UMVUZO HEALTH

ID / PASSPORT	
Broker Code:	

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

MEMBER APPLICATION FORM

A. DETAILS OF MAIN MEMBER

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

Company name		Employee no	
Paypoint		Operations/Shaft	
Date of permanent employment	YYYY MM DD	Medical aid start date	YYYY MM DD

Option: (mark with an "X")	Activator		Ultra Affordable		Ultra Affordable Value	
	Standard		Supreme		Extreme	

*If **Ultra Affordable / Ultra Affordable Value** is selected **AND** income is below threshold, kindly attach payslip to this application form*

Main member name	Surname	ID / PASSPORT	
Date of birth YYYY MM DD	Gender	Race	Email	
Postal / Physical address		Cell 1	
	Code	Cell 2	

B. DETAILS OF BENEFICIARIES

Spouse/Life Partner

Name	Surname	ID / PASSPORT	Relationship				
Email		Date of birth YYYY MM DD	Cell		Gender	Race	
Name	Surname	ID / PASSPORT	Relationship				
Email		Date of birth YYYY MM DD	Cell		Gender	Race	

Adult dependants (>25)

Name	Surname	ID / PASSPORT	Relationship				
Email		Date of birth YYYY MM DD	Cell		Gender	Race	
Name	Surname	ID / PASSPORT	Relationship				
Email		Date of birth YYYY MM DD	Cell		Gender	Race	

Child dependants (≤25)

Name	Surname	ID / PASSPORT					
Date of birth YYYY MM DD	Race	Gender	Relationship				
Name	Surname	ID / PASSPORT					
Date of birth YYYY MM DD	Race	Gender	Relationship				

C. BANK DETAILS (FOR REFUND PURPOSES ONLY)

Bank name		Account number					
Branch name		Branch code		Account type (mark with an "X")	Cheque		Savings	

D. PROTECTION OF PERSONAL INFORMATION

1. The privacy and security of your personal information (which includes the personal information of your dependants) are important to Umvuzo Health Medical Scheme. The Scheme will only process personal information, which includes collecting, using, storing, sharing, analysing, automated and manual processing of such information, in accordance with its Privacy Policy, available at https://www.umvuzohealth.co.za and if the processing is permitted by law, for a legitimate interest or otherwise with your consent, if necessary.
2. Umvuzo Health Medical Scheme may require additional personal information about you and your dependants to assess your eligibility for Scheme membership, apply underwriting as permitted by the Medical Schemes Act 131, 1998 and the Umvuzo Health Medical Scheme registered rules to perform the contract between the principal member and the Scheme.
3. All conversations between you or any of your dependants and Umvuzo Health Medical Scheme, its agents or contracted parties, will be recorded and all information obtained through these conversations will form part of the records of Umvuzo Health Medical Scheme.
4. By signing this form, you authorise Umvuzo and/or its agents to obtain any information that they may require concerning you or any of your dependants (such as health information) for any purpose directly related to the medical scheme membership or which is authorised in terms of the Medical Schemes Act, the Scheme Rules or any other legislation, from any person who holds such information (such as healthcare practitioners).
5. By signing this form, you guarantee that to the extent that it may be required by law, you have the necessary authority or permission from your dependants to provide the consent, permissions and personal information on their behalf as set out in this document and as may be required from time to time by Umvuzo Health Medical Scheme.

E. MEMBER'S UNDERTAKING

I _____ (full name and surname) hereby declare that:

The contents of this document have been explained to me in a language that I understand and that all my questions have been answered satisfactorily.

All information supplied on this application form is, to the best of my knowledge and belief, true, correct and complete, and that I will advise the Scheme as soon as any of the information changes.

I have read the Privacy Policy of Umvuzo Health Medical Scheme and that I fully understand my/our rights in respect of my/our personal information processed by the Scheme, how the Scheme will process my/our information and with whom it will be shared.

I provide the consent below out of my own free will without any undue influence from any person whatsoever.

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 as specifically detailed by the scheme.

I understand the medicine benefit of my selected Option and the fact that benefits can be driven by medicine formularlaries/lists, protocols and Scheme rules and that any medicine 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 grant permission to any health care provider, person or party who may be in possession of 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 my premium must be payed 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 Medical Scheme 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 Medical Scheme.

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

_____

Signature of applicant (main member)

Date | Y | Y | Y | Y | M | M | D | D |

_____

Name & signature of witness/broker (if applicable)

Date | Y | Y | Y | Y | M | M | D | D |

_____

Signature of employer

_____

Employer stamp as verification

APPLICATION REQUIREMENT: To ensure your application is processed, please complete and sign the Medical Conditions Disclosure form on page 3 and 4. All fields marked with * is mandatory.

UMVUZO HEALTH

I	D		/		P	A	S	S	P	O	R	T	*

Call Centre: 0861 083 084

rx health

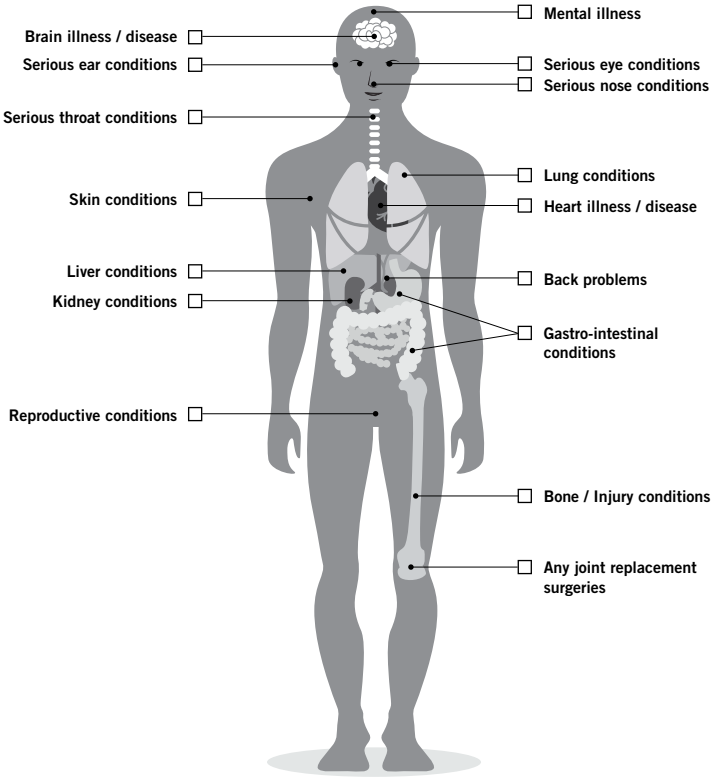
MEDICAL CONDITIONS DISCLOSURE FORM

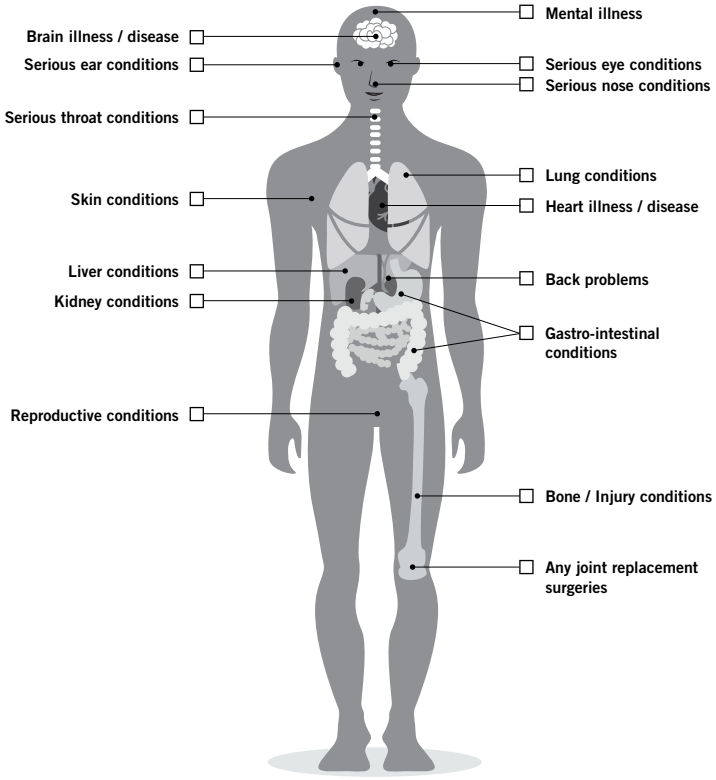
APPLICATION REQUIREMENT: To ensure your application's speedy processing, please fill out all fields marked with an asterisk *.

Company name *		Paypoint/Branch	
Name *	Surname *	I D / P A S S P O R T	
Contact number *	Email *		

Have you or your dependants suffered from any of the following conditions and/or injuries? (mark with an "X")

MAIN MEMBER		Spouse		Adult dependant (>25)	





Male		Are you currently pregnant?	Yes	No	Weeks	
Female						

Name	Surname
Contact	Male
Email	Female

Are you currently pregnant?	Yes	No	Weeks	

PAST MEDICAL HISTORY (mark with an "X")

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

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

Vehicle accident		Road accident fund		Injury on duty	

If you marked **Yes (Y)** on any of the above please indicate the date of the incident	Y	Y	Y	Y	M	M	D	D

PAST MEDICAL HISTORY (mark with an "X")

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

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

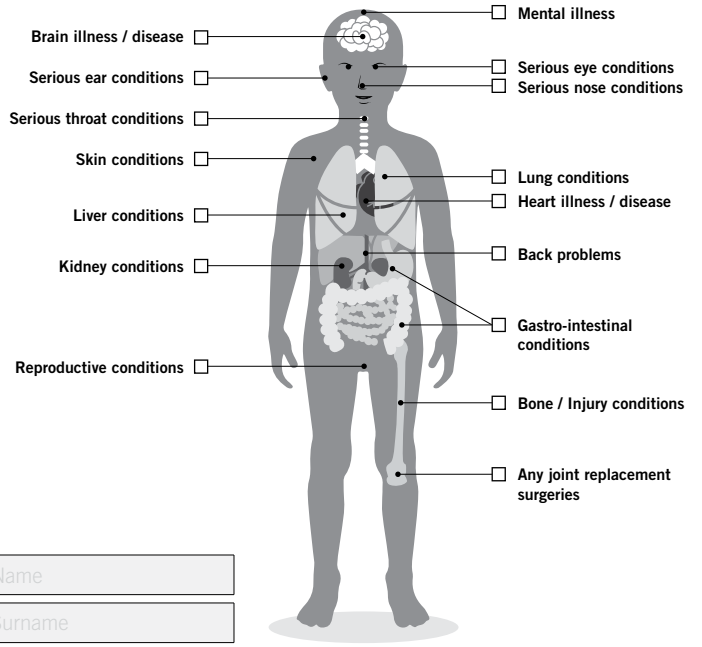
Vehicle accident		Road accident fund		Injury on duty	

If you marked **Yes (Y)** on any of the above please indicate the date of the incident	Y	Y	Y	Y	M	M	D	D

Initial		*

I	D		/		P	A	S	S	P	O	R	T	*

Adult dependant >25 ☐	Child dependant ≤25 ☐	Gender



Name

Surname

Contact number | Email

Are you currently pregnant? | Yes | No | Weeks

PAST MEDICAL HISTORY (mark with an "X")

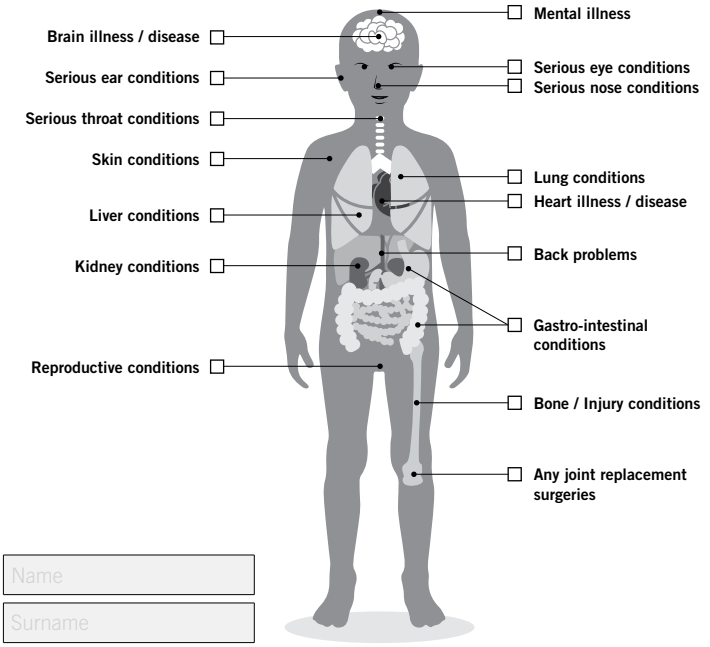
Previous operation		Previously hospitalised	
Diabetes		Asthma	
Cancer treatment / diagnosis		Epilepsy	
High blood pressure		Cholesterol	
HIV		Chronic medication	

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

Vehicle accident		Road accident fund		Injury on duty	

If you marked **Yes (Y)** on any of the above please indicate the date of the incident | Y | Y | Y | Y | M | M | D | D |

Adult dependant >25 ☐	Child dependant ≤25 ☐	Gender



Name

Surname

Contact number | Email

Are you currently pregnant? | Yes | No | Weeks

PAST MEDICAL HISTORY (mark with an "X")

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? (Mark with Y/N)

Vehicle accident		Road accident fund		Injury on duty	

If you marked **Yes (Y)** on any of the above please indicate the date of the incident | Y | Y | Y | Y | M | M | D | D |

THE IMPORTANCE OF DISCLOSING YOUR HEALTH STATUS

In terms of the **registered Scheme Rules** you have a duty to **disclose** any **material information on request**. This includes the **duty** to fill out the above **health history** form **openly and honestly.**

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.**

In terms of Section 29 of the **Medical Schemes Act**, failure to **disclose material information** gives Umvuzo Health Medical Scheme will take such steps as may be the right to **cancel or suspend** a member's membership or that of any of **his/her dependants**.

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

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

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 more effectively.

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. Umvuzo Health Medical Sheme will take such stepsas may be required to ensure that it complies with any law in respect of transfer, storage, security and use of the personal information.

I confirm that the above information is a true and correct record. I agree to notify the Scheme and its contracted providers should there be any change in my health or medical requirements.

Member signature *

Date * | Y | Y | Y | Y | M | M | D | D |

Email to: disclosure@umvuzohealth.co.za