UMVUZO HEALTH

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APPLICATION FORM

A. DETAILS OF MAIN MEMBER

Company name																	
Date of permanent employment	Y	Y	Y	Y	M	M	D	D	Start date requested	Y	Y	Y	Y	M	M	D	D
Date received	Y	Y	Y	Y	M	M	D	D									
Employee number									Pay point								
Option: (please tick)	Activator		Ultra affordable		Standard		Supreme		Extreme								

B. DETAILS OF BENEFICIARIES

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

Full name	Surname	Identity number (13) digit / Passport	Date of birth	Gender	Race	Relationship
Main member						
Main member						
Spouse						
Spouse 1						
Spouse 2						
Adult dependants (>21)						
Adult dependant 1						
Adult dependant 2						
Child dependants (<21)						
Child dependant 1						
Child dependant 2						
Child dependant 3						
Child dependant 4						

C. CONTACT DETAILS

Physical address		
	Code	
Postal address		
	Code	

D. CONTACT NUMBERS

Telephone number (H)		Telephone number (W)	
Fax number		Cellphone number	
Email			

E. BANK DETAILS

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

Complete the following by ticking YES (Y) or NO (N)

Do you have or have you - or your dependants - experienced problems with:

1	Heart and Blood Circulation. Please mark this if you suffer from high blood pressure, varicose veins, swollen legs due to heart problems, stroke, clots, heart beating too fast or too slow, or anything else related to heart and circulation.	Y	N
2	Lungs and Airways. Please mark this if you suffer from allergies, asthma, sinus problems, nose symptoms, bronchitis, tonsil and adenoid symptoms, TB, snoring, sleep apnea, if you are a smoker or anything else related to your lungs and airways.	Y	N
3	Metabolism. Please mark this if you suffer from symptoms like chronic tiredness, thyroid problems, diabetes, poor food absorption or anything else related to your metabolism.	Y	N
4	Cancer and Growths. Please mark this if you have or had any kind of cancer including skin cancer or any growths or lumps anywhere on your body.	Y	N
5	Muscles and Joints. Please mark this if you have any symptoms such as joint pain, arthritis, back or neck problems, broken bones, shoulder, hip or knee symptoms or anything else related to bones and joints.	Y	N
6	HIV. Please mark this if you are HIV positive, if you suspect you may be or if you had been tested for HIV. All information is kept strictly confidential.	Y	N
7	Pregnancy, Female and Male Organs. Please mark this if you are pregnant, if you suspect you are or if you've missed a period, if you have any kind of problems with menstruation, suffer from endometriosis or any breast problems. Please mark this if you have prostate symptoms, bladder problems, difficulty in passing urine or sexual functioning. Also mark here if you suffer from urinary infection or anything else related to sexual organs or urinary problems.	Y	N
8	Medication. Please mark this if you are taking or recently took any kind of medication, especially for longer than two weeks, including vitamins, chronic medication, natural remedies, any kind of muti or supplement.	Y	N
9	Other. Please mark this if you have any other kind of symptom, problem or condition not listed above or if you are in need of any kind of operation or test.	Y	N

Please elaborate on the questions answered "YES" above and mention for whom it is.

_____

_____

Would you like to discuss it further? Please supply your cellphone number and we will call you:

_____

If applicable, please supply a membership certificate from previous schemes as proof of previous medical aid membership, to avoid underwriting.

F. 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.

_____ 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