

Married?	Disabled?	Full-time student?	
Is your dependant financially dependant on you?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Does your dependant earn an income?		<input type="checkbox"/> Y	<input type="checkbox"/> N
If yes, what is the monthly income?		<input type="text"/>	<input type="text"/>

Married?	Disabled?	Full-time student?	
Is your dependant financially dependant on you?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Does your dependant earn an income?		<input type="checkbox"/> Y	<input type="checkbox"/> N
If yes, what is the monthly income?		<input type="text"/>	<input type="text"/>

Please attach copies for the following: 1) Copy of Birth certificate, 2) Copy of ID.

A dependant who is self-supporting (i.e. earning more than the maximum social pension) will have to enrol as a principal member.

1.3 Details of previous membership (kindly attach a membership certificate of previous medical scheme).

Name of the Scheme	<input type="text"/>
From	<input type="text"/> DDMMYYYY To <input type="text"/> DDMMYYYY

Name of the Scheme	<input type="text"/>
From	<input type="text"/> DDMMYYYY To <input type="text"/> DDMMYYYY

Has your dependant above ever been declined, loaded or exclusions applied by a medical scheme?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
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If "YES" please provide details _____

C. DETAILS OF CURRENT MEDICAL PRACTITIONER

1 Name of Principal Member's Doctor	<input type="text"/>
Telephone	<input type="text"/>
Date of first Consult	<input type="text"/> DDMMYYYY

2 Name of Dependant/s' Doctor	<input type="text"/>
Telephone	<input type="text"/>
Date of first Consult	<input type="text"/> DDMMYYYY

NOTE: Please ensure that above details are correct and completed in full as this may delay acceptance of application as well as authorisation request.

DETAILS FOR NOMINATION OF MEDICAL PRACTITIONER – FOUNDATION PLAN ONLY

Dependant Type	1 Principal member
Name of practice or name and surname of doctor:	<input type="text"/>
Tel Number:	<input type="text"/>
Practice Number:	<input type="text"/>
Region:	<input type="text"/>
Suburb:	<input type="text"/>

Dependant Type	2 Spouse / Partner / Dependant 1
Name of practice or name and surname of doctor:	<input type="text"/>
Tel Number:	<input type="text"/>
Practice Number:	<input type="text"/>
Region:	<input type="text"/>
Suburb:	<input type="text"/>

Dependant Type	3 Dependant 2
Name of practice or name and surname of doctor:	<input type="text"/>
Tel Number:	<input type="text"/>
Practice Number:	<input type="text"/>
Region:	<input type="text"/>
Suburb:	<input type="text"/>

Dependant Type	4 Dependant 3
Name of practice or name and surname of doctor:	<input type="text"/>
Tel Number:	<input type="text"/>
Practice Number:	<input type="text"/>
Region:	<input type="text"/>
Suburb:	<input type="text"/>

D. SPECIFIC HEALTH QUESTIONS

State whether any of your dependants have ever been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including but not limited to:

1. Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia, clotting disorders.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Cancer, growths, abscess or tumours of any kind, whether benign or malignant.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Cardiovascular (heart and blood vessels) disorders e.g. congenital heart conditions, chest pain, coronary artery disease / ischaemic heart disease, high blood pressure, valvular disease, arrhythmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever, shortness of breath, palpitations, angina, deep vein thrombosis, pulmonary embolism, atherosclerosis lymphatics.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Ear, nose and throat disorders e.g. hearing/speech impairment, ear infections, sinus problems, nasal/throat surgery, ear discharge, hoarseness, mouth disorders, tonsils, adenoids, grommets, previous nasal injuries, upper airway infections, cleft lip/palate, epistaxis, hayfever / rhinitis, blocked nose.	<input type="checkbox"/> YES	<input type="checkbox"/> NO

5. Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities, sugar in urine, nutritional disorders, metabolic syndrome, hypo/hyperglycaemic coma.	<input type="checkbox"/>	<input type="checkbox"/>
6. Eye related disorders e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts, lens implants, infections, refractive and laser surgery, short or far sightedness, pterygium.	<input type="checkbox"/>	<input type="checkbox"/>
7. Gastro-intestinal disorders e.g. recurrent indigestion, heartburn, reflux, ulcers, bowel disorders, gallbladder disorders, liver disorders and pancreas disorders, hiatus hernia, piles, anal fissures, rectal bleeding, ulcerative colitis or have you or any of your dependants ever had a gastroscopy or colonoscopy, spleen disorders, Crohn's disease.	<input type="checkbox"/>	<input type="checkbox"/>
8. a. Gynaecological and obstetrical disorders e.g. ectopic pregnancy, caesarian section, fibroids, endometriosis, menstrual irregularities, abnormal papsmear, receiving hormone treatment, vaginal bleeding, laparoscopic surgery, dilatation and curretage, miscarriages, pregnancy related problems, cysts, infertility, breast disorders.	<input type="checkbox"/>	<input type="checkbox"/>
8. b. Pregnancy - expected date of delivery.	<input type="text" value="D D M M Y Y Y Y"/>	<input type="checkbox"/>
9. Male genito-urinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system.	<input type="checkbox"/>	<input type="checkbox"/>
10. Musculo-skeletal disorders e.g. osteo-arthritis, rheumatoid arthritis, back problems, gout, osteoporosis, all joint problems e.g. knee, shoulder, bones, limbs, spine, fractures, carpal tunnel syndrome, bunion, spondylosis, hernia, kyphosis.	<input type="checkbox"/>	<input type="checkbox"/>
11. Neurological disorders e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue, headache, migraine, polio, paralysis, Guillian-Barre, meningitis, Parkinson's Disease, Alzheimer Disease, dementia.	<input type="checkbox"/>	<input type="checkbox"/>
12. Psychological disorders e.g. insomnia, anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit disorder, post traumatic stress, schizophrenia, bi-polar disorders, mood swings, attempted suicide, anorexia/bulimia nervosa.	<input type="checkbox"/>	<input type="checkbox"/>
13. Renal (kidney) disorders e.g. blood in the urine, urinary tract stones, recurrent infections, kidney failure, bladder problems, dialysis, Addisons Disease, nephritis.	<input type="checkbox"/>	<input type="checkbox"/>
14. Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema or cigarette smoking related disorders, tuberculosis, persistant cough, allergies, chronic obstructive pulmonary disease, pneumoconiosis.	<input type="checkbox"/>	<input type="checkbox"/>
15. Skin disorders e.g. eczema, psoriasis, melanoma, skin cancer, burns, acne, scars, keloids, growths, warts, ingrown toe nails.	<input type="checkbox"/>	<input type="checkbox"/>
16. State whether you or any of your dependants have received medical advice or treatment for any infectious and tropical disease e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitis, bilharzia, malaria, cholera.	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you or any of your dependants have any birth defects or hereditary disorders?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you or any of your dependants ever sought counselling or treatment for HIV or AIDS related infections or ever tested positive for HIV or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you or any of your dependants ever been diagnosed and/or treated for an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>
20. Previous injuries and trauma including sports injuries?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you or any of your dependants ever been told to improve your adherence to medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever required rehabilitation following an event i.e. stroke or motor vehicle accident?	<input type="checkbox"/>	<input type="checkbox"/>

If "yes" answered to any of the questions above, please supply full details below.

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current Condition

If the space provided is insufficient please complete addendum.

Addendum attached YES NO

SURGERY AND HOSPITAL ADMISSIONS

1. Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that, the new dependant(s) have undergone in the past, and/or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS they expect to undergo in the future.

Applicant	Surgical Procedure/Hospital Admission	Date	Reason	Doctor	Current Condition

CHRONIC MEDICATION

1. Please supply details of any chronic medication (prescribed medicines used continuously for more than 3 (three) months) currently prescribed for any of your new dependants.

2. Do you or the dependants expect chronic medication to be prescribed in the next 12 months?

YES	NO
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If so please supply details below.

Applicant	Prescribed Medication	Medical Condition	Date Started/To be Started

E. GENERAL HEALTH QUESTIONS

1. Do you or any of your dependants expect to receive any treatment in the next 12 months and do you or your dependants expect to be, or are currently hospitalised?	YES	NO
2. Has any close blood relative (excluding dependants named in this application form) ever been diagnosed with heart disease, high blood pressure, high cholesterol, diabetes or any other hereditary disease?	YES	NO
3. Do you or any of your dependants have incomplete dental treatment plans, dental implants, orthodontic treatment, dentures, wisdom teeth problems or do you or any of your dependants currently receive, or expect to receive dental treatment in the next 12 months?	YES	NO
4. Are you or any of your dependants currently involved in any third party claim or WCA claim that may include medical treatment? If so please provide below, FULL details of injuries, surgery, investigative procedures for which claims will be or have been lodged.	YES	NO
5. Do you or any of your dependants smoke, or did you or any of your dependants receive medical advice to reduce the quantity of tobacco used? If so, specify whether cigarettes, cigars or a pipe and how many are or were smoked per day.	YES	NO
6. Do you or any of your dependants consume alcohol? If so, specify what type of alcohol and quantity consumed per week.	YES	NO
7. Have you or any of your dependants ever received medical advice, counselling or treatment to reduce alcohol consumption for alcohol abuse or alcoholism?	YES	NO
8. Do you or any of your dependants use stimulants, any illegal drug substances, or ever been treated for illegal drug substance abuse or addiction?	YES	NO
9. Investigations and/or specialised treatment. In and out of hospital.		
a. Are you or any of your dependants currently undergoing, or expect to undergo investigations for any medical condition and/or symptoms not yet diagnosed?	YES	NO
b. Are you or any of your dependants currently receiving or expect to receive specialised treatment (i.e. chemotherapy, radiotherapy, bone marrow transplant, mechanical ventilation, oxygen therapy, dialysis, psychotherapy or counselling)?	YES	NO
10. In the past 2 years, have you or any of your dependants had any x-rays, electrocardiogram or other examinations including genetic testing, or tumour markers, operations or been hospitalised?	YES	NO

If “yes” answered to any of the questions above, please supply full details below.

Question	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and consulting doctor's details)

If the space provided is insufficient, please provide additional information to this application. - see page 6

HEIGHT AND WEIGHT

Spouse / Partner / Dep.1	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg
Dependant 2	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg
Dependant 3	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg
Dependant 4	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg

F. APPLICABLE RULES OF RESOLUTION HEALTH MEDICAL SCHEME WITH REGARDS TO “DEPENDANTS”

- 4.13 **“Child”**: a member’s natural child, or a stepchild or legally adopted child or a child in the process of being placed in foster care or being adopted, or a child for whom the member has a duty of support, or a child who has been placed in the custody of the member or his spouse or partner, and who is not a member or a registered dependant of a member of this or any other registered Scheme.
- 4.26 **“Dependant”**: a member’s spouse or partner who is not a member or a registered dependant of a member of a medical Scheme;
 - 4.26.1 A member’s child who is not a member or a registered dependant of a member of a medical Scheme;
 - 4.26.2 The immediate family of a member in respect of whom the member is liable for family care and support and is not a member or a registered dependant of a member of another scheme. Provided that the dependant shall be regarded as an adult dependant unless under the age of 25 years;
 - 4.26.3 Such other persons who are recognised by the Board as dependants for purposes of these Rules.
- 4.27 **“Dependent on”**: in relation to a child, a child under the age of **25 (twenty five)** who is studying at a registered institution and is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child who, due to a mental or physical disability, is dependent upon the member, and if he is older than **25 (twenty five)** and still dependent. Proof of registration and/or dependence must be submitted to the Scheme on an annual basis.
- 4.36 **“Late joiner”**: an applicant or the adult dependant of an applicant who, at the date of application for membership, or admission as a dependant, as the case may be is 35 years of age or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from the date proceeding 1 April 2001, without a break in coverage exceeding 3 consecutive months since 1 April 2001.
- 4.57 **“Social pension”**: the appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act, 1992 (Act No. 59 of 1992).
- 4.58 **“Spouse”**: the person to whom the member is married in terms of any law or custom.

7.1 Registration of dependants:

- 7.1.1 A member may apply for the registration of his dependants at the time that he applies for membership in terms of Rule 8;
- 7.1.2 If a member applies to register a new born or newly adopted child within 30 days of the date of birth or adoption of the child, such child shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption. Documentary proof of birth, or of the adoption of the child, must accompany the application for registration. If the application for registration is not received by the Scheme within the 30-day period, the child will be registered from the date that the application is received by the Scheme;
- 7.1.3 If a member, who marries subsequent to joining the Scheme, applies within 30 days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of marriage and benefits will accrue as from the date of marriage. The spouse shall not qualify for benefits until such time as the member qualifies for benefits. If the application for registration is not received by the Scheme within the 30-day period, the child will be registered from the date that the application is received by the Scheme;
- 7.1.4 In the event of any person becoming eligible for registration as a dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the member may apply to the Scheme for the registration of such person as a dependant, whereupon the provisions of Rule 8 shall apply **mutatis mutandis**; *Provided that*: No person in Rule 4.22(2), (3) and (4) may be registered as a dependant of a member if such person is self supporting.
- 7.1.5 In relation to a child, a child under the age of 25 (twenty five) who is studying on a full time basis at a registered institution is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child who, due to a mental or physical disability, is dependent upon the member, and if he is older than 25 (twenty five) and still dependent may be registered as a dependant. Proof must be submitted to the Scheme on an annual basis.

8. Terms and Conditions applicable to membership:

- 8.2 No person may:
 - 8.2.1 Be a member of more than one registered medical scheme;
 - 8.2.2 Be admitted as a dependant of more than one member of a particular registered medical scheme or a member of a different medical scheme;
 - 8.2.3 Claim or accept benefits in respect of himself or any of his registered dependants from any medical scheme other than the Scheme of which he is a member or a registered dependant of a member.
- 8.4 Waiting periods
 - 8.4.1 *The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application:*
 - 8.4.1.1 A general waiting period of up to three months; and
 - 8.4.1.2 A condition-specific waiting period of up to 12 months.
 - 8.4.2 *The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application.*
 - 8.4.2.1 A condition specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits;
 - 8.4.2.2 In respect of any person contemplated in this sub rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.
 - 8.4.3 *The scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application, a general waiting period of up to three months. Except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.*
- 8.6 The registered dependants of a member must participate in the same benefit option as the member.

I/we the undersigned, confirm that I/we have read the Applicable Rules of Resolution Health Medical Scheme with regards to “dependants” and understand the implications.

Signed at _____ Date

D	D	M	M	Y	Y	Y	Y
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SIGNATURE

Signature of Principal Member

WHAT TO EXPECT WITH YOUR APPLICATION:
 Upon receipt of the application:
 - We capture and check your details.
 - If any details are missing, you will be contacted in writing or telephonically.
 - We will advise you or your intermediary in writing, SMS or an E-mail to inform you of your acceptance to join Resolution Health Medical Scheme. This correspondence may contain certain conditions:
 • You sign these terms of acceptance to confirm that you accept any waiting period/s or late joiner penalties (if we apply any) and return it to us.
 • When we activate your membership, you will receive an SMS from us.
 • You will then receive a membership pack in the post. This will contain details about your plan selection to get you started.
 If you do not hear from us 7 (seven) days after submission, please contact your financial advisor or call us on **0861 796 6400**.

OFFICE USE ONLY

CATEGORY	A	B	C
COPY <input type="checkbox"/>	ORIGINAL <input type="checkbox"/>		
NO WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 MONTHS WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TWELVE MONTHS WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PMB PAYMENT	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
LATE JOINER PENALTY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEMBERSHIP PACK TO UNDERWRITING			
<div style="border: 1px solid black; width: 150px; height: 20px; margin: 0 auto;"></div> Signature			

Resolution Health Medical Scheme

FOR OFFICE USE ONLY

Members Number

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Group Reference Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Commencement

D	D	M	M	Y	Y	Y	Y
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ADDENDUM FOR SECTION D (SPECIFIC HEALTH QUESTIONS) OF APPLICANT FOR REGISTRATION OF ADDITIONAL DEPENDANTS

(Note: Please complete all sections in **BLACK** ink)

Tel: 0861 796 6400

ID Number																		Membership Number																
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Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current Condition

SURGERY AND HOSPITAL ADMISSIONS

Applicant	Surgical Procedure/Hospital Admission	Date	Reason	Doctor	Current Condition

CHRONIC MEDICATION

Applicant	Prescribed Medication	Medical Condition	Date Started/To be Started