RESOLUTION health Medical Scheme

FOR OFFICE USE ONLY

Members Number

Group Reference Number

Date of Commencement D D M M Y Y Y Y

MEMBER APPLICATION FORM

Notes: The Registration of additional dependants form, must be completed for each additional adult dependant i.e. other than your spouse/partner.
Faxed copies will not be accepted.

This application form must be received at the Scheme within one month following the date on which it was signed. Failure to do so will result in this application being null and void. Incomplete application forms will be returned.

Tel: 0861 796 6400

A. DETAILS OF APPLICANT (Note: Please complete all sections in **BLACK** ink) (Please attach copy of SA ID document / Passport)

Surname		Title	
First Name(s) *(in full)*		Initials	
ID Number		Date of Birth	D D M M Y Y Y Y
		Gender	M F
Passport Number		Income Tax Number	
Employer Name			
Employee Number		Branch	
Occupation Full Details			
Date of Employment	D D M M Y Y Y Y	Language	

B. FAMILY MEMBERS TO BE INCLUDED (Note: Please attach copies of SA ID document / Passport:)

1) Dependant children or other members of immediate family in respect of whom the member is liable for care and support
2) Adult dependant - 21 years and older to complete “registration of additional dependant” application form

	1	2
Dependant Type	Spouse ☐ Child ☐	Child ☐
Surname		
First Name(s) *(in full)*		
Initials	Title Gender M F	Title Gender M F
ID Number		
Passport Number		
Date of Birth	D D M M Y Y Y Y Age	D D M M Y Y Y Y Age
Relationship to Applicant		

	3	4
Dependant Type	Spouse ☐ Child ☐	Child ☐
Surname		
First Name(s) *(in full)*		
Initials	Title Gender M F	Title Gender M F
ID Number		
Passport Number		
Date of Birth	D D M M Y Y Y Y Age	D D M M Y Y Y Y Age
Relationship to Applicant		

If documents are not attached:

I the principle member, hereby declare that all reasonable efforts have been made to obtain documentary evidence of my dependant/s ID numbers, but have been unsuccessful. Proof will be submitted upon availability.

SIGNATURE

Signature of Applicant

C. CONTACT DETAILS

Residential Address

Code

Postal Address

Code

Telephone (W)

Cell

Cell

Telephone (H)

Fax

Email Address

SMS Correspondence YES NO

Email Correspondence YES NO

D. DETAILS OF PREVIOUS MEMBERSHIP - APPLICANT

(Should membership certificates not be attached at time of submission, waiting periods will be imposed)

Name of Scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Name of Scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Proof Attached YES NO

Have you or any of your dependants ever been declined, or had late joiner penalties or exclusions/waiting periods imposed by a medical scheme? (If "yes" please provide details) YES NO

DETAILS OF PREVIOUS MEMBERSHIP - SPOUSE/PARTNER

(Should membership certificates not be attached at time of submission, waiting periods will be imposed)

Name of Scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Name of Scheme

from D D M M Y Y Y Y to D D M M Y Y Y Y

Proof Attached YES NO

Have you or any of your dependants ever been declined, or had late joiner penalties or exclusions/waiting periods imposed by a medical scheme? (If "yes" please provide details) YES NO

E. PLAN AND PRODUCT SELECTION (Please indicate with an "X" where applicable)

Only complete this section if plan selection was not made at employer group level on the Employer Application form or if your employer has allowed you to overide the group level selection.

- [ ] HOSPITAL PLAN
- [ ] PROGRESSIVE PLAN
- [x] Medical Current Account (Complusory)
- [ ] PRESTIGE PLAN

- [ ] FUNDAMENTAL PLAN

Income Category [ ] R0 - R5000 [ ] R5001 - R8000 [ ] R8000 +

I need to submit proof of income. I have attached the following (please tick appropriate box): [ ] Bank statement in accordance with FICA

[ ] Latest salary advise [ ] Auitor / Accounts letter [ ] Commission / fees statement [ ] An official signed affidavit

Requested date of commencement D D M M Y Y Y Y NOTE: SUBJECT TO UNDERWRITING

Signed at ______________________ on this ____________ day of ______________ / ____________

SIGNATURE

Signature of Applicant

F. DETAILS OF MEDICAL PRACTITIONERS

Include last 3 practitioner details:

1 Name of Doctor

Telephone Date of first Consult D D M M Y Y Y Y

2 Name of Doctor

Telephone Date of first Consult D D M M Y Y Y Y

3 Name of Doctor

Telephone Date of first Consult D D M M Y Y Y Y

NOTE: Please ensure that above details are correctly and fully completed as this may delay acceptance of application form as well as authorisation request.

G. SPECIFIC HEALTH QUESTIONS

State whether you or any of your dependants have ever suffered from, 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.	YES	NO
2. Cancer, growths, abscess or tumours of any kind, whether benign or malignant.	YES	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, arrythmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever, shortness of breath, palpitations, angina, deep vein thrombosis.	YES	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.	YES	NO
5. Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities, sugar in urine, nutritional disorders, metabolic syndrome, hypo/hyperglycaemic coma.	YES	NO
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.	YES	NO
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.	YES	NO
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.	YES	NO
8. b. Pregnancy - expected date of delivery. D D M M Y Y Y Y	YES	NO
9. Male genito-urinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system.	YES	NO
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, carpel tunnel syndrome, bunion, spondylosis.	YES	NO
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.	YES	NO
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.	YES	NO
13. Renal (kidney) disorders e.g. blood in the urine, kidney stones, recurrent infections, kidney failure, bladder problems, dialysis, Addisons Disease.	YES	NO
14. Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema or cigarette smoking related disorders, tuberculosis, persistant cough, allergies, chronic obstructive pulmonary disease.	YES	NO
15. Skin disorders e.g. eczema, psoriasis, melanoma, skin cancer, burns, acne, scars, keloids, growths, warts.	YES	NO
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, hepatitus, bilharzia, malaria, cholera.	YES	NO
17. Do you or any of your dependants have any birth defects or hereditary disorders?	YES	NO
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?	YES	NO
19. Have you or any of your dependants ever been diagnosed and/or treated for an immune system problem?	YES	NO
20. Previous injuries and trauma including sports injuries?	YES	NO
21. Have you or any of your dependants ever been told to improve your adherence to medical treatment?	YES	NO
22. Have you ever required rehabilitation following an event i.e. stroke or motor vehicle accident?	YES	NO

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 you or any of your dependants have undergone in the past, and/or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants 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 you or any of your depandants.
2. Do you or any of your dependants expect chronic medication to be prescribed in the next 12 months? YES NO

   If so please supply details below.

Applicant	Prescribed Medication	Medical Condition	Date Started/To be Started

H. GENERAL HEALTH QUESTIONS

Question		
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.

HEIGHT AND WEIGHT

Applicant	Initials	Height cm	Weight kg
Adult Dependant 1	Initials	Height cm	Weight kg
Adult Dependant 2	Initials	Height cm	Weight kg

N.B. Any misrepresentation or non-disclosure of material medical or factual information will render all benefits granted by the Scheme null and void. In addition, any payment made due to such actions will be recovered from the member by the Scheme.

I. PAYMENT METHOD

Payment Method: Debit Order | Persal | EFT | Via Employer

(For approved groups only)

J. CONTRIBUTION COLLECTION DETAILS

Core Contribution	R
Medical Current Account	R
TOTAL MONTHLY CONTRIBUTION	R

J. CONTRIBUTION COLLECTION DETAILS (Continued)

Name of Bank		Branch	
Account Type		Branch Code	
Name of Account Holder			
Account Number		Debit Order Date	1st / 5th

Resolution Health Medical Scheme ("the Scheme") / Agility Global Health Solutions Africa (Pty) Ltd is hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted, and similarly I authorise my bank to debit my account with amounts drawn against it by the Scheme / Agility Global Health Solutions Africa (Pty) Ltd.

I understand that the withdrawals hereby authorised will be processed by computer through a system known as ABSA Link Direct Service / Debit Order / Multidata and I also understand that the details of each withdrawal will be printed on my bank statement or on an accompanying voucher.

I agree to pay any bank charges relating to this, ABSA Link Direct Service / Debit Order / Multidata, instruction.

The authority may be cancelled by myself giving the Scheme / Agility Global Health Solutions Africa (Pty) Ltd thirty (30) days notice in writing, sent by prepaid registered post, but I understand that I shall not be entitled to any refund of amounts which the Scheme / Agility Global Health Solutions Africa (Pty) Ltd has withdrawn while this authority was in force if such amounts were legally owning to the Scheme. Receipt of this instruction by the Scheme / Agility Global Health Solutions Africa (Pty) Ltd shall be regarded as receipt thereof by my bank.

I further agree to advise the Scheme / Agility Global Health Solutions Africa (Pty) Ltd in writing of any changes which may occur.

Signature of Account Holder SIGNATURE

K. CLAIM REIMBURSEMENT DETAILS

Claim refunds can only be paid by direct credit to your bank account. All claims will be reimbursed at medical scheme rate, unless otherwise indicated.

Name of Bank		Branch	
Account Type		Branch Code	
Name of Account Holder			
Account Number			

Signature of Account Holder SIGNATURE

L. MEMBER ACKNOWLEDGEMENT AND DECLARATION

General

1. *I, the undersigned applicant:*

1.1 Hereby apply for myself and my dependants to be registered on the Resolution Medical Scheme ("the Scheme") and agree to abide by and undertake to familiarise myself with the Rules of the Scheme;

1.2 Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and, should there be any change in the state of health or change in personal status by myself or any of my dependants from the date of signing this application form and the date of acceptance of risk by the Scheme, notification of such change will be provided to the Scheme in writing with full details of such condition / ailment within 30 days from the change in circumstances;

1.3 Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null and void and all contributions paid shall be forfeited;

1.4 Understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary, including the result of such medical examinations and tests that they may require me or my dependants to undertake;

1.5 Consent to the Scheme addressing any requests for information, tests or examinations directly to any dependants of mine over the age of 18, with the same legal consequences as if the request had been addressed to me in my capacity as a member;

1.6 Acknowledge that it is my responsibility as a member to ensure that claims are submitted within the 4 month submission period (Rule 15.2).

1.7 Acknowledge that it is my responsibility as a member to ensure that the monthly contribution is received by the Scheme in terms of the Rules of the Scheme;

1.8 Acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any contribution is not paid on the due date; and

1.9 Undertake to inform the Scheme within 30 days should the situation change (Rule 7.2.1).

1.10 Is familiar with and has full knowledge of the irrefutable conditions and benefits of the option elected, notwithstanding misrepresentation by any other party;

1.11 That neither myself or my dependants are dependants of another medical scheme;

1.12 Hereby consent to all conversations between myself, the Scheme or any party as being recorded;

Authority

2. Accepting that I am curtailing my and my dependants' right to privacy, but in order to facilitate the assessment of the risk and the consideration of any claim, I irrevocably authorise:

2.1 The Scheme to obtain from any person, whom I hereby so authorise and direct to give, any information which the Scheme deems necessary.

2.2 I further authorise and instruct the Scheme and any hospital concerned to give any information relating to myself and my dependants to the Medical Case Managers appointed by the Scheme, for the purposes of ensuring that the members of the Scheme receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources.

2.3 I understand and accept that the above authorisation constitutes a partial waiver of my and my dependants' right to privacy.

3. *declare that:*

3.1 My dependant(s) is/are residing with me.

3.2 I am liable for his/her family care.

3.3 The dependant(s) is/are my immediate family (Must be blood related).

3.4 My dependant(s) is/are not in receipt of remuneration of more than the maximum social pension per month.

3.5 My dependant(s) is/are not a member(s) or dependant(s) of another medical scheme.
(Evidence / affidavit to prove the above must be submitted with this application).

Termination

4. On termination of my membership of the Scheme:

4.1 I undertake to repay the Scheme any amount by which claims paid out of or from my Medical Current Account exceed contributions and other net credits paid into such account, where applicable.

4.2 I understand that should contributions and other net credits to my Medical Current Account exceed claims paid from this account, this excess will be paid to me subject to the approval in terms of the Medical Schemes Act 131 of 1998, where applicable.

4.3 One month written notice (Rule 12.2.1).

M. INTERMEDIARY DECLARATION

1. *I, the undersigned applicant hereby confirms:*

1.1 that the appointed intermediary is accredited at date of signing the application form

1.2 that the appointed intermediary is licensed by the FSB in terms of the FAIS Act

1.3 that the appointed intermediary has made his/her name, physical, postal address and contact number available

1.4 that I am aware of commission payable by the Scheme on this transaction to the appointed intermediary

1.5 that the appointed intermediary is contractually bound to the Scheme

1.6 that there has been no material misrepresentation of facts by the appointed intermediary and that in such an event the appointed intermediary undertakes to refund all monies paid to the Scheme

1.7 that I have been given all the relevant information with regards to the application information from the appointed intermediary

1.8 that the advice given to me by the appointed intermediary was in my best interest and unprejudiced

N. INTERMEDIARY DETAILS

Name of Brokerage ____ Brokerage Code ____

Address ____ Consultant / Agent Sub-code ____

____ Code ____

Full Name of Consultant / Agent ____

Telephone Number ____ Email Address ____

Fax Number ____

SIGNATURE

Signature of Broker

SIGNATURE

Signature of Consultant

SIGNATURE

Signature of Applicant

O. SCHEME DECLARATION

1. *We hereby confirm:*

1.1 that the applicant and his/her dependants' personal and medical information, (obtained from healthcare providers with applicant's consent) will be kept confidential

1.2 that both personal and medical information obtained will not be used or sold commercially

1.3 that data security measures are in place

1.4 that staff of RHMS as well as its contracted third parties are bound by confidentiality agreements

1.5 that the Scheme and its contracted third parties use application information for the processing of the application, re-imbursement of claims to determine benefits and access levels of care in respect of managed health care principles

1.6 that the Scheme's contractual agreements ensure the confidentiality of data management, scheme administration and managed health care agreements

1.7 that should the Scheme assume responsibility for breach in confidentiality, the management thereof will be in accordance to Scheme Rules and Protocols

Signed at ____________________ on this __________ day of ____________ / ________

SIGNATURE

Signature of Applicant

DISEASE MANAGEMENT - ICD10

OFFICE USE ONLY

CATEGORY	A	B	C
COPY ☐ ORIGINAL ☐			
NO WAITING PERIOD	☐	☐	☐
3 MONTHS WAITING PERIOD	☐	☐	☐
TWELVE MONTHS WAITING PERIOD	☐	☐	☐
PMB PAYMENT YES ☐ NO ☐			
LATE JOINER PENALTY	☐	☐	☐
MEMBERSHIP PACK TO UNDERWRITING			

Signature

RESOLUTION health Medical Scheme