Application Form

Attention: Profmed New Business
E-mail: applications@profmed.co.za | Fax: 012 679 4439

1 Eligibility*

**Eligibility criteria apply.*

a) Profession and Occupation

Profession [ ] Are you retired? Yes [ ] No [ ]

If your profession has a registering body or authority with which you are required to register before you may practice, please provide the following information:

Name of the registering body or authority [ ] Are you registered? Yes [ ] No [ ] Your registration number [ ]

Current occupation/employment [ ]

b) Qualifications

Degree/Qualification	Academic Institution	Minimum Duration of Degree/Qualification

(Please attach copy of degree(s)/qualification(s). Attach additional information if space is insufficient.)

c) Are you a member of PPS? Yes [ ] No [ ] PPS member number [ ]

2 Benefit Option

a) Please select one of the following benefit options by ticking the appropriate box:

ProPinnacle [ ] ProSecure Plus [ ] ProSecure [ ] ProActive Plus [ ] ProActive [ ]

b) Financial advice

Note: In terms of the FAIS Act, this section must be completed.
My decision to join Profmed, and my choice of benefit option, is based on (please tick the appropriate box):

[ ] The advice received from Carla Haskins [name], a Profmed consultant.

[ ] The advice received from Carla Haskins (Compendium Insurance Brokers) [name], my independent broker.

[ ] I have not received advice from or been influenced in any way by a Profmed consultant or an independent broker. I have considered my personal requirements and those of my dependants and I acknowledge the risk that my decision could be inappropriate to my circumstances, needs or objectives without having obtained a full healthcare needs analysis.

c) Date membership to commence

D D M M Y Y Y Y

3 Personal Details

a) Principal member *(please attach a copy of ID document)*

Title | First names

Surname | Maiden name | Gender: Male | Female

ID/Passport no. | Date of birth D D M M Y Y Y Y

Street address | Postal address

Post code | Post code

Telephone: Work | Home

Cell | Fax

E-mail address

Gross monthly income from all sources R p.m.

Are you a Government employee? Yes No If yes, please attach a copy of your latest salary advice.

b) Spouse/Partner *(please attach a copy of ID document)*

Title | First names

Surname

Relationship to principal member (e.g. wife, husband, common-law wife, etc.)

ID/Passport no. | Date of birth D D M M Y Y Y Y

Telephone: Work | Home

Cell | Fax

E-mail address

Gross monthly income from all sources R p.m.

c) Dependants

Child dependants:

If your dependant(s) are 21 years and older but younger than 28, please provide proof of study or proof of financial dependance, whichever is applicable, in order for your dependant(s) to qualify as child dependants.

Adult dependants:

Dependants who are 28 years and older are required to submit proof of dependence on the principal member to qualify for membership. Three months' recent bank statements of all the dependants' bank accounts, a tax directive from SARS or their latest tax return is required. In the case of dependants who are mentally or physically disabled, a medical report in this regard is required from an independent doctor.

Dependant 1

Title | First names

Surname

ID/Passport no. | | Date of birth D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Relationship to principal member

Dependant 2

Title | First names

Surname

ID/Passport no. | Date of birth D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Relationship to principal member

Dependant 3

Title | First names

Surname

ID/Passport no. | Date of birth D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Relationship to principal member

Dependant 4

Title | First names

Surname

ID/Passport no. | Date of birth D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Relationship to principal member

Dependant 5

Title | First names

Surname

ID/Passport no. | Date of birth D D M M Y Y Y Y

Gender: Male ☐ Female ☐ Relationship to principal member

(Attach additional information if space is insufficient.)

4 Bank Details

a) Refunds

I authorise Profmed to deposit any credits due to me into my bank account:

Name of account holder

Name of bank | Branch name | Branch code

Account number | Type of account: Cheque | Transmission | Savings

b) Debit order instruction for contributions

Contributions are deducted on the 1st of each month. Debit order instruction is not necessary if the employer pays your TOTAL membership contribution.

I authorise Profmed to debit my bank account in respect of my monthly contributions.

Name of account holder

Name of bank | Branch name | Branch code

Account number | Type of account: Cheque | Transmission | Savings

Signature of account holder | Date: D D M M Y Y Y Y

Please note: If your membership date is confirmed after the monthly contribution debit orders have been generated, a double contribution will be deducted the following month.

5 Details of Previous Medical Scheme(s)

Please provide below the details of all previous medical scheme membership and attach the relevant membership certificates. To avoid a late joiner penalty or a waiting period being imposed, please provide proof of your membership of all previous medical schemes. General and/or condition-specific waiting periods and/or late joiner penalties will be imposed if you do not have proof of sufficient medical cover.

Surname	First Names	Date of Birth	Scheme and Membership Number	Date From	Date To

(Attach additional information if space is insufficient.)

Late joiner penalties will be applied in respect of persons over the age of 35 years who were without medical scheme cover for the periods indicated hereunder:

1 - 4 years	@ 5%	x the relevant contribution	15 - 24 years	@ 50%	x the relevant contribution
5 - 14 years	@ 25%	x the relevant contribution	25+ years	@ 75%	x the relevant contribution.

Note: It is illegal to belong to more than one medical scheme at the same time.

6 Details of your General Practitioner

Do you make use of the services of a general practitioner? Yes ☐ No ☐ If yes, please provide the details of your general practitioner:

Name | Telephone

7 Medical Questionnaire

This section is extremely important. Any misstatement in, or omission from this form may lead to refusal to admit any claims for treatment given, suspension or termination of membership. A 12-month condition-specific waiting period may be applied to any condition declared, subject to the requirements of the Medical Schemes Act No. 131 of 1998. It is essential to declare all conditions/illnesses/symptoms, no matter how insignificant they may seem. If the space provided below is insufficient, please attach additional information to the application form. Disclosure is not limited to the example conditions cited below. Related, consequent and suspected conditions and symptoms must also be disclosed. Should a new medical condition arise or be diagnosed between the time of completing this form and the commencement date of membership, please inform the Scheme immediately.

Did you or any of your dependants ever suffer from any of the following diseases or medical conditions or disorders, or receive treatment, advice and/or medication for any of them?

	Yes	No
1. Any blood disease or condition (e.g. anaemia, haemophilia)?		
2. Any psychological or psychiatric disease or condition (e.g. depression, anxiety, neurosis, tension)?		
3. Any neurological disease or condition (e.g. epilepsy, fainting, paralysis, stroke, Alzheimer's, Parkinson's, multiple sclerosis)?		
4. Any migraines?		
5. Any transmissible disease (e.g. Hepatitis B, Hepatitis C)?		
6. Any disease/affection of the skin (e.g. acne, eczema, psoriasis)?		
7. Any affection of the bone system and/or joints (e.g. osteoporosis, rheumatism, gout, arthritis, back problems, hip problems, knee problems)?		
8. Any affection of the muscular system (e.g. muscular dystrophy)?		
9. Any affection of the heart or blood circulation system (e.g. hypertension, coronary heart disease, chest pains, irregular heartbeat, rheumatic fever, heart failure, valve lesions)?		
10. Any affection of the chest or respiratory system (e.g. asthma, bronchitis, chronic cough, TB or other lung diseases)?		
11. Any affection of the digestive system, liver and gallbladder (e.g. gastric ulcers, hernia, poor digestion, gallstones, spastic colon)?		
12. Any affection of the urinary system and/or sex organs (e.g. bladder infection, nephritis, kidney stones, prostatitis)?		
13. Any affection/disorder of the eyes (e.g. cataracts, glaucoma)?		
14. Any affection of the ears, nose or throat, irrespective of whether it is congenital or developed later (e.g. deafness)?		
15. Any affection/disorder of the teeth or gums?		

	Yes	No
16. Any metabolic condition (e.g. Gaucher's disease, porphyria)?		
17. Diabetes mellitus?		
18. High cholesterol?		
19. Any condition of the thyroid gland?		
20. Any cancer, malignant or pre-malignant tumours?		
21. Any other physical disease/condition, irrespective of whether it is congenital or developed later (e.g. spasticity, cleft palate)?		
22. Do you suffer from chronic sinusitis?		
23. Any affection of the female organs (e.g. womb, ovaries, abnormal Pap smears, breasts, endometriosis)?		
24. Varicose veins?		
25. A disease or condition for which you or any of your dependants have received a gratuity, pension, pay-out and/or guaranteed medical treatment from the Compensation Commissioner, Department of War Pensions or arising from the Motor Vehicle Insurance Act during the past 24 months?		
26. Is any female member/dependant currently pregnant? If so, provide expected date of confinement below.		
27. Do you or any of your dependants suffer from any chronic disease for which you and/or your dependants have to use chronic medication?		
28. Are you aware of any existing condition(s) that may require medical or surgical treatment within the next 12 months?		
29. Are you or any of your dependants currently undergoing any other medical and/or surgical treatment?		
30. Have you or any of your dependants undergone any medical and/or surgical treatment?		
31. Were you or your dependants subjected to any waiting periods, exclusions or penalties by your previous medical scheme?		

If you indicated yes to any of the questions in the medical questionnaire above, please provide full details of the condition below. Attach additional information if this space is insufficient.

Question number	Name of patient	Type of illness	Date diagnosed	Date of last treatment	Treatment received and/or medication used

8 Additional Information

a) Documents

To facilitate the quick and efficient processing of your membership, use the tick boxes below to ensure all the applicable documents accompany this application form:

- Copy of principal member's ID ☐
- Copy of spouse/partner's ID ☐
- Copy of certificate(s) of degree(s)/qualification(s) ☐
- Membership certificate(s) of all previous medical scheme cover ☐
- Proof of study or dependence in respect of child dependants older than 21 years but younger than 28 years ☐
- Proof of study or dependence in respect of dependants 28 years or older ☐
- Additional information in respect of sections 1, 5 and 7 of this application form ☐
- Copy of latest salary advice in respect of Government employees ☐

b) Courier address

Your membership welcome pack will be couriered to you. Please provide an address at which you or a person delegated by you will be available to accept delivery during office hours.

Receiver's name

Receiver's contact number **(very important)**

Company name

Building name

Exact street address (not a P.O. Box address)

Suburb

City/Town

Province

9 Declaration by Applicant

I am applying for benefits from Profmed and warrant and declare that the information given and statements made herein, whether entered on the form by me or on my behalf, are correct and complete in every respect. I confirm that I have read and understand the requiremens and implications of Section 7 and that I have declared all medical conditions. I understand that acceptance of my membership of Profmed is subject to the eligibility criteria.

I declare that in the event of any amount being paid by the Scheme arising out of injuries which may involve a claim against any other party, I undertake to refund the Scheme the whole amount relevant to medical expenses incurred by the Scheme that I recover from any other source.

I hereby authorise any medical practitioner or other person and/or the administrator of Profmed, who may be in possession of or may acquire any information concerning my health or that of my dependants, to disclose the information to Profmed, and agree that compliance with this authorisation shall be a condition precedent to payment of any benefits by the Scheme.

I hereby consent to the disclosure by Profmed from time to time of any information including, without restriction, the generality thereof, personal, commercial, medical or general information provided by me to Profmed from time to time and any information obtained pursuant to this application. Any disclosure shall only be made in fulfillment of the legal obligations of Profmed and its administrator, managed healthcare providers or any organisation acting on behalf of Profmed.

I acknowledge that acceptance of this application shall be conditional upon there having been no deterioration in the state of my health or that of my dependants between the date of completion of the application and the date of membership. I undertake to advise Profmed immediately of any such deterioration.

I grant permission for myself and on behalf of my dependants registered on Profmed, to any medical practitioner, person or party who may be in possession of or obtain information concerning my/my dependants' health status, treatment received or anticipated, as well as any other relevant health information, including my/my dependants' HIV status, to divulge such information to Profmed or its representatives (e.g. third-party administrator, managed care organisation, etc.) on request, also after my death or the death of any of my dependants. I understand that the health information may, and on occasion shall be used to evaluate the payment of benefits for certain diseases/medical conditions. I guarantee that, to the extent that it may be required by law, I have the necessary consent from my dependants to provide this permission.

I agree that this declaration shall be the basis of the contract to recieve benefits from Profmed and that my membership of Profmed is subject to the conditions, exclusions and limitations of benefits in accordance with the Medical Schemes Act and the rules of the Scheme. I also agree that should any information be incorrect, inexact or incomplete, the contract shall be null and void and all money paid to the Scheme shall be forfeited. I agree to abide by the rules of the Scheme, as amended from time to time.

Profmed may deal with me electronically and may treat electronic communication (e-mail, fax, telephone, etc.) as being the same as written authority and confirmation. I agree further that, where I choose to use electronic methods to transact with Profmed, I will carry the risk of such use.

Should Profmed not apply underwriting conditions to my application, I accept membership of Profmed without further notification.

Signature of applicant ______________________ Date D D M M Y Y Y Y

10 Details of Broker

Surname ______________________ Initials ______

Profmed broker number ______________________

FSP number ______ Business/company name ______________________

Signature of Profmed broker ______________________ Date D D M M Y Y Y Y

FSP. No.: 43918

01/2017