Contact centre: 0860 002 101
General enquiries: service@alliancemidmed.co.za
Authorisation enquiries: auths@alliancemidmed.co.za
Clinical enquiries: clinical@alliancemidmed.co.za
www.alliancemidmed.co.za

ALLIANCE-MIDMED MEDICAL SCHEME

ADD DEPENDANT APPLICATION FORM

Alliance-MidMed Medical Scheme will only process this Add Dependant Application if it has been completed in full and the supporting documentation requested has been submitted with this application. Please complete with black ink.

SECTION 1. PERSONAL DETAILS

When do you want cover to start for your dependant/s?

1. PRINCIPAL MEMBER DETAILS

Title | Title

Surname

Member number

2. ADDING A SPOUSE OR LIFE PARTNER (PLEASE SUBMIT MARRIAGE CERTIFICATE OR AFFIDAVIT OF CO-HABITATION)

Title | Title

Surname

First name(s)

Maiden name | Gender M F

Identity number

Please submit copy of ID/Passport

Passport number

Please provide date of birth if using passport number D D M M Y Y Y Y

Telephone number

Email address

Race | African | Coloured | Indian/Asian | Other | Do not want to disclose

Although you do not have to share information about your race if you choose, the Scheme is required by the Council of Medical Schemes to collect this data for statistical purposes.

Disability status | Date of diagnosis D D M M Y Y Y Y

Disability details

Doctor details

3. ADDING OTHER DEPENDANTS (PLEASE SUBMIT BIRTH CERTIFICATES, APPOINTMENT OF COURT OR ADOPTION CERTIFICATES)

First name(s) 1.

Surname

Identity number | Gender M F

Telephone number

Email address

Relationship to principal

Adult over 21 years Y N (If Yes, please complete Section 2) | Contact number

Race | African | Coloured | Indian/Asian | Other | Do not want to disclose

Although you do not have to share information about your race if you choose, the Scheme is required by the Council of Medical Schemes to collect this data for statistical purposes.

Disability status | Date of diagnosis D D M M Y Y Y Y

Disability details

Doctor details

First name(s) 2.

Surname

Identity number | Gender M F

Telephone number

Email address

Relationship to principal member

Adult over 21 years Y N (If Yes, please complete Section 2) | Contact number

Race | African | Coloured | Indian/Asian | Other | Do not want to disclose

Although you do not have to share information about your race if you choose, the Scheme is required by the Council of Medical Schemes to collect this data for statistical purposes.

Disability status | Date of diagnosis D D M M Y Y Y Y

Disability details

Doctor details

First name(s) 3.

Surname

Identity number | Gender M F

Telephone number

Email address

Relationship to principal member

Adult over 21 years Y N (If Yes, please complete Section 2) | Contact number

Race | African | Coloured | Indian/Asian | Other | Do not want to disclose

Although you do not have to share information about your race if you choose, the Scheme is required by the Council of Medical Schemes to collect this data for statistical purposes.

Disability status | Date of diagnosis D D M M Y Y Y Y

Disability details

Doctor details

If adding more than 3 dependants please attach additional pages.

SECTION 2. ADULT DEPENDANT DETAILS

Excluding your spouse or life partner, are the adult dependants financially dependent on you? Y N

Do these adult dependants receive any income? e.g. pension, salary, wages, grant? Y N

If YES, please declare gross monthly income: Dependant 1: R

Dependant 2: R

Race | African | Coloured | Indian/Asian | Other | Do not want to disclose

Although you do not have to share information about your race if you choose, the Scheme is required by the Council of Medical Schemes to collect this data for statistical purposes.

Disability status | Date of diagnosis D D M M Y Y Y Y

Disability details

Doctor details

SECTION3. PREVIOUS MEDICAL SCHEMES' DETAILS

Please list previous medical schemes' details for adult dependants. If no previous cover, please declare so.

Name of beneficiary

Name of scheme

Date joined D D M M Y Y Y Y | End date D D M M Y Y Y Y

Have your dependants ever had a waiting period, exclusion or late joiner penalty imposed? Y N

Have your dependants ever been refused cover by a life assurance company? Y N

Have your dependants ever had membership terminated by a medical scheme? Y N

If you have answered YES to any of the above questions, please provide details below.

SECTION 4. EMPLOYER VERIFICATION (IF APPLICABLE)

I/We are not aware of any fact other than those stated which should be made known to the Scheme and do hereby certify the applicant to be a permanent staff member and that Alliance-MidMed Medical Scheme may add the dependant contributions to be billed.

Signature _____ Date D D M M Y Y Y Y

Designation | | | | | | | | | | | | | | Contact number | | | | | | | | | | |

SECTION 5: HEALTH QUESTIONNAIRE

Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or results in immediate termination of your membership.

If the nature of any conditions of yours or your dependants is of such a sensitive nature that confidentiality is required, you may use a sealed envelope enclosing all relevant documentation that will give the administration insight and full understanding of the condition. This sealed enveloped may be attached to this application form or may be submitted directly to Alliance-MidMed Medical Scheme.

Have your dependants ever had any of the following:
(If yes to any of the questions, please provide full details. You may also attach any relevant documentation and additional pages if you need more space).

Any disorder of the heart, blood vessels or circulatory system (e.g. blood pressure, chest pain, heart murmurs, palpitations, thrombosis, shortness of breath, stroke, raised cholesterol, calf cramps during light or moderate pace walking)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Respiratory or lung trouble (e.g. asthma, bronchitis, persistent cough, tuberculosis, or coughing)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Disease or disorder of the kidneys, bladder or reproductive organs (e.g. stones, protein in urine, prostatis or trouble passing urine)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Any nervous, mental, neurological complaint or psychiatric conditions (e.g. fits, epilepsy, blackouts, persistent headaches, paralysis, anxiety or depression)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Disorder of the digestive system, abdomen or liver (e.g. hernias, gastric/duodenal ulcer, recurrent indigestion/heartburn, rectal bleeding, hepatitis, jaundice, cirrhosis)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name

Ear, eyes, throat or nose disorder? (e.g. defective vision, deafness and recurrent tonsillitis). Do your dependants wear glasses or contact lenses?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Skin disorders (e.g. psoriasis, dermatitis or eczema)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Any hereditary or congenital conditions (e.g. Down's syndrome, poryphyria, congenital abnormality)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Diabetes or sugar in the urine?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Leukemia, anemia, blood, spleen or bleeding disorders?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Any endocrine, glandular disorders (e.g. thyroid, Addison's or Cushing's syndrome)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Tumour growth or cancer, benign or malignant?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Congenital mental insufficiency, brain dysfunction, birth syndromes?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name

Ever treated for HIV Aids, TB, Infectious diseases, hepatitis or sexually transmitted disease?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Any connective tissue, autoimmune disorders (leprosy, sarcoid, multiple sclerosis, lupus)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Are any of your dependants undergoing or planning to undergo any specialist dentistry treatments (e.g. wisdom teeth removal, orthodontics, braces, maxillofacial procedures etc.)?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Are any of your dependants pregnant or planning a pregnancy in the next 12 months?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Are there any other conditions, health concerns whether diagnosed or not that you have not already detailed for which medical advice, diagnosis, treatment, or care that has been recommended, received or could potentially result in a claim within the next 6 months?			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name
Have any of your dependants immediate family suffered or died from diabetes, heart disease, HIV/Aids, TB high blood pressure, raised cholesterol, mental or any hereditary disease? If "yes" please state age of relative and type of diseases.			YES	NO
Which dependant?	Condition & date diagnosed	Treatment	Still on treatment?	Doctor's name

SECTION 6. CONDITIONS, UNDERTAKINGS AND WARRANTIES

1. I hereby apply for my dependants to join Alliance-MidMed Medical Scheme.
2. I acknowledge that any breach of warranty or non-disclosure of any information by me or my dependants that is relevant to the assessment of this application will make any contracts to which this application relates null and void. I will also forfeit all contributions that I paid to Alliance-MidMed Medical Scheme. In such an event Alliance-MidMed Medical Scheme will have the right to reclaim any amounts that Alliance-MidMed Medical Scheme may have paid to me or any person on behalf of me or my dependants under such contracts.
3. I will notify Alliance-MidMed Medical Scheme if any alterations take place in any circumstances on which Alliance-MidMed Medical Scheme based its assessment of its risk after the date of this application and the date of Alliance-MidMed Medical Schemes acceptance of the risk. I acknowledge the failure to do so will make any contracts to which this application relates null and void. In such an event Alliance-MidMed Medical Scheme will have the right to reclaim any amounts that Alliance-MidMed Medical Scheme may have paid to me or any person on my or my dependants behalf under such contracts.
4. I am aware that Alliance-MidMed Medical Scheme Rules will bind my dependants and I understand that the registered rules are decisive in the case if disputed.
5. I authorise access to any medical or other information required by Alliance-MidMed Medical Scheme or the Administrator during the process of

assessment as well as any further claims procedures. I furthemore authorise my service provider to prove ICD10 codes on all my accounts.

6. I shall notify Alliance-MidMed Medical Scheme, through pre-authorisation, should any of my dependants require hopitalisation for a non-emergency event and acknowledge that failure to do so will result in a penalty being applied or a reduction in benefits provided by Alliance-MidMed Medical Scheme for any procedure undertaken.
7. No benefit will be payable by Alliance-MidMed Medical Scheme unless they are satisfied as to the validity of the claim and have received all the information which they may require from my dependants.
8. I consent to Alliance-MidMed Medical Scheme addressing any request for information tests or examinations directly to any dependant of mine over the age of 21, with the same legal consequences as if the request had been addressed to me in my capacity as a principal member.
9. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and indemnify Alliance-MidMed Medical Scheme against any claim which may arise as a result of my failure to do so.
10. I understand the following under the following underwriting may apply to my adults dependants: A three month general waiting period, a twelve month exclusion on a pre-existing condition and a late joiner contribution penalty.
11. I acknowledge that should this application be submitted via the internet or facsmile, it solely for the purposes of convenience and neither I nor the Administrator (subject to its sole discretion) nor Alliance-MidMed Medical Scheme will rely on the information herein contained without me first providing Alliance-MidMed Medical Scheme with a signed hard copy of this application.
12. I warrant that the contents of this application are true, correct and complete.

Signed at _____ this _____ day of _____ 20 _____

Signature of Principal Applicant: _____