ____________________

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Commission payable: ____________________

SECTION 9 THE FUND RESERVES THE RIGHT TO CANCEL

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

A) FAILURE TO TIMEOUSLY PAY THE MONTHLY CONTRIBUTIONS AS SPECIFIED IN THE RULES

B) FAILURE TO REPAY ANY DEBT TO THE FUND

C) SUBMISSION OF FRAUDULENT CLAIMS

D) THE NON DISCLOSURE OF MATERIAL INFORMATION

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SECTION 10 FUND DECLARATION

Sizwe Medical Fund declares that the member's personal details and medical information, obtained from healthcare providers with the consent of the member, shall be kept confidential and will not be used for purposes of related company business nor sold for commercial purposes. All staff within the Fund and contracted third parties are bound by internal confidentiality agreements. Information given to the Fund will be used for the following purposes: processing the member's application, re-imbursement of claims, determining member entitlements to benefits, managed care and risk management practices. In the event of a breach in confidentiality, the Fund assumes responsibility and the breach will be managed according to the Fund's internal protocols.

SECTION 11 INCOME DECLARATION AND BANKING DETAILS FOR REFUND PURPOSES AND DEBIT ORDER AUTHORITY

A) Banking details

Bank: ___________________________________ Branch: _____________________________________ Branch code: ____________

Type of account: ______________________________________ Account number: ____

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

B) DPM members to select debit order date

☐ 01 ☐ 15 ☐ 25

C) Income declaration (compulsory for all members)

I hereby declare that my monthly income is R __________________________________

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

D) Contribution payments

I hereby authorise that the monthly contributions, as raised by the Sizwe Medical Fund, may be withdrawn from the above mentioned account on the 1st of each month for the current month's membership contribution. This payment will represent the full monthly contribution payable to the Fund. I further understand that if payment is not made to the Fund on the 1st of each month, then my membership can be terminated with immediate effect and all benefits derived from the Fund will cease. I hereby declare that the information in this application is true and correct and agree that any false declaration could render my application null and void.

Date of first payment: DD / MM / YYYY

SECTION 12 ESSENTIAL DOCUMENTS (COMPULSORY)

Please provide the following documentation with your application	Are the relevant documents attached?			
Copy of ID for yourself and your dependants	YES		NO	
Birth certificates of children (where ID is not available)	YES		NO	
Clinic cards for newborn babies (within 30 days of birth to avoid waiting periods)	YES		NO	
Documentary proof in the case of adopted/foster children	YES		NO	
Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting periods)	YES		NO	
Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable)	YES		NO	
Membership certificates with termination dates from previous medical aids, for member and dependants (where applicable)	YES		NO	
Written confirmation that claimant is a member of the Unemployment Insurance Fund (if unemployed)	YES		NO	
Proof of taxable income (i.e, pay slip, SARS IT34 form, etc)	YES		NO	
Either an original cancelled cheque (for a cheque account) or an original bank statement (for a transmission or savings account) so that claims can be paid directly into your bank account.	YES		NO	

PLEASE ENSURE THAT THIS SECTION IS COMPLETED IN FULL AND ALL NECESSARY DOCUMENTS ARE ATTACHED WITH YOUR APPLICATION. FAILURE TO SUBMIT THE RELEVANT DOCUMENTS WILL DELAY THE PROCESSING OF YOUR MEMBERSHIP APPLICATION.

If you have any queries,
please call our Customer Care on 0860 100 871 or visit www.sizwe.co.za
222 Smit Street, Braamfontein, Johannesburg, 2000