SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

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membership@sizwehosmed.co.za
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CONTINUATION OF MEMBERSHIP FORM

Please use black ink to complete all sections and return as soon as possible to ensure speedy registration.

Continuation as: Individual ☐ Group ☐ Widow(er) ☐ Orphan ☐

Select Plan: Essential Copper ☐ Access Core ☐ Access Saver ☐ Gold Ascend ☐ Gold Ascend EDO ☐ Value Platinum ☐ Value Platinum Core ☐ Titanium Executive ☐

FOR INTERNAL USE ONLY

Membership No.:	
Employer group:	

SECTION 1 PERSONAL DETAILS OF PRINCIPAL MEMBER

(as per ID) First Name (s):					
Surname:		Title:		Initials:	
Membership number:					
ID number:					
Postal Address:					
				Postal Code:	
Physical Address:					
				Postal Code:	
Tel (work):		Cell:			
Tel (home):					
Email:					

SECTION 2 TO BE COMPLETED BY THE PRINCIPAL MEMBER/ WIDOW(ER'S) EMPLOYER (IF APPLICABLE)

Date joining Fund: D D M M Y Y Y Y Date of benefit: D D M M Y Y Y Y

Income category:			
Member's share of contribution:		Employer's share of contribution:	
Total monthly contribution:		Payroll/persal number:	
Employer/ account number:			
NB: Proof of income/ salary slip to be submitted with this form.			
Name:		Company/division:	
Email:			
Tel:		Designation:	

Date D D M M Y Y Y Y

We confirm that the applicant is employed/or is the widow(er) and that contributions are being deducted in accordance with the applicant's income and eligible dependants, in terms of the appropriate contribution table.

Any further changes to the employee's/widow(er)'s status will be advised to the Scheme within seven days.

official stamp of employer

Signature of employer: _____

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SECTION 3 — PRINCIPAL MEMBER & DEPENDANT DETAILS (SHADED AREAS FOR OFFICE USE ONLY)

Gender codes	Marital codes		Relationship codes		
M = Male	M = Married	S = Single	S = Spouse	C = Child	0 = Other
F = Female	D = Divorced	W=Widowed	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.) The main application, spouse or partner and all dependants applying for cover needs to complete this section.

NB: GREY SHADED AREAS FOR OFFICE USE ONLY

PRINCIPAL MEMBER 01

(as per ID) First Name (s):

Surname: | Gender: | Marital status:

ID number: | Date of birth: D D M M Y Y Y Y

How tall are you? metres | How much do you weigh? kg

Do you have a history of previously diagnosed cancer? Yes ☐ No ☐

If yes, kindly specify and provide further details:

Waiting period: Yes ☐ No ☐

Reason:

Condition-specific waiting period:

Reason:

SPOUSE OR PARTNER 02

(as per ID) First Name (s):

Surname: | Gender: | Marital status:

ID number: | Date of birth: D D M M Y Y Y Y

How tall are you? metres | How much do you weigh? kg

Do you have a history of previously diagnosed cancer? Yes ☐ No ☐

If yes, kindly specify and provide further details:

Waiting period: Yes ☐ No ☐

Reason:

Condition-specific waiting period:

Reason:

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CONTINUATION OF MEMBERSHIP FORM

DEPENDANT CODE 03					
If there is a difference between the surname of any child dependant and the principal member please state reason					
(as per ID) First Name (s):					
Surname:		Gender:		Marital status:	
ID number:		Date of birth:	D D M M Y Y Y Y		
How tall are you?	metres	How much do you weigh?	kg		
Do you have a history of previously diagnosed cancer?	Yes: ☐	No: ☐			
If yes, kindly specify and provide further details:					

Waiting period:	Yes: ☐	No: ☐	
Reason:			
Condition-specific waiting period:			
Reason:			

DEPENDANT CODE 04					
If there is a difference between the surname of any child dependant and the principal member please state reason					
(as per ID) First Name (s):					
Surname:		Gender:		Marital status:	
ID number:		Date of birth:	D D M M Y Y Y Y		
How tall are you?	metres	How much do you weigh?	kg		
Do you have a history of previously diagnosed cancer?	Yes: ☐	No: ☐			
If yes, kindly specify and provide further details:					

Waiting period:	Yes: ☐	No: ☐	
Reason:			
Condition-specific waiting period:			
Reason:			

NOTE: Child dependants who are aged between 21 and 25 years, who are either 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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CONTINUATION OF MEMBERSHIP FORM

SECTION 4 MEDICAL HISTORY OF PRINCIPAL MEMBER AND REGISTERED DEPENDANTS

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

		Mark one	Dependant number (Mark with X where applicable)	ICD-10 code	Date of last treatment
1	**Cardiovascular Conditions** Heart failure, hypertension, shortness of breath (angina), high blood pressure	☐ ☐	☐ ☐ ☐ ☐ ☐		
2	**Respiratory Conditions** Asthma, COPD Chronic obstructive pulmonary disease, tuberculosis, bronchitis	☐ ☐	☐ ☐ ☐ ☐ ☐		
3	**Neurological Conditions** Stroke, epilepsy, paralysis, weakness, myasthenia gravis	☐ ☐	☐ ☐ ☐ ☐ ☐		
4	**Grastro Intestinal Conditions** Gastric/ duodenal ulcer, liver disorder, gal bladder stones, pancreatitis hepatitis, hiatus hernia,	☐ ☐	☐ ☐ ☐ ☐ ☐		
5	**Genito Urinary Condition** Kidney stones, prostatic hypertrophy, renal failure glomerolonephros, STI's (including HIV)	☐ ☐	☐ ☐ ☐ ☐ ☐		
6	**Endocrine Conditions** Diabetes insipid us, thyroid disorders, addison's disease, diabetes mellitus, osteoporosis	☐ ☐	☐ ☐ ☐ ☐ ☐		
7	**Blood Conditions** Anaemia, blood clotting problems, deep vein thrombosis, leukaemia, lymphoma	☐ ☐	☐ ☐ ☐ ☐ ☐		
8	**Gynaecoloaical & Obstetric Conditions** Abnormal papsmear, abnormal bleeding pregnancy, miscarriage, polycystic ovarian	☐ ☐	☐ ☐ ☐ ☐ ☐		
9	**Mental Health Conditions** Depression, dementia, bipolar disorder, ADHD	☐ ☐	☐ ☐ ☐ ☐ ☐		
10	**Musculoskeletal (back, bone, muscle pain)** Arthritis, sarcoidosis, fibromyalgia, ankylosing spondylitis, sjogren's syndrome	☐ ☐	☐ ☐ ☐ ☐ ☐		
11	**Tumour & Growths** Breast lumps, cancer, abnormal papsmear, abnormal mogram results, prostate specific antigen (PSA)	☐ ☐	☐ ☐ ☐ ☐ ☐		
12	**Ear, Nose and Throat** Chronic otitis media, cochlear implant, sinus problems, adenoiditis, nasal surgery	☐ ☐	☐ ☐ ☐ ☐ ☐		
13	**Eyes Conditions** Glaucoma, squint, blurred vision, macular degeneration, ptosis, uveitis, retinal detachment	☐ ☐	☐ ☐ ☐ ☐ ☐		
14	Are you or any of your dependants expecting to have medical investigations or surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months?	☐ ☐	☐ ☐ ☐ ☐ ☐		
15	Have you or any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application?	☐ ☐	☐ ☐ ☐ ☐ ☐		
16	Have you or any of your dependants been diagnosed with or received treatment for any conditions not mentioned in the questions above in the last 12 months before this application?	☐ ☐	☐ ☐ ☐ ☐ ☐		
17	Are you now pregnant?	☐ ☐			
	If yes, how many months?				
	If yes, is this a multiple birth?	☐ ☐			

Please provide any other relevant information:

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SECTION 5 MEDICAL HISTORY: PRINCIPAL MEMBER & DEPENDANTS DETAILS

DISCLAIMER: I will inform the Fund of any changes in my health status or the health of my dependant/s within 30 days of the change occurring from the date of application and within 90 days of the activation date.

Question no.	Name of patient	Nature and duration of complaint and full details of treatment being or expected to be received. N.B. Please specify all medication	Name and telephone number of attending doctor or hospital

SECTION 6 LATE SPOUSE'S DETAILS

(as per ID) First Name (s):					
Surname:		Title:		Initials:	
Membership number:					
ID number:					
Employer:					

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CONTINUATION OF MEMBERSHIP FORM

SECTION 7 INCOME DECLARATION AND BANKING DETAILS (FOR REFUND PURPOSES AND DEBIT ORDER AUTHORITY)

BANKING DETAILS			
Bank:			
Account number:			
Account Type:	Current: ☐	Savings: ☐	Transmission: ☐

CONTRIBUTION PAYMENTS

I hereby authorise that the monthly contribution, as raised by the Sizwe Hosmed Medical Scheme, may be withdrawn from the above mentioned account on the 1st of each month for the current month's membership contributions. If I am a Direct Paying Member, I understand that my contributions are collected monthly in advance. I further understand that, if payment is not made to the Scheme 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.

Income declaration (compulsory for all members)

I hereby declare that my monthly income is R _____ per month.
(Substantiating proof of income must be attached and must be resubmitted to the Scheme on an annual basis.)

NOTE: If the account holder is not the principal member of the Scheme, the principal member agrees to refund monies being paid into the above account and both Sizwe Hosmed Medical Scheme is not responsible for the is money once paid.

Date of first payment: D D M M Y Y Y Y

Signature: _____ Date: D D M M Y Y Y Y

SECTION 8 ESSENTIAL DOCUMENTS (COMPULSORY)

Please provide the following documentation with your application

	Are the relevant documents attached?			
Copy of your ID as well as your dependant	Yes		No	
Birth certificates for children (where ID is not available)	Yes		No	
Clinic cards for new born 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 cohabitation (where applicable)	Yes		No	
Membership certification with termination dates from previous medical aids, for member and dependants (where applicable)	Yes		No	
Proof of study for dependant/s between ages 21-25 years or an affidavit proving financial dependency	Yes		No	
Dependant/s, or doctor's letter for mentally or physically disabled children	Yes		No	
Proof of taxable income (i.e., payslip, SARS ITA 34 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 the form is completed in full and all the necessary documents are attached with your application.
Failure to submit the relevant documents will delay the processing of your membership application.**

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CONTINUATION OF MEMBERSHIP FORM

SECTION 9 SCHEME DECLARATION

As Sizwe Hosmed Medical Scheme we are strongly committed to protecting your personal data. We are required by POPIA to explain how we obtain, use, disclose and otherwise process your information, which may include health and financial information (Personal information). Sizwe Hosmed Medical Scheme and its administrator will keep your information, including your personal information supplied to us in this application confidential. Acceptance of the terms and conditions is a requirement for activation and servicing of your medical scheme membership. You agree to us processing your personal information for the following purpose:

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 already given your consent for the disclosure of this 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 your website to inform yourself of any changes.

BROKER DETAILS:

Broker:	
Full name(s):	
Tel:	
Email:	

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