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

DOCTOR SELECTION FORM

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

NOTE: PLEASE ENSURE THAT THE MEMBER AND DEPENDANT DETAILS ON THIS FORM ARE THE SAME AS ON YOUR/THEIR ID DOCUMENT OR BIRTH CERTIFICATE.

MEMBER DETAILS

	PRINCIPAL MEMBER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
SURNAME					
FIRST NAMES (as per ID)					
ID NO.					
DATE OF BIRTH					
GENDER					
EMAIL ADDRESS					
MOBILE NO.					

GENERAL PRACTITIONER DETAILS (GP)

NAME OF GP					
PRACTICE NO.					
GP ADDRESS					
GP TEL. NO.					

DENTIST DETAILS

NAME OF DENTIST					
PRACTICE NO.					
DENTIST ADDRESS					
DENTIST TEL. NO.					

OPTOMETRIST DETAILS

NAME OF OPTOMETRIST					
PRACTICE NO.					
OPTOMETRIST ADDRESS					
OPTOMETRIST TEL NO.					

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:

- Administration of your health care option;
- Provision of managed care services to you;
- Providing relevant information to a contracted third party;
- To profile and analyse risk;
- For research purposes; and
- 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.

If you have more than four dependants, please complete a second form.

Applicant's signature

Date

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