ID	/	P	A	S	S	P	O	R	T			

UMVUZO HEALTH

Alenti Office Park, Building D, 457 Witherite Road, The Willows, Pretoria, 0040
P.O. Box 1463, Faerie Glen, 0043. **T:** +27 (0) 12 845 0000 **F:** +27 (0) 86 670 0242
Call Centre: 0861 083 084

www.umvuzohealth.co.za

APPLICATION FORM

A. DETAILS OF MAIN MEMBER

Company name							
Date of permanent employment	Y Y Y Y M M D D	Medical aid start date requested	Y Y Y Y M M D D				
Employee number		Pay point/Branch					
Option: (please tick)	Ultra Affordable		Standard		Supreme		Extreme	
If Activator/Ultra Affordable Value is selected, kindly complete the GP nomination form					Activator		Ultra Affordable Value	
Main member name	Surname	ID / P A S S P O R T						
Date of birth	Gender	Race	Email					
Postal/Physical address					Cell 1			
	Code				Cell 2			

Home language (please tick)

English		Afrikaans		isiZulu		isiXhosa		isiNdebele		XiTsonga	
TshiVenda		SiSwati		SeTswana		SeSotho		SePedi		Other	

B. DETAILS OF BENEFICIARIES **Race** - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured • **Gender** - **F** = Female, **M** = Male

Spouse

Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship
Email			Cell			
Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship
Email			Cell			

Adult dependants (≥21)

Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship
Email			Cell			
Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship
Email			Cell			

Child dependants (<21)

Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship
Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship
Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship
Name	Surname	ID / P A S S P O R T	Date of birth	Gender	Race	Relationship

C. BANK DETAILS (FOR REFUND PURPOSES ONLY)

Bank name						
Branch		Branch code				
Account number		Account type (please tick)	Cheque		Savings	

D. MEMBER'S UNDERTAKING

I _____ (full name) hereby state that:

All information given herein is true to the best of my knowledge and conviction and I am aware that false information or omission may have repercussions based on Scheme rules and processes.

I have familiarised myself with the rules, benefits and networks of the Scheme and subject myself to them.

I understand that I must get authorisation to visit a specialist, go to hospital, get a scan and make use of an emergency visit or any other service stipulated by the Scheme.

I understand the medication benefit of my selected Option and the fact that benefits can be driven by formularies, protocols and Scheme rules and that any medication outside these parameters will be for my own account.

I hereby undertake to comply with the management of benefits by the Authorisation Centre and the guidelines they follow and to co-operate to the best of my ability with their processes and procedures.

I irrevocably grant permission to any provider, person or party who may be in possession of or obtain information concerning my health or that of my dependants, to divulge such information to Umvuzo Health or its duly contracted agents upon request, also after my death.

I understand to pay my premium on or before the 3rd day of each month and to pay my share of accounts.

I hereby authorise Umvuzo Health to recover such payments from my employer, whom I authorise to deduct the amount from my salary or if I resign, from my pension and or any other money due to me and to pay this over to Umvuzo Health.

The above mechanisms may be used to cover any incurred cost should I resign from my job or terminate my Umvuzo Health medical Scheme membership prior to such cost being recovered.

Upon signing this document, I understand that I am entering into a binding agreement with Umvuzo Health and that it is my responsibility to make sure that all the beneficiaries listed on this application, as well as any beneficiaries I add in future, are fully informed about all aspects of my agreement with Umvuzo Health.

I hereby accept the appointment that my representatives made on my behalf with regards to Health Care Consultants and/or Brokers. I will specifically inform the Scheme in writing should I wish to revoke the appointment of the Health Care Consultant and / or Broker.

I consent that Umvuzo queries 3rd party data sources to confirm information provided.

_____ Date Y Y Y Y M M D D

Signature of applicant (main member)

_____ Date Y Y Y Y M M D D

Signature of witness (broker if applicable)

_____ _____

Signature of employer | Employer stamp as verification

Medicine bag received (please tick) Yes ☐ No ☐

Please note that your application will not be processed without the receipt of the completed and signed Medical Conditions Disclosure Form on page 3 and 4.

ID	/	P	A	S	S	P	O	R	T			

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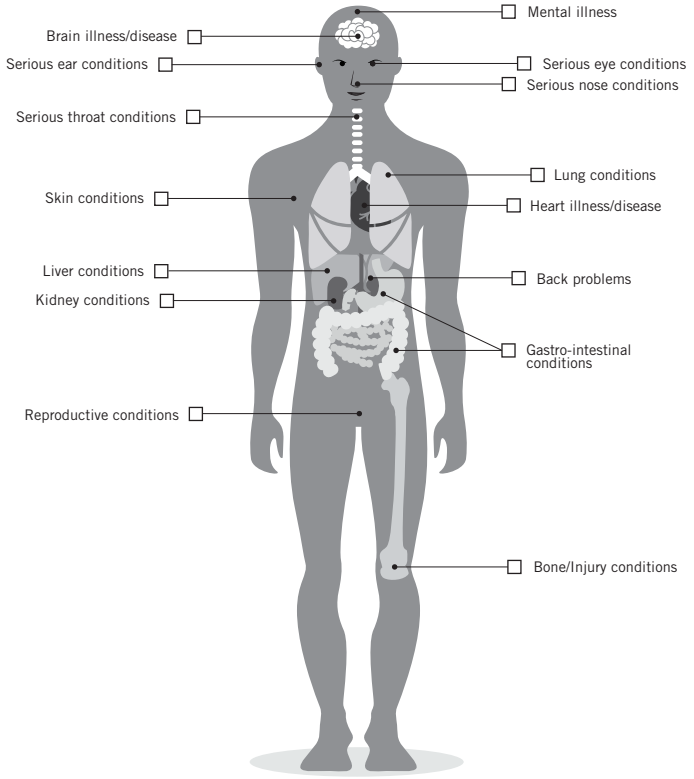
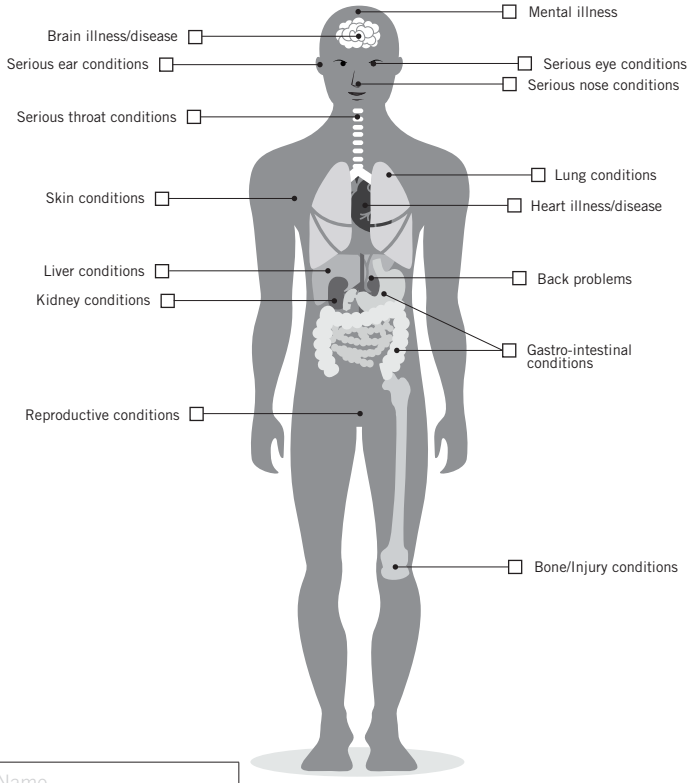
MEDICAL CONDITIONS DISCLOSURE FORM

Company name			
Name	Surname	ID/Passport number	
Contact number			

Have you or your dependants suffered from any of the following conditions (please tick the appropriate box)

MAIN MEMBER		Spouse		Adult dependant	





		Name	
Male		Surname	Male
Female		Contact number	Female
Are you currently pregnant	Yes / No	Are you currently pregnant	Yes / No
If yes, specify how many weeks		If yes, specify how many weeks	

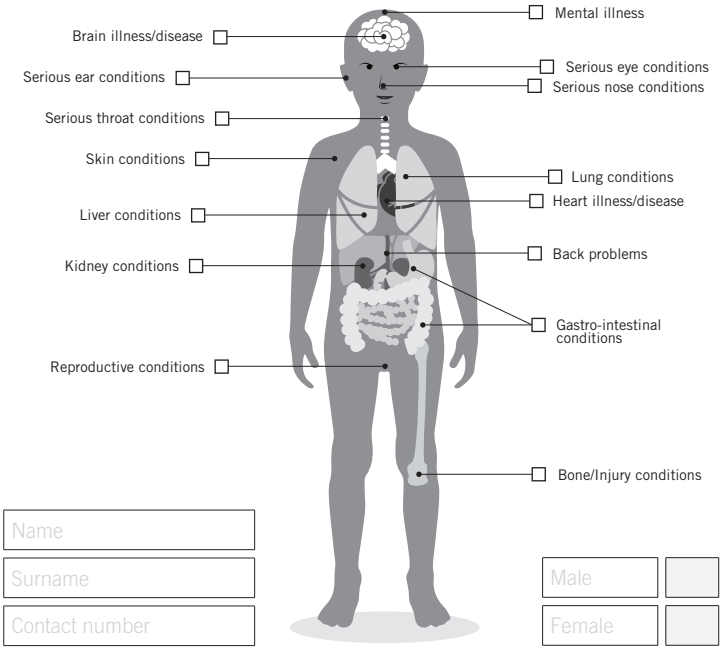
PAST MEDICAL HISTORY (please check the appropriate box)				PAST MEDICAL HISTORY (please check the appropriate box)			
Previous operation		Previously hospitalised		Previous operation		Previously hospitalised	
Diabetes		Asthma		Diabetes		Asthma	
Cancer treatment/diagnosis		Epilepsy		Cancer treatment/diagnosis		Epilepsy	
High blood pressure		Cholesterol		High blood pressure		Cholesterol	
HIV		Chronic medication		HIV		Chronic medication	

DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N)						DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N)					
Vehicle accident		Road accident fund		Injury on duty		Vehicle accident		Road accident fund		Injury on duty	
Any additional information not indicated above.						Any additional information not indicated above.					

The scheme and its contracted providers will only collect personal information consistent with the purpose for which it is required and will only process personal information in a manner that is adequate, relevant and not excessive in the context of the purpose for which it is processed and will take such steps as may be required to ensure that it complies with any law in respect of transfer, storage, security and use of the personal information.

Initial

Adult dependant		Child dependant	



Name			
Surname		Male	
Contact number		Female	
Are you currently pregnant		Yes	No
If yes, specify how many weeks			

PAST MEDICAL HISTORY (please check the appropriate box)

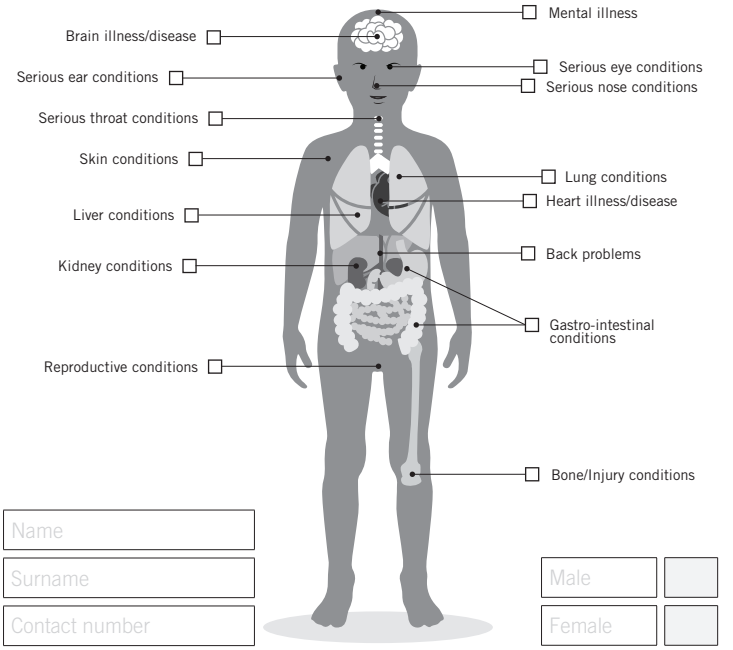
Previous operation		Previously hospitalised	
Diabetes		Asthma	
Cancer treatment/diagnosis		Epilepsy	
High blood pressure		Cholesterol	
HIV		Chronic medication	

DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N)

Vehicle accident		Road accident fund		Injury on duty	

Any additional information not indicated above.

Adult dependant		Child dependant	



Name			
Surname		Male	
Contact number		Female	
Are you currently pregnant		Yes	No
If yes, specify how many weeks			

PAST MEDICAL HISTORY (please check the appropriate box)

Previous operation		Previously hospitalised	
Diabetes		Asthma	
Cancer treatment/diagnosis		Epilepsy	
High blood pressure		Cholesterol	
HIV		Chronic medication	

DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Y/N)

Vehicle accident		Road accident fund		Injury on duty	

Any additional information not indicated above.

THE IMPORTANCE OF DISCLOSING YOUR HEALTH STATUS

Section 5 of the Medical Schemes Act states that members have the duty to disclose any material information on request and fill out the health history form openly and honestly.

Full disclosure of any health issues is vital in forging and maintaining a good relationship with your medical scheme.

By disclosing your health status in detail, we can ensure that the clinical and financial risk of you as our member and the medical scheme are well managed.

Disclosure will assist you and your dependants in gaining access to medical care funding - but non-disclosure can lead to funding being refused.

In the case of non-disclosure, you may face non-payment of the accounts incurred for the illness not disclosed to the scheme, you may even be dismissed from the scheme.

In order to manage risk effectively, the scheme holistically manages each individual member's unique healthcare funding needs and disclosing your health status, allows us to manage your health should you have any illness or condition.

I confirm that the above information is a true and correct record. In signing this disclosure, I am permitting this information to be disclosed to in accordance with the relevant laws of the Republic of South Africa. I agree to notify The scheme and its contracted providers should there be any change in my health or medicinal requirements.

Member signature

Date Y Y Y Y M M D D

OFFICE USE ONLY

Administration contact		Processed by	Notes
Clinical contact		Processed by	Notes
Chronic registration		Processed by	Notes

Email to: disclosure@umvuzohealth.co.za