

4. Adult Child Title Initials

Surname (if different from principal member)

First name/s

Relationship to principal member eg. spouse, child, etc. Gender M F Date of birth

Marital status Single Married Divorced Widowed Cohabiting

Maiden name (if applicable)

ID / passport number

Tax number (if applicable)

Section 5. Medical details

Please note: failure to disclose medical conditions could limit and /or exclude you from receiving certain benefits, or result in the termination of your membership.

Do you or any of your dependants currently suffer or have suffered from any of the following:

1. Chronic illness? (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression, anxiety, systemic lupus erythematosus, epilepsy, and / or thyroid disorder) If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					

2. Gastro-intestinal disorders? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and / or spastic colon) If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					

3. Muscle, bone, skin or nerve illnesses or disorders? (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc.) If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					

4. Urinary or genital disorders? (e.g. Kidney stones, prostate disorders, endometriosis, ovarian cysts, menstrual disorder) If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					



5. Ear, nose or throat disorders? (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics) If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					

6. Blood disorders, cancer, etc.? If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					

7. Are you or any of your dependants pregnant? If yes, please provide details.

Name of beneficiary	Trimester of pregnancy	Confirmed pregnancy		Expected date of delivery	Complications (if any)	Attending GP/Specialist	
		YES	NO			Y	N
		YES	NO				
		YES	NO				

8. Have you or any of your dependants had surgery in the past, or are you planning to have a surgical procedure in the next 12 months? If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					

9. Is there any other condition or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months? If yes, please provide details.

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1 st treatment	Date of last treatment	Name of medication	Attending GP/Specialist	
		YES	NO				Y	N
		YES	NO					
		YES	NO					

Current Doctor

Name and surname

Telephone He / she has been your doctor since Y Y M M years



Section 8. Termination of dependant membership due to death, divorce, over-age child dependant, etc.

Attach certified copy of divorce decree / death certificate

Full name/s as reflected on your fund membership card	Relationship	Date joined								Date terminated							
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
Reason for termination:																	

Section 9. To be completed by employer – compulsory

Company name

Scheme code Pay point code Group Dependant/s subsidised YES NO

The above details have been noted and contributions will be adjusted in terms of the Scheme Rules and include arrears, if applicable.

EMPLOYER STAMP

Total current contribution R

Total new contribution R

Arrears (if applicable) R

Company representative's signature and designation _____

Date

Section 10. Medical fund acknowledgement and declaration

- Bonitas takes the protection of personal information very seriously and for this reason all reasonable measures are taken to protect your personal information and to keep it confidential. Personal information refers to information that identifies or relates specifically to you or your dependants, for example, name, age, gender, health status, identity number and email address. In short, any information that we know about you or a dependant will be regarded as your personal information.

We use your information or obtain information about you for the following purposes:

- Underwriting (conditions applicable to your membership and benefits)
- Assessment and processing of medical services claims
- Fraud prevention and detection
- Statistical analysis
- Audit & record keeping purposes
- Compliance with legal & regulatory requirements
- Verifying your identity
- Sharing information with service providers we engage to process such information, on our behalf or who renders services to us.
- You may access the personal information that we hold and request us to correct any errors or to delete this information.

- To protect you and your dependants' personal information, Bonitas has data security measures in place, i.e. access control to restrict the disclosure of personal information to only authorised individuals, confidentiality agreements with service providers and staff members, and for the purposes of disaster and data recovery plans.

Section 11. Acknowledgement and declaration

- I, the undersigned, hereby make application to be admitted as a member of Bonitas Medical Fund. When admitted I agree to abide by the rules of Bonitas which are available for me to read on the Bonitas website www.bonitas.co.za or will be provided to upon my request to Bonitas .
- I warrant that the information I have provided in this application form, pertaining to me and my dependants are true and correct.
- I warrant that I have the explicit consent of my dependants to disclose personal information about them to Bonitas and will on request from Bonitas provide such consent, in written form, to Bonitas.



4. I declare that any false statement in the above application or the non-disclosure of any material information will render my membership null and void, and that any monies paid to the Scheme shall be forfeited to the Scheme.
5. Bonitas also has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation. Should my or my dependants' circumstances alter subsequent to the date of filling in this application, prior to or after the acceptance of my membership by Bonitas, I shall promptly notify Bonitas of the changes. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership, and Bonitas shall also be entitled to reclaim any amounts it may have erroneously paid to any service provider on my or my dependants behalf.
6. I authorise and instruct my employer to deduct and pay over any amounts (that may become due and owing on my behalf) to Bonitas from time to time and I also authorise any persons, bodies or institutions who may hold retirement funds for my benefit, to deduct and pay to Bonitas all amounts that may become due and owing to Bonitas from time to time.
7. I agree that should Bonitas incur any legal costs or expenses to recover any contributions owed by me or any other amount due by me to Bonitas for whatever reason, I shall be responsible for such costs and expenses on the attorney/client scale. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any money owing to Bonitas.
8. I understand that it is my responsibility as the principal member to ensure that the monthly contributions are received by Bonitas.
9. Should any contribution be unpaid, it may result in me and my dependants being suspended from Bonitas until all arrear contributions have been settled. Should two months' contributions be outstanding, Bonitas shall have the right to immediately cancel my Bonitas membership. I also understand that should my membership be suspended or terminated, I shall not be entitled to any benefits arising from my membership whatsoever.
10. I shall inform Bonitas of any changes to my or my dependants' health or personal status, as required by the Bonitas Rule, within 30 days of the change in circumstances.
11. I authorise my and my dependants' healthcare provider to disclose information to Bonitas and its contracted third parties, provided such information is treated as confidential at all times.
12. I agree to provide Bonitas with any medical or historical information or grant Bonitas access to medical information reasonably requested pertaining to a particular ailment, disease, disorder, condition or disability.
13. I agree that should I be accepted as a member of Bonitas, I shall provide Bonitas with all information including medical information that Bonitas may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Bonitas rules. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.
14. I declare that my dependants are not beneficiaries of another registered medical scheme.
15. I understand that the following conditions (underwriting), which will impact my and my dependants' right to benefits may be applicable to my membership as prescribed by the Medical Schemes Act No. 131 of 1998:
 - 15.1 a 3 (three) month general waiting period in respect of all benefits;
 - 15.2 a 12 (twelve) month exclusion in respect of a pre-existing condition;
 - 15.3 a late-joiner contribution penalty
16. I authorise and permit Bonitas to take all reasonable steps to verify information provided by me in this application form.
17. I agree to submit proof of identification to Bonitas on demand.
18. I consent to my telephone conversations with Bonitas being recorded and forming part of Bonitas' records. I also agree that such records shall remain the sole property of Bonitas.
19. I warrant that the information provided above is true and accurate and should my application be accepted by Bonitas, the contents of this application form shall constitute the basis of my agreement with Bonitas.
20. As a government employee, I acknowledge that Bonitas will strictly adhere to Persal policies and procedures.
21. As a direct paying member, I acknowledge that monthly contributions are payable in advance in accordance with the Rules of Bonitas .

Section 12. Acknowledgement and declaration

I acknowledge that I have read and understood the content of this application form. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

All information declared on the application form will be kept confidential by the medical scheme.

Signed at _____ on this _____ day of _____ 20 _____

Signature of principal member _____

