Registration Number 1464
PO Box 1672 | Port Elizabeth | 6000
7 Lutman Street | Richmond Hill | Port Elizabeth | 6001
info@suremedhealth.co.za
www.suremedhealth.co.za
086 008 0888

APPLICATION FOR MEMBERSHIP

Checklist:

- ☐ 1. ID documents of principle member as well as dependents
- ☐ 2. Birth certificates for children
- ☐ 3. Proof of taxable income (eg pay slip)
- ☐ 4. Proof of student registration
- ☐ 5. Legal adoption forms (if children adopted)
- ☐ 6. Membership certificates of previous Medical Schemes.
- ☐ 7. Marriage certificate
- ☐ 8. Affidavit, should any dependent's surname differ from principal member's surname
- ☐ 9. Copy of cancelled cheque or bank statement for collecting contributions and/or claim refunds

SECTION 1: YOUR OPTION

Please select one option by placing an "X" in the appropriate box

☐ **CHALLENGER** ☐ **NAVIGATOR**

☐ **SHUTTLE*** ☐ **EXPLORER***

GP Nomination Form to be completed if **Explorer or **Shuttle** option is selected.*

FOR FURTHER DETAILS PLEASE CONSULT THE LATEST BENEFIT GUIDE ON THE WEBSITE: www.suremedhealth.co.za

ADDITIONAL MEMBERSHIP CARD REQUIRED? ☐ YES ☐ NO

Join Date Y Y Y Y M M D D

SECTION 2: PERSONAL DETAILS

Title | Initials | First Names | Surname

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | Tax Number

Country of Issue

Gender: M ☐ F ☐

Please select one option by placing an "X" in the appropriate box

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Traditional Marriage

Language Preference: ☐ English ☐ Afrikaans ☐ Xhosa ☐ Other: *Specify*

Ethnic Group: ☐ Asian ☐ Black ☐ Coloured ☐ White

Telephone Number (Home) (code)

Telephone Number (Work) (code)

Cellphone Number

E-mail Address

Physical Address

Street Number / Street Name
Suburb
City
Province / State
Code

Postal Address ☐ Same as Physical

Street Number / Street Name
Suburb
City
Province / State
Code

ID/Passport Number:

Primary Member Consent Section

You give permission to make information available to the third party/family member specified below.

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box

☐ All consent ☐ Updating details ☐ Financial info ☐ Clinical info ☐ None

Relationship

Print Name and Surname of Member:

Signature:

Date: Y Y Y Y M M D D

SECTION 3: EMPLOYER TO COMPLETE AND SIGN

Private Member ☐ **Please only fill in marked fields*

Tax Number*

Basic Salary* R

Employer

Paypoint

Scheme Join Date Y Y Y Y M M D D

Clock/Payroll Number

Date of Employment Y Y Y Y M M D D

Date of Benefit Y Y Y Y M M D D

Number of Subsidised Dependants: Spouse ☐ Children ☐ Adult Dependents ☐

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the selected Suremed Health Rules. **All sections of the application form have been completed and signed.**

Employer's Telephone Number c o d e

Employer's Fax Number c o d e

COMPANY STAMP REQUIRED

Employer's E-mail Address

Name of Medical Scheme/ Salary Administrator

Designation

Signature:

Date: Y Y Y Y M M D D

SECTION 4: INTERMEDIARY DETAILS *(To be completed by Broker – if applicable)*

Application Information: ☐ New Business ☐ Addition to Existing Group

Group Size:

Name of Group / Individual:

Joining Date: Y Y Y Y M M D D

Intermediary Details:

Brokerage Name

CMS Number

CMS Number Expiry Date Y Y Y Y M M D D

FSB License Number

Start Date Y Y Y Y M M D D

Broker Name

CMS Number

CMS Number Expiry Date Y Y Y Y M M D D

FSB License Number

Start Date Y Y Y Y M M D D

Telephone Number c o d e

Fax Number c o d e

Cellphone Number

Please indicate prefered method of communication: ☐ E-mail ☐ SMS

Broker Signature:

Date: Y Y Y Y M M D D

ID/Passport Number:

SECTION 5: PREVIOUS MEDICAL SCHEMES

Please provide full details of previous membership of registered Medical scheme (starting with most recent) and provide proof by attaching your Certificates of Membership. (Your previous Medical scheme membership card will not be accepted)

Scheme Name | Date from (Y Y Y Y M M D D) | Certificate Attached ☐ YES ☐ NO

Membership Number | Date to (Y Y Y Y M M D D) | Years / Months on Medical scheme (Y Y M M)

Scheme Name | Date from (Y Y Y Y M M D D) | Certificate Attached ☐ YES ☐ NO

Membership Number | Date to (Y Y Y Y M M D D) | Years / Months on Medical scheme (Y Y M M)

Scheme Name | Date from (Y Y Y Y M M D D) | Certificate Attached ☐ YES ☐ NO

Membership Number | Date to (Y Y Y Y M M D D) | Years / Months on Medical scheme (Y Y M M)

SECTION 6: YOUR DEPENDANT'S DETAILS

A. SPOUSE'S DETAILS

Title | Initials | First Names | Surname

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | **Gender:** ☐ M ☐ F

Telephone Number (Home) (code) | Telephone Number (Work) (code) | Cellphone Number

E-mail Address

Physical Address

Street Number / Street Name

Suburb

City

Province / State

Code

Postal Address ☐ Same as Physical

Street Number / Street Name

Suburb

City

Province / State

Code

Spouse's Consent Section

You give permission to make information available to the third party/family member specified below.

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box

☐ All consent ☐ Updating details ☐ Financial info ☐ Clinical info ☐ None

Relationship

Print Name and Surname of Member:

Signature:

Date: (Y Y Y Y M M D D)

ID/Passport Number:

B. OTHER DEPENDANTS

Note: Additional documentation is required when adding a Common Law Partner / Adopted Child / Foster Child.
Please refer to Checklist on page 1. Acceptance of dependants will be decided in accordance with the Scheme Rules.

D1

First Names | Surname | Cellphone Number

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | Relationship | **Gender:** M F

If your dependant is your child and is 21 years and older, or your parent, are they: Married: YES NO

Financially dependant on you? YES NO | Does your dependant earn an income? YES NO | Monthly Income: **R**

D2

First Names | Surname | Cellphone Number

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | Relationship | **Gender:** M F

If your dependant is your child and is 21 years and older, or your parent, are they: Married: YES NO

Financially dependant on you? YES NO | Does your dependant earn an income? YES NO | Monthly Income: **R**

D3

First Names | Surname | Cellphone Number

Identity Number | Date of Birth (Y Y Y Y M M D D) | Relationship | **Gender:** M F

If your dependant is your child and is 21 years and older, or your parent, are they: Married: YES NO

Financially dependant on you? YES NO | Does your dependant earn an income? YES NO | Monthly Income: **R**

D4

First Names | Surname | Cellphone Number

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | Relationship | **Gender:** M F

If your dependant is your child and is 21 years and older, or your parent, are they: Married: YES NO

Financially dependant on you? YES NO | Does your dependant earn an income? YES NO | Monthly Income: **R**

D5

First Names | Surname | Cellphone Number

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | Relationship | **Gender:** M F

If your dependant is your child and is 21 years and older, or your parent, are they: Married: YES NO

Financially dependant on you? YES NO | Does your dependant earn an income? YES NO | Monthly Income: **R**

D6

First Names | Surname | Cellphone Number

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | Relationship | **Gender:** M F

If your dependant is your child and is 21 years and older, or your parent, are they: Married: YES NO

Financially dependant on you? YES NO | Does your dependant earn an income? YES NO | Monthly Income: **R**

ID/Passport Number:

SECTION 7: BANKING DETAILS

I hereby instruct Suremed Health Medical Scheme to electronically collect contributions or to deposit refunds into my bank account. I understand that credit card accounts may not be used for these transactions. I also irrevocably authorise Suremed Health Medical Scheme to reverse any erroneous transaction and/or to rectify any incorrect electronic transfer of funds without prior notice.

Account Holders Signature: Date: Y Y Y Y M M D D

PLEASE TICK (MORE THAN ONE OPTION CAN BE SELECTED)

☐ USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS (PENSIONERS AND PRIVATE MEMBERS – *Contribution payments deducted in Advance*)

☐ USE THIS ACCOUNT FOR CLAIM REFUNDS

BANK NAME

BRANCH NAME

ACCOUNT HOLDER NAME

BANK ACCOUNT NUMBER

BANK DATE STAMP REQUIRED

ACCOUNT TYPE ☐ CURRENT ☐ CHEQUE ☐ SAVINGS ☐ TRANSMISSION

*Submit a copy of a cancelled cheque or confirmation of banking details for collecting contributions and/or claim refunds.

*If the bank account is in another person's name, then the account holder should also sign this form, giving the Scheme permission to deduct the contributions from his/her account with a copy of the account holder's ID document

SECTION 8: MEDICAL HEALTH QUESTIONAIRE

SECTION A: Information on symptoms, conditions or disorders

(Must be completed for the main applicant, spouse/partner and all dependants).

Please indicate if you or any dependant in this application ever experienced, been 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. Please include congenital abnormalities.

IMPORTANT - PLEASE SUPPLY DETAILS ON PAGE 7 FOR ANY CONDITION THAT HAS BEEN TICKED.
This section is extremely important. Any omission or misrepresentation of information may lead to refusal to admit to pay any claims for treatment received, or the scheme can terminate your membership. All conditions, symptoms or disorders have to be declared, no matter how insignificant they may seem.

1. Tumours, growths and skin disorders ☐ YES ☐ NO	**List member or dependant name/s**
Example: abnormal pap smear results, skin lesions, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal PSA result.	

2. Heart and circulation conditions ☐ YES ☐ NO	**List member or dependant name/s**
Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure cardiomyopathy, valvular heart disease or heart valve replacement, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.	

3. Gynaecological and obstetric conditions ☐ YES ☐ NO	**List member or dependant name/s**
Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, menopause, ectopic pregnancy.	

Are you or any dependants pregnant or suspect pregnancy? ☐ YES ☐ NO

If yes, list dependant name and date of last menstrual period Y Y Y Y M M D D

4. Mental health ☐ YES ☐ NO	**List member or dependant name/s**
Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, autism, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, counselling, bulimia.	

ID/Passport Number:

5. Metabolic or endocrine conditions ☐ YES ☐ NO

List member or dependant name/s

Example: diabetes (high blood sugar), thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency.	

6. Gastrointestinal conditions ☐ YES ☐ NO

List member or dependant name/s

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, stomach ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.	

7. Brain and nerve conditions ☐ YES ☐ NO

List member or dependant name/s

Example: stroke, epilepsy, multiple sclerosis, motor neuron disease,myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, vetriculo-peritoneal shunt (VP shunt), mental retardation, CVA, bleeding on the brain.	

8. Breathing and respiratory conditions ☐ YES ☐ NO

List member or dependant name/s

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia.	

9. Musculoskeletal (back, bone and muscle pain) ☐ YES ☐ NO

List member or dependant name/s

Example: arthritis (any form), ongoing neck and/or back pain, ankylosing spondylitis, lupus, Sjögren's syndrome,scleroderma,polymyositis, dermatomyositis, polyarteritis nodosa,Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease,scoliosis, kyphosis,spinal stenosis,neurogenic bladder, gout, fractures, physical disability	

10. Kidney or urinary conditions including current or past dialysis ☐ YES ☐ NO

List member or dependant name/s

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndromepolycystic kidney disease, urinary incontinence, bladder infections, other bladder or kidney problems	

11. Blood conditions ☐ YES ☐ NO

List member or dependant name/s

Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders.	

* **HIV and AIDS:** If you and/or any of your dependants are HIV positive or have AIDS and would prefer not to disclose your and/or their HIV status on this form due to confidentiality you or they must call us on **WELLNESS NUMBER: 086 010 3228** with in seven working days from the date we activate your Medical Scheme 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 Wellness Programme. The Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period may therefore apply to this condition. If you do not let us know about your HIV status within 7days of your membership being active, we may end your Medical Scheme membership.

12. Eye conditions ☐ YES ☐ NO

List member or dependant name/s

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.	

13. Ear, nose and throat (ENT) and dentistry conditions ☐ YES ☐ NO

List member or dependant name/s

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

14. Male urogenital conditions ☐ YES ☐ NO

List member or dependant name/s

Example: prostate disorders, urogenital defects, varicoceles, tumours, undescended testes, phimosis, urinary incontinence.	

Are there any other conditions or symptoms not listed above, for which medical advice, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months?

☐ YES ☐ NO *If yes, please provide details in Section B on the next page*

ID/Passport Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Have you or any of your dependants had surgery in the past, or are you planning to have a surgery in the next 12 months? ☐ YES ☐ NO *If yes, please provide details in Section B below.*

Do you or any of your dependants currently use medication on a daily basis? ☐ YES ☐ NO *If yes, please provide details in Section B below.*

SECTION B: Beneficiary detail on symptoms, condition or disorders

Patient Name	Diagnosis	Date Diagnosed	Date of last symptoms, consult or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD
		YYYYMMDD	YYYYMMDD		YYYYMMDD

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CONSENT FOR SUREMED HEALTH TO PROCESS PERSONAL INFORMATION

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of Suremed Health.

Suremed Health and the Administrator, Momentum Thebe Ya Bophelo, a division of Momentum Metropolitan Life Limited, will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then Suremed Health will not be able to administer or offer you membership of the medical scheme.

Please read the statements below and sign your acceptance thereof.

1. I authorise, and give consent to Suremed Health and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Suremed Health membership risk profiling and management, administration of my membership and as set out in this section.
2. If I have consented to the disclosure of my personal information, Suremed Health or the Administrator may provide my personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between Suremed Health or the Administrator which requires them to do so.
3. I acknowledge that I must give Suremed Health and the Administrator all information and evidence they may require from time to time. I authorise Suremed Health and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Suremed Health may require concerning my or any of my dependants in assessing any risk or claim in relation to this application, my membership of Suremed Health and risk profiling or management. I consent to that person providing, and instruct that person to provide, Suremed Health and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
4. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
5. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my persona information unless processing is required by law.
6. I have the right to request my personal information which is in the possession of Suremed Health and the Administrator, provided that I furnish adequate identification.
7. I have the right to request Suremed Health and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
8. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.
9. It remains the responsibility of the applicant to make full disclosure of the required information pertaining to the applicant and/or all the dependants. Should you wish to add a medical report from your family practitioner you are welcome to do so. The Medical Schemes Act makes provisions for a membership to be terminated where non-disclosure of material information is proven and the law does not recognise ignorance as an excuse. Your signature to the application form indicates, amongst others, that you understand the terms and conditions of membership, and that the information furnished in the application form is true and correct. If you are unsure about any of the questions, please do not hesitate to contact the Medical Scheme call centre.
10. Disclosure of information: Any breach of any warranty or non-disclosure of any information by myself or my dependants relevant to the assessment of this application will render my membership null and void, and all contributions paid by me will be forfeited to the Scheme.

Print Name and Surname of Member:

ID/Passport Number:

Signature:

Date: Y Y Y Y M M D D

ID/Passport Number:

primecure health
leading integrated healthcare

GP Nomination Form

IMPORTANT NOTE: *Please note that this GP Nomination Form must be completed in full and emailed to changemygp@primecure.co.za, fax 086 680 7124 or call the Prime Cure contact centre on 0861 665 665 . Upon approval, confirmation of change will be faxed/emailed/SMSed to the requestor within 24 hours of receipt.*

A Principal Member Details

First Name | Surname
ID/Passport No: | Tel (H):
Tel (W): | Tel (C):
Email:
Medical Aid: | Option:
Medical Aid No: | Employer:
GP Practice Name: | GP Practice No:
GP Practice Name: | GP Practice No:
Members Signature: | Date: D D M M Y Y Y Y

B Dependant Details

1. First Name: | Surname:
ID/Passport No: | Dependant Code:
GP Practice Name: | GP Practice No:
GP Practice Name: | GP Practice No:

2. First Name: | Surname:
ID/Passport No: | Dependant Code:
GP Practice Name: | GP Practice No:
GP Practice Name: | GP Practice No:

3. First Name: | Surname:
ID/Passport No: | Dependant Code:
GP Practice Name: | GP Practice No:
GP Practice Name: | GP Practice No:

4. First Name: | Surname:
ID/Passport No: | Dependant Code:
GP Practice Name: | GP Practice No:
GP Practice Name: | GP Practice No:

5. First Name: | Surname:
ID/Passport No: | Dependant Code:
GP Practice Name: | GP Practice No:
GP Practice Name: | GP Practice No:

6. First Name: | Surname:
ID/Passport No: | Dependant Code:
GP Practice Name: | GP Practice No:
GP Practice Name: | GP Practice No:

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CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

1. **This application is applicable to the Navigator and Challenger options.** For Explorer and Shuttle options please contact Prime Cure (0861 665 665) for assistance with chronic medication authorisation
2. One application must be completed per beneficiary applying for chronic medication. To download an additional application form visit: www.suremedhealth.co.za
3. Allow one working day for the processing of your application.
4. The original prescription must be given to the provider who dispenses your medication.
5. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
6. Approval of chronic medication is subject to the rules and chronic protocols of the Scheme.
7. You may contact the Pharmacy Benefit Management (PBM) Team at (041) 395 4482 or chronic@suremedhealth.co.za
8. Send completed forms via fax 086 680 8855, mail PO Box 1672, Port Elizabeth, 6000 or chronic@suremedhealth.co.za

B. MEMBER DETAILS

Scheme | Option | Membership Number

Title | Initials | First Names | Surname

Identity Number/ Passport Number | Date of Birth (Y Y Y Y M M D D) | E-mail Address

Postal Address

Street Number / Street Name
City
Suburb
Province / State
Code

Telephone Number (Home) code
Telephone Number (Work) code
Fax Number code
Cellphone Number

C. PATIENT DETAILS *(Beneficiary who requires Chronic Medication)*

Title | Initials | First Names | Surname

Identity Number | Date of Birth (Y Y Y Y M M D D)

Telephone Number (Home) code | Telephone Number (Work) code | Fax Number code

Cellphone Number | E-mail Address

The outcome of this application must be communicated to me via my email address: ☐ YES ☐ NO

Patient Name: ID Number:

D. PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my (or my minor dependant's) condition to the PBM Team.
- Any information concerning this application will remain confidential at all times.
- It may be a pre-condition to the approval of the Chronic Medication Benefit that I (or my minor dependent) register and comply with the requirements of a Disease Management Programme.
- My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of this application.
- This funding authorisation is at all times subject to the Scheme rules even if a beneficiary's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
- This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical criteria and protocols.
- The Scheme and its Administrator shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Name (or member if patient is a minor)

Signature:

Date: Y Y Y Y M M D D

Clinical Information Consent Section

*You give permission to make **clinical information** available to the third party/family member specified below.*

Title | Initials | First Names | Surname | Relationship

Identity/Passport Number | Contact Number

Print Name and Surname of Patient

Signature:

Date: Y Y Y Y M M D D

E. CLINICAL CRITERIA

The following information is required when applying for a new chronic condition.

Certain conditions which do not appear on the form below may be considered for approval on the Chronic Benefit, although not all long-term conditions, which a doctor may define as chronic, will fulfill the criteria for approval.

** Chronic conditions only available on certain options of Suremed Health.*

Condition	Requirements
Addison's Disease	1. Initial Specialist Application. 2. ACTH Stimulation Test. 3. Serum Cortisol Test.
Ankylosing Spondylitis*	1. Initial Specialist Application.
Asthma	1. Lung function test (8 years of age and older).
Bipolar Mood Disorder	1. Specialist to complete Section K.
Asthma	1. Lung function test (8 years of age and older).
Bronchiectasis	1. Initial Specialist Application. 2. Attach relevant radiology report.
Cardiac failure	1. Specialist to complete section G.
Cardiomyopathy	1. Initial Specialist Application.
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator.
Chronic Renal Disease	1. Initial Specialist (Nephrologist) Application. 2. Serum Urea, Creatinine and GFR.
Coronary Artery Disease	1. Stress ECG confirming diagnosis. 2. Attach history of previous cardiovascular disease event(s).
Crohn's Disease	1. Initial Specialist Application. 2. Diagnostic reports to be supplied
Depression*	1. Prescriber to complete Section K.
Diabetes Insipidus	1. Initial Specialist Application. 2. Water deprivation test results.

Patient Name: ID Number:

Condition	Requirements
Diabetes Mellitus	1. Prescriber to complete Section G and H. 2. Please attach the diagnostic Fasting/Random Blood Glucose results *The application cannot be reviewed if this is not completed.* *The Scheme subscribes to the LifeSense Diabetic Management programme for the Navigator and Challenger options.*
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code. 2. ECG confirming diagnosis.
Epilepsy	1. EEG report confirming diagnosis. 2. Attach detailed seizure history.
Glaucoma	1. Initial Specialist Application. 2. Supply initial diagnostic intra-ocular pressure/s.
Haemophilia	1. Initial Specialist Application. 2. Haemophilia A (Factor VIII as % of Normal). 2. Haemophilia B (Factor IX as % of Normal).
HIV & AIDS	1. The Scheme subscribes to the LifeSense AIDS Management programme for the Navigator and Challenger options. *Please call 0860 506 080 for further information.*
Hyperlipidaemia	1. Prescriber to complete Section G and J. 2. Please attach the diagnosing Lipogram. *The application cannot be reviewed if this is not submitted.*
Hypertension	1. Prescriber to complete Section G and I. 2. Initial Specialist Application if younger than 18 years of age.
Hyperthyroidism	1. Attach initial diagnostic report.
Hypothyroidism	1. Attach initial diagnostic report.
Multiple Sclerosis	1. Initial Specialist Application. 2. Comprehensive disease history. 3. Extended Disability Status score (EDSS).
Myasthena Gravis*	1. Initial Specialist application
Osteoporosis*	1. DEXA bone mineral density (BMD) scan and report on any additional risk factors.
Parkinson's Disease	1. Initial Specialist Application.
Rheumatoid Arthritis (RA)	1. Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented. 2. Initial Specialist Application for Leflunomide and Specialist Motivation for Biologic DMARDs. 3. Baseline Disease Activity Scores.
Schizophrenia	1. Psychiatrist to complete Section K.
Systemic Lupus Erythematosus	1. Initial Specialist Application. 2. Comprehensive disease history
Ulcerative Colitis	1. Initial Specialist Application. 2. Diagnostic reports to be supplied

F. PATIENT HEALTH INFORMATION *(to be completed by doctor)*

Weight: kg Height: m Hip/Waist ratio: Smoker? ☐ YES ☐ NO Ave per day:

Exercise: Frequency times per week Intensity: ☐ Low ☐ Medium ☐ High

Current Blood Pressure mmHg Available Blood Glucose Result mmol/L ☐ Fasting ☐ Random

G. CARDIOVASCULAR *(to be completed by doctor when applying for hypertension, hyperlipidaemia or diabetes mellitus)*

Is microalbuminuria present? ☐ YES ☐ NO Is GFR less than 60ml/min? ☐ YES ☐ NO

Please indicate which of the following co-morbidities/risk factors apply to this patient?

☐ Peripheral arterial disease ☐ Nephropathy ☐ Retinopathy ☐ Heart Failure
☐ Left ventricular hypertrophy ☐ Chronic renal disease ☐ Cardiomyopathy ☐ Prior stroke/TIA
☐ Prior myocardial infarction ☐ Prior CABG ☐ Prior Stent ☐ Angina

If heart failure is present, please indicate classification below:

NYHA/ACC-AHA Classification: ☐ A ☐ B/I(Mild) ☐ C/II(Mild)-III(Moderate) ☐ D/IV(Severe)

H. DIABETES MELLITUS

Please attach the laboratory diagnostic Fasting or Random Blood Glucose results.
The application cannot be reviewed if this is not submitted.

Patient Name: | ID Number:

I. HYPERTENSION *(to be completed by doctor when applying for hypertension)*

Please supply two blood pressure readings, performed on two different occasions, before initiating drug therapy, for a newly diagnosed patient.

(1.) Date: Y Y Y Y M M D D | mmHg | (2.) Date: Y Y Y Y M M D D | mmHg

J. HYPERLIPIDAEMIA *(to be completed by doctor when applying for hyperlipidaemia)*

Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.

Is there a family history of early-onset arteriosclerotic disease? ☐ YES ☐ NO *If yes, please provide details below:*

Does the patient suffer from familial hyperlipidaemia? ☐ YES ☐ NO Has this been verified by an Endocrinologist? ☐ YES ☐ NO

If yes, please provide details below:

Please risk your patient as per the Framingham coronary prediction algorithm %

K. PSYCHIATRIC CONDITIONS *(to be completed doctor by when applying for psychiatric disorders)*

Please indicate DSM IV diagnosis

Please indicate number of relapses

L. MEDICAL PRACTITIONER DETAILS & ADDITIONAL NOTES

Surname | Initials | Practice Number

Speciality | Telephone Number (code) | Fax Number (code)

Cellphone Number | E-mail Address

The outcome of this application must be communicated to me via: ☐ Email address ☐ Fax number

MEDICAL PRACTITIONER ADDITIONAL NOTES:

Patient Name: | ID Number:

M. CONDITION AND MEDICATION DETAILS *(to be completed by doctor)*

ICD-10 Code	Medication prescribed (Name, strength & dosage)	Date medication initiated & prescriber details	Repeats
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	
		Y Y Y Y M M D D	

Name of Medical Practitioner: | Signature: | Date: Y Y Y Y M M D D

N. HOW THE CHRONIC BENEFIT WORKS

The Chronic Benefit includes cover for medication from a specified list of chronic conditions which is in accordance with the Scheme option. These conditions have been selected according to clinical and actuarial criteria.

Chronic Disease List - The Prescribed Minimum Benefit regulations require that medical schemes cover the diagnosis, medical management and medication for a specified list of 27 chronic conditions known as the Chronic Disease List. All such conditions meeting approval criteria will be authorised under the PMB Chronic Medication benefit.

Extended Chronic Disease List - Certain Suremed Health options provide cover for an extended disease list. All such conditions meeting approval criteria will be authorised under the Chronic Medication benefit in line with treatment protocols and Scheme rules.

The PBM team will authorise an amount for all approved chronic conditions. The approved amount (Chronic Drug Amount - CDA) is determined based on the treatment protocols for all levels of treatment for each condition. The CDA is the maximum Rand amount that will be approved for the class/category of each drug that is authorised.