

MEMBER APPLICATION FORM

UNDERWRITING FREE

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/Shift																	
Date of permanent employment	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td> </tr> </table>	Y	Y	Y	Y	M	M	D	D	Medical aid start date	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td> </tr> </table>	Y	Y	Y	Y	M	M	D	D
Y	Y	Y	Y	M	M	D	D												
Y	Y	Y	Y	M	M	D	D												

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

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

***If **Activator** is selected, the HealthyMe programme form is required to be completed and submitted along with this application.*

Main member name	Surname	<table border="1"> <tr> <td>I</td><td>D</td><td></td><td>/</td><td></td><td>P</td><td>A</td><td>S</td><td>S</td><td>P</td><td>O</td><td>R</td><td>T</td> </tr> </table>	I	D		/		P	A	S	S	P	O	R	T
I	D		/		P	A	S	S	P	O	R	T			
Date of birth	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td> </tr> </table>	Y	Y	Y	Y	M	M	D	D	Gender	Race	Email			
Y	Y	Y	Y	M	M	D	D								
Postal/Physical address				Cell 1											
	Code		Cell 2												

Have you had an incident or claim related to? (Mark with Y/N) Please include the year of incident where applicable.

Vehicle accident	☐	Road accident fund	☐	Injury on duty	☐	Previous operation	☐	If you marked Yes (Y) , please indicate the year of the incident	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	Y	Y	Y	Y
Y	Y	Y	Y										

B. DETAILS OF DEPENDANTS

Please Note: Certificate of membership is required to avoid waiting periods and/or underwriting for dependants, where applicable.

Spouse/Life Partner

Name	Surname	<table border="1"> <tr> <td>I</td><td>D</td><td></td><td>/</td><td></td><td>P</td><td>A</td><td>S</td><td>S</td><td>P</td><td>O</td><td>R</td><td>T</td> </tr> </table>	I	D		/		P	A	S	S	P	O	R	T	Relationship
I	D		/		P	A	S	S	P	O	R	T				
Email		Date of birth	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td> </tr> </table>	Y	Y	Y	Y	M	M	D	D	Cell		Gender	Race	
Y	Y	Y	Y	M	M	D	D									

Has this dependant had an incident or claim related to? (Mark with Y/N) Please include the year of incident where applicable.

Vehicle accident	☐	Road accident fund	☐	Injury on duty	☐	Previous operation	☐	If you marked Yes (Y) , please indicate the year of the incident	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	Y	Y	Y	Y
Y	Y	Y	Y										

Adult dependants (Older than 25 years of age)

#1 Adult dependant name	Surname	<table border="1"> <tr> <td>I</td><td>D</td><td></td><td>/</td><td></td><td>P</td><td>A</td><td>S</td><td>S</td><td>P</td><td>O</td><td>R</td><td>T</td> </tr> </table>	I	D		/		P	A	S	S	P	O	R	T
I	D		/		P	A	S	S	P	O	R	T			
Email		Date of birth	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td> </tr> </table>	Y	Y	Y	Y	M	M	D	D	Cell		Relationship	
Y	Y	Y	Y	M	M	D	D								

Has this dependant had an incident or claim related to? (Mark with Y/N) Please include the year of incident where applicable.

Vehicle accident	☐	Road accident fund	☐	Injury on duty	☐	Previous operation	☐	If you marked Yes (Y) , please indicate the year of the incident	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	Y	Y	Y	Y
Y	Y	Y	Y										

#2 Adult dependant name	Surname	<table border="1"> <tr> <td>I</td><td>D</td><td></td><td>/</td><td></td><td>P</td><td>A</td><td>S</td><td>S</td><td>P</td><td>O</td><td>R</td><td>T</td> </tr> </table>	I	D		/		P	A	S	S	P	O	R	T
I	D		/		P	A	S	S	P	O	R	T			
Email		Date of birth	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td> </tr> </table>	Y	Y	Y	Y	M	M	D	D	Cell		Relationship	
Y	Y	Y	Y	M	M	D	D								

Has this dependant had an incident or claim related to? (Mark with Y/N) Please include the year of incident where applicable.

Vehicle accident	☐	Road accident fund	☐	Injury on duty	☐	Previous operation	☐	If you marked Yes (Y) , please indicate the year of the incident	<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	Y	Y	Y	Y
Y	Y	Y	Y										

B. DETAILS OF DEPENDANTS CONTINUED

Child dependants (25 years of age or younger)

#1 Child dependant name	Surname	I	D		/		P	A	S	S	P	O	R	T
Date of birth	Y	Y	Y	Y	M	M	D	D	Race	Gender	Relationship			

Has this dependant had an incident or claim related to? (Mark with Y/N) Please include the year of incident where applicable.

Vehicle accident		Road accident fund		Previous operation		If you marked Yes (Y) , please indicate the year of the incident	Y	Y	Y	Y
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#2 Child dependant name	Surname	I	D		/		P	A	S	S	P	O	R	T
Date of birth	Y	Y	Y	Y	M	M	D	D	Race	Gender	Relationship			

Has this dependant had an incident or claim related to? (Mark with Y/N) Please include the year of incident where applicable.

Vehicle accident		Road accident fund		Previous operation		If you marked Yes (Y) , please indicate the year of the incident	Y	Y	Y	Y
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#3 Child dependant name	Surname	I	D		/		P	A	S	S	P	O	R	T
Date of birth	Y	Y	Y	Y	M	M	D	D	Race	Gender	Relationship			

Has this dependant had an incident or claim related to? (Mark with Y/N) Please include the year of incident where applicable.

Vehicle accident		Road accident fund		Previous operation		If you marked Yes (Y) , please indicate the year of the incident	Y	Y	Y	Y
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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

- 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.
- 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.

E. MEMBER'S UNDERTAKING

I _____

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 formularies/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.

Signature of applicant (main member)

Date	Y	Y	Y	Y	M	M	D	D
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Signature of authorised employer representative

(full name and surname) hereby declare that:

I grant permission to any healthcare 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 paid 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.

Name & signature of witness/broker (if applicable)

Date	Y	Y	Y	Y	M	M	D	D
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Employer stamp as verification

IMPORTANT INFORMATION ABOUT THIS SHORTENED APPLICATION FORM

This shortened application form may be used for employees and their direct dependants where no underwriting applies, including:

- during the annual open period for membership effective 1 January;
- for employees of new employer groups joining during an agreed underwriting-free open period; and
- when a new employee joins the Scheme within three months of starting permanent employment.

Where these conditions do not apply, the full application form, including the required health disclosures, must be completed, and underwriting may apply.