SIZWE HOSMED
MEDICAL SCHEME
*Your choice for quality care*

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Johannesburg,
2198

# EMPLOYER GROUP APPLICATION FORM

DOCUMENTS REQUIRED

| | Yes | No |
|---|---|---|
| • Main member's copy of ID | ☐ | ☐ |
| • Bank account holder's copy of ID | ☐ | ☐ |
| • Dependant's copy of ID | ☐ | ☐ |
| • Birth certificate of child (where ID is not available) | ☐ | ☐ |
| • Documentary proof if dependant is adopted/foster child/student/disability status/adult dependant | ☐ | ☐ |
| • Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable) | ☐ | ☐ |
| • Membership certificate from previous medical aid (where applicable) | ☐ | ☐ |
| • Proof of banking detail (a bank statement or a bank-stamped letter, or a cancelled cheque) | ☐ | ☐ |

Broker Stamp

Broker No.

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

## SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss | Initials | First name

Surname | 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 B: SIZWE HOSMED MEMBERSHIP DETAILS

Option: Titanium Executive ☐ Plus ☐ Platinum Enhanced ☐ Platinum Enhanced EDO ☐ Gold Ascend ☐ Gold Ascend EDO ☐ Value ☐ Value Core ☐ Access ☐ Access Core ☐ Essential Copper ☐

Employer name | Payroll no.

Join date | Total contribution R | Gross monthly salary R

## SECTION C: 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 D: MEDICAL CONDITIONS

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

Please remember to register your chronic medication at our ChroniLine. Also register on our Chronic Disease Management Programme to qualify for additional benefits.

## SECTION E: EMPLOYER DETAILS

| | | | |
|---|---|---|---|
| Company | | | |
| Region | | Date of employment | |

Name _____ Employer signature _____ Designation _____ Date _____

## 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 | | | | | | | |

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 by 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 _____ Employer Name _____ Employer Signature _____ Effective date of first deduction _____ Date _____

| | |
|---|---|
| Membership Number | |
| Department | |
| Depot | |
| Tel | |
| Municipality name | Broker |

Employer stamp

**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 and its administrator (3Sixty Health (Pty) Ltd) 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.