SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

0860 100 871
086 608 0771
membership@sizwehosmed.co.za
Waterfall Office Park,
1 Bekker Rd, Vorna Valley,
Midrand
1696

EMPLOYER GROUP APPLICATION FORM

DOCUMENTS REQUIRED

- Main member's copy of ID or Passport and copies of birth certificate or ID for all beneficiaries.
- Membership certificate from previous medical aid (where applicable).

SECTION A: SIZWE HOSMED SCHEME PLAN SELECTION

Preferred Option: Essential Copper ☐ Access Core ☐ Access Saver ☐ Gold Ascend ☐ Gold Ascend EDO ☐ Value Platinum ☐ Value Platinum Core ☐ Titanium Executive ☐

Start date		Broker Firm Name			
		Broker Code		Name of broker/agent	

SECTION B: EMPLOYER DETAILS

Employer Name		Payroll no.		Employer Stamp
Employer Group Number		Date of Employment		

Name

Employer signature | Designation | Date

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL:

SECTION C: MEMBER DETAILS

Title: Mr/Mrs/Miss		Initials		First name	
Surname		Gender M ☐ F ☐		Identity no.	
Tel. no. (h)		(w)		(Cell)	
Email					
Residential address					
				Postal code	
Postal address					
				Postal code	

Race (please tick)	African	Coloured	Indian/Asian	White	Preferred method of communication (please tick)	Email ☐	SMS ☐	Post ☐

SECTION D: PARTICULARS OF DEPENDANTS

	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Name and Surname of dependant					
ID number (compulsory)					
Relationship to member (spouse, partner, daughter etc.)					
Sex (M/F)					
Race (African, Coloured, Indian/ Asian, White)					
Address, if different from member					
Cell no.					

Note: Full 13 digit ID numbers are required in full in order to have the dependant considered for processing.

SECTION E: MEDICAL CONDITIONS

Kindly supply the Scheme with any current medical and chronic conditions:

Member initials _____

16502|SH | CP | 220926

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	1st	15th	25th	31st			

I authorise Sizwe 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 Sizwe Hosmed, without prejudice to the rights of Sizwe Hosmed. I further authorise Sizwe 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 Sizwe 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 Sizwe 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 Sizwe Hosmed. I undertake to notify Sizwe Hosmed immediately of any change in respect of my details. I acknowledge that Sizwe 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. Sizwe Hosmed is hereby authorised to debit my bank account with my portion of accounts paid on my behalf by Sizwe Hosmed.

Name _____ Signature _____ Date

SECTION G: BANK DETAILS (FOR CLAIMS REFUND)

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

SECTION H: UNDERTAKING BY MAIN MEMBER

I acknowledge that:

a. I am aware that, once I have decided to move to another medical aid scheme – for which provision is made by my employer – I will not be allowed to move to another scheme during the next 12 months.

b. The onus rests with me to ensure that my application is submitted to my Support Services Division.

c. The onus rests with me to provide cancellation to my current Medical Aid before the deduction for Sizwe Hosmed Medical Scheme can be implemented.

d. I must register my chronic medication with Sizwe Hosmed.

e. I agree to access www.sizwehosmed.co.za to access full conditions and undertakings of the Scheme as a member of Sizwe Hosmed Medical Scheme.

f. Where applicable: Member Savings Account allocations will be pro-rated depending on when joining the option.

g. The Scheme has the sole right to collect negative balances owed to the Scheme by the member even when member has terminated from the Scheme.

Signature of member _____ Date

Fund Declaration

As Sizwe Hosmed Medical Scheme we are strongly committed to protecting your personal data. We are required by POPIA to explain why and how we collect, use, and disclose your personal information, which may include health and financial information. Sizwe Hosmed Medical Scheme will keep your information supplied to us in this application confidential. Acceptance of these terms and conditions is a requirement for activation and servicing of your medical scheme membership. You give us consent to process your personal information for the following purposes:

a. Administration of your health care option;

b. Provision of managed care services to you;

c. Providing relevant information to a contracted third party;

d. To profile and analyse risk;

e. For research purposes; and

f. To comply with legislation.

Please note that we will only share your information with a third party if you have granted us your consent for the disclosure of the information to such third party or if a contractual relationship exists in terms of which we are obliged to provide your information to such third-party. We may amend this notice from time to time, please check our website to inform yourself of any changes.

Member initials _____