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Member Application Form

A Checklist:

- ✓ ID documents of principle member as well as dependants
- ✓ Birth certificates for children
- ✓ Legal adoption forms if children adopted
- ✓ Affidavit, should any dependant's surname differ from principal member's surname
- ✓ Proof of student registration
- ✓ Membership certificates of previous Medical Schemes
- ✓ Proof of taxable income (e.g. pay slip)
- ✓ Copy of cancelled cheque or bank statement for collecting contributions and/or claim refunds to confirm the bank account
- ✓ Marriage certificate

B Join Date Selection:

Please fill in Join Date selection:

Join Date: _____

*GP Nomination form to be completed on the Suremed Shuttle mobile app.
*Chronic Medication Application form can be accessed on the Suremed Shuttle Mobile App or on the Primecure website.

C Personal Details

Title: _____

Surname: _____

Full Names: _____

Identity Number/Passport: _____ **Date:** _____

Country of origin: _____

Telephone No: _____ **Fax:** _____ **Cell:** _____

Email Address: _____

Address: _____

_____

_____

Marital Status: _____

Gender: _____

Ethnic Group: _____

Language Preference: _____

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D Dependants Details:

Full Name	Surname	Relationship	Gender	Date of Birth/ ID number	Inception Date

E Employer Details

Employer Name: _____

Branch: _____

Date of Employment: _____

Gross Anual Salary: _____

F Broker Details

Broker House Name: _____

FSP No: _____ **Broker Code:** _____

Consultant Full Name: _____ **Designation:** _____

Signature: _____ **Date:** _____

G 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:** _____ Certificate attached ○ Yes ○ No

Membership number: _____ **Date to:** _____

Scheme Name: _____ **Date from:** _____ Certificate attached ○ Yes ○ No

Membership number: _____ **Date to:** _____

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H Medical History

1. Complete the table below by selecting Yes or No for each medical condition listed. If Yes, complete the details of the patient/s that have been diagnosed with the condition.

Condition	Select Yes or No for each condition	Name of patient	Has the patient received Treatment for this condition, including any medicine, or doctors visits in the last year?
Addison's disease	◯ Yes ◯ No		◯ Yes ◯ No
Asthma	◯ Yes ◯ No		◯ Yes ◯ No
Bipolar mood disorder	◯ Yes ◯ No		◯ Yes ◯ No
Bronchiectasis	◯ Yes ◯ No		◯ Yes ◯ No
Cardiac failure	◯ Yes ◯ No		◯ Yes ◯ No
Cardiomyopathy	◯ Yes ◯ No		◯ Yes ◯ No
Chronic Obstructive Pulmonary Disease (COPD)	◯ Yes ◯ No		◯ Yes ◯ No
Chronic renal disease	◯ Yes ◯ No		◯ Yes ◯ No
Coronary artery disease	◯ Yes ◯ No		◯ Yes ◯ No
Crohn's disease	◯ Yes ◯ No		◯ Yes ◯ No
Diabetes insipidus	◯ Yes ◯ No		◯ Yes ◯ No
Diabetes Type 1	◯ Yes ◯ No		◯ Yes ◯ No
Diabetes Type 2	◯ Yes ◯ No		◯ Yes ◯ No
Dysrhythmia	◯ Yes ◯ No		◯ Yes ◯ No
Epilepsy	◯ Yes ◯ No		◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No		◯ Yes ◯ No
Haemophilia	◯ Yes ◯ No		◯ Yes ◯ No
HIV	◯ Yes ◯ No		◯ Yes ◯ No
Hyperlipidaemia	◯ Yes ◯ No		◯ Yes ◯ No
Hypertension	◯ Yes ◯ No		◯ Yes ◯ No
Hypothyroidism	◯ Yes ◯ No		◯ Yes ◯ No
Multiple sclerosis	◯ Yes ◯ No		◯ Yes ◯ No
Parkinson's disease	◯ Yes ◯ No		◯ Yes ◯ No
Rheumatoid arthritis	◯ Yes ◯ No		◯ Yes ◯ No
Schizophrenia	◯ Yes ◯ No		◯ Yes ◯ No
Systemic lupus erythematosus	◯ Yes ◯ No		◯ Yes ◯ No
Ulcerative colitis	◯ Yes ◯ No		◯ Yes ◯ No

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2. Have you, or any of your dependants been diagnosed with a medical condition other than the ones listed in the table above, or are you planning to have surgery for any condition in the next 12 months?

◯ Yes ◯ No

If yes, please give us the medical diagnosis or a description of the medical condition or surgery:

Important: It remains the responsibility of the applicant to include full disclosure of the required medical information. If you fail to disclose pre-existing medical conditions, all amounts due to Suremed Health Medical Scheme for claims paid in relation to the medical condition in the first 12 months from the Policy start date must be refunded to the Medical Scheme.

I Premium Payer 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.

Please select option (more than one option can be selected)

☑ Employer contribution (Member bank details not required)

☑ Use this account for contribution collections (Pensioners and Private Members) - Contribution payments deducted in advance

☑ Contributions paid by a third party and not the main member

Bank Name:
Branch Name:
Account Holder Name:
Bank Account Number:

Account Type: ◯ **Current** ◯ **Cheque** ◯ **Savings** ◯ **Transmission**

*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.

Account holder signature: **Date:**

J Claim Refund Banking Details

☑ Use above Premium Payer Banking Details

Or fill in the below

Bank Name:
Branch Name:
Account Holder Name:
Bank Account Number:

Account Type: ◯ **Current** ◯ **Cheque** ◯ **Savings** ◯ **Transmission**

*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.

Account holder signature: **Date:**

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K Consent Declaration

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, orporation, 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.
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 personal 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.

I, _____ (full name and Surname of Member) hereby declare that this application form, whether in my handwriting or not, is accurate and complete and forms the basis of the contract of insurance between the Scheme and myself.

Identity Number/ Passport Number: _____

Signature: _____ **Date:** _____