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

MEMBER APPLICATION

1. The privacy and security of your personal information (which includes the personal information of your dependants) are important to Alliance-Midmed Medical Scheme. The Scheme will only process personal information, which includes collect, use, store and share such information, in accordance with its Privacy Policy, available on our website at www.alliancemidmed.co.za, and if the processing is permitted by law, for a legitimate interest or with otherwise with your consent, if necessary.

2. Alliance-Midmed 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 and to perform the contract between the principal member and the Scheme.

3. All conversations between you or any of your dependants and Alliance-Midmed Medical Scheme, its agents or contracted parties, will be recorded and all information obtained through these conversations will form part of the records of Alliance-Midmed Medical Scheme.

4. I now hereby declare that –
   - I had an adequate opportunity to read and understand the contents of this document / 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 Alliance-Midmed 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 of my own free will without any undue influence from any person whatsoever.

5. I authorise Alliance-Midmed Medical Scheme and/or its agents to obtain any information that they may require concerning me or any of my dependants (such as health information) for any purpose directly related to our 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 health care practitioners). [Note: Consider I expressly authorise any health care service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to Alliance-Midmed Medical Scheme, or its contracted service providers, on request.]

6. I guarantee that, to the extent that it may be required by law, I have the necessary authority or permission from my 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 Alliance-Midmed Medical Scheme.

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ALLIANCE-MIDMED MEDICAL SCHEME

MEMBER APPLICATION

Alliance-MidMed Medical Scheme (the Scheme) will only process this application form if it has been completed in full and the supporting documentation requested has been submitted with this application. Please complete in black ink and print clearly.

1. PRINCIPAL APPLICANT

Surname | Title
First name(s) | Initials
Maiden name | Gender M F
Marital status | Single | Married | Divorced | Widowed | Language preferences E A
Race | African | Coloured | Indian/Asian | Other | Do not want to disclose

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Identity/Passport number | Country of origin
Cellphone number | Telephone (home)
Email address
Physical address
Code
Postal address
Code
Company name
Employment date D D M M Y Y Y Y | Employee number
Occupation | Tax number
Would you like access to the Scheme website? Your e-mail address will be used for communication Y N
Disability status | Date of diagnosis D D M M Y Y Y Y
Disability details
Doctor details

2. SPOUSE OR LIFE PARTNER (PLEASE SUBMIT MARRIAGE CERTIFICATE OR AFFIDAVIT FOR CO-HABITATION WITH APPLICATION)

Surname | Title
First name(s) | Initials
Maiden name | Gender M F
Identity/Passport number | Date of birth D D M M Y Y Y Y
Country of origin
Cellphone number
Telephone (home) | Telephone (work)
Race | African | Coloured | Indian/Asian | Other | Do not want to disclose

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

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

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

DEPENDANT 1

First name(s) | Gender M F

Surname

Identity/Passport number | Adult over 21 years Y N (If YES, please complete section 2)

Relationship to principal

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

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

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

Disability details

Doctor details

Telephone | Email Address

(Dependants older than 18 years)

DEPENDANT 2

First name(s) | Gender M F

Surname

Identity/Passport number | Adult over 21 years Y N (If YES, please complete section 2)

Relationship to principal

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

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

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

Disability details

Doctor details

Telephone | Email Address

(Dependants older than 18 years)

DEPENDANT 3

First name(s) | Gender M F

Surname

Identity/Passport number | Adult over 21 years Y N (If YES, please complete section 2)

Relationship to principal

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

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

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

Disability details

Doctor details

Telephone | Email Address

(Dependants older than 18 years)

DEPENDANT 4

First name(s) | Gender M F

Surname

Identity/Passport number | Adult over 21 years Y N (If YES, please complete section 2)

Relationship to principal

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

You do not have to give us this information about your race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

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

Disability details

Doctor details

Telephone | Email Address

(Dependants older than 18 years)

If more than 4 dependants, please attach additional pages. If dependants are over 21 years of age, please submit proof of dependency or a supporting affidavit detailing financial dependency to Principal applicant.

SECTION 2: BANKING DETAILS

	USE THIS ACCOUNT FOR ALL TRANSACTIONS
	USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS ONLY

(Reimbursement will only be via direct deposit into the nominated bank account, no cheque payments can be made.
Claims cannot be reimbursed if details are incorrect or not provided).

Claims reimbursements: Reimbursements will only be paid directly into the nominated bank account. Claims cannot be reimbursed if details are incorrect or not provided. Please attach an original or certified copy of your bank statement - to verify your bank account details; alternatively we will accept a signed and stamped letter from the bank confirming your bank account details. No refund can be made to credit card account details.

Name of account holder																											
Name																											
Bank name																			Branch code								
Account number																											

Account type		Current		Savings		Transmission

(Please submit original proof of banking details for debit order. If employer is responsible for pay contributions, the employer must also complete section 4).

Alliance-MidMed Abbreviated Name: MIDMED

Name of account holder																											
Name																											
Bank name																			Branch code								
Account number																											

Account type		Current		Savings		Transmission

	USE THIS ACCOUNT FOR CLAIMS AND SAVINGS REFUNDS ONLY

1. I authorise Alliance-MidMed (the Scheme) to debit this account with R_____ in accordance with the Schemes' debit order system starting on my Join date as stipulated in Section 3.
2. I understand that by providing these details, I authorise the Scheme to pay claim reimbursements directly into this account.
3. I will not hold the Scheme responsible for incorrect details provided and agree to inform the Scheme in writing of any changes to details.
4. I understand that by providing these details I authorise the Scheme to pay claim reimbursements directly into this bank account.
5. I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks. I also understand that details of each withdrawal will be printed on my bank statement. Such most contain my reference number, which must be included in the said payment instruction and if provided to me should enable to identify the agreement
6. I understand that I may cancel this Authority and Mandate on 1(one) month's prior written notice to the Scheme.
7. I/We agree that although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel the Agreement. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force, if such amounts were legally owing to you.
8. I/We acknowledge that this Authority may be ceded or assigned to a third party if the Agreement is also ceded or assigned to that third party, but in the absence of such assignment of the Agreement this Authority and Mandate cannot be assigned to any third party.

Signature of bank account holder: _____ Date D D M M Y Y Y Y

SECTION3: EMPLOYMENT WARRANTY

1. I warrant that the principal applicant detailed Section 1 is an employee of our organisation	Y	N
2. I warrant that the principal applicant detailed in Section 2 has a salary of	R	
3. Alliance-MidMed Medical Scheme may bill our organisation for the amount due respect of	Y	N

Name																											
Designation																											

Authorised signatory

Company stamp

Date D D M M Y Y Y Y

Join date D D M M Y Y Y Y

SECTION 4: HEALTH QUESTIONNAIRE

Have you or any of your dependants ever had any chronic conditions, illnesses, hospital admissions, symptoms or illness, whether diagnosed or not and the treatments undertaken including any medications and provide full details. (Additional pages may be attached.)

Note that we do not underwrite if you join the scheme within 30-days of employment at the participating employer.

Where you join later or where there is a break in membership, we use the previous 12-month's information for underwriting. We use the historical information to partner with you to manage your chronic condition and improve outcomes and quality of life where it is possible.

	Should you rather wish to disclose your pre-exisiting conditions with a registered Nurse telephonically	Y	N
	(if YES, please provide your contact number)		

1	Any disorder of the heart, blood vessels or circularly 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)	Y	N
2	Respiratory or lung trouble (e.g. asthma, bronchitis, persistent cough, tuberculosis, or coughing of blood)	Y	N
3	Disease or disorder of the kidneys, bladder or reproductive organs (e.g. stones, protein in urine, prostatitis or trouble passing urine)	Y	N
4	Any nervous, mental, neurological complaint or psychiatric conditions (e.g. fits, epilepsy, blackouts, persistent headaches, paralysis, anxiety or depression)	Y	N
5	Disorder of the digestive system, abdomen or liver (e.g. hernia's, gastric/duodenal ulcer, recurrent indigestion/heartburn, rectal bleeding, hepatitis, jaundice, cirrhosis)	Y	N
6	Ear, eyes, throat or nose disorder (e.g. defective vision, deafness and recurrent tonsillitis) Do your dependants wear glasses or contact lenses?	Y	N
7	Disease or disorder of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, pain)	Y	N
8	Skin disorders (e.g. psoriasis, dermatitis or eczema)	Y	N
9	Any hereditary or congenital conditions (e.g. down's syndrome, porphyria, congenital abnormality)	Y	N
10	Diabetes or sugar in the urine	Y	N
11	Leukemia, anaemia, blood, spleen or bleeding disorders	Y	N
12	Any endocrine, glandular disorders (e.g. leprosy, sarcoidosis, multiple sclerosis, lupus)	Y	N
13	Growth, tumour or cancer of any kind, whether benign or malignant	Y	N
14	Congenital mental insufficiency, brain dysfunction, birth syndromes	Y	N
15	Ever treated for HIV/AIDS, TB, infectious diseases, hepatitis or sexually transmitted diseases	Y	N
16	Any connective tissue, autoimmune disorders (e.g. leprosy, sarcoidosis, multiple sclerosis, lupus)	Y	N
17	Are you or any of your dependants currently undergoing, or planning to undergo, any specialist dentistry treatment (e.g. wisdom teeth removal, orthodontics, braces, maxillofacial procedures)	Y	N
18	Are you or any of your dependants pregnant or planning of pregnancy in the next 12 months	Y	N
19	Are there any other conditions, symptoms, health concerns whether diagnosed or not that you have not already detailed for which medical advice, diagnosis, treatment or care has been recommended, received or could potentially result in a claim within the next 6 months	Y	N
20	Have you or any of your dependants' immediate family suffered or died from diabetes, heart disease, HIV/AIDS, TB, high blood pressure	Y	N

SECTION 4: HEALTH QUESTIONNAIRE

Question no.	Which beneficiary?	Condition & date	Cost of treatment/ medication	Still on treatment?	Doctor's name

SECTION 5: PREVIOUS MEDICAL SCHEMES' DETAILS

Please list previous medical schemes' details. If no previous cover, please declare so. Details must be provided for spouse and adult dependants if different from principal member. Previous and current membership certificates must be submitted with this application.
Failure to complete this accurately and in full will affect underwriting outcome.

Name of beneficiary	Name of scheme	Date joined	Date ended

SECTION 6: MEDICAL SCHEMES DECLARATION

Alliance Mid-Med Medical Scheme declares that:

1. A member's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential.
2. Member information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes.
3. The medical scheme has data security measures in place.
4. The medical scheme has granted access, to certain persons within the organisation and its contracted third parties, to a beneficiaries' personal and health information.
5. All staff within the medical scheme and its contracted third parties are bound by internal confidentiality agreements.
6. The medical scheme and its contracted third parties will use the medical/health/diagnosis/procedure information provided for the following purposes: processing the application for membership; reimbursement of claims, determining member entitlement to benefits and risk management practice.
7. The medical scheme has ensured that confidentiality agreements have been entered into with all contracted third parties who have access to beneficiary information for the purposes of data transfer and management, scheme administration and managed care arrangements.
8. In the event of a breach of confidentiality, the medical scheme assumes responsibility and the breach will be managed according to the schemes'internal protocols.

SECTION 7: CONDITIONS, UNDERTAKING AND WARRANTIES

1. I hereby apply for my dependants and myself to join Alliance-MidMed Medical Scheme, administered by Alliance-MidMed Medical Scheme (the Administrator).
2. I acknowledge that any breach of any 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 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.
3. I will notify Alliance-MidMed Medical Scheme if any alteration takes place in any circumstances on which Alliance-MidMedi Medical Scheme based its assessment of its risk after the date of this application and before the date of Alliance-MidMed Medical Scheme acceptance of the risk. I acknowledge that 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 depandant's behalf under such contracts.
4. I am aware that Alliance-MidMed Medical Scheme rules will bind me when my membership commences. I understand that registered rules are decisive in the case of a dispute. I am aware that I had the opportunity to read the Alliance-MidMed Medical Scheme rules before signing this application and that, even if I have not taken up the offer, I will be deemed to have read the rules.
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 furthermore authorise my service provider to provide ICD10 codes on all my and any dependants' accounts.
6. I shall notify Alliance-MidMed Medical Scheme, through pre-authorisation, should any of my dependants require hospitalisation for a nonemergency 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 claim and have received all the information which they may require from my dependants.
8. I consent to Alliance-MidMed Scheme addressing any request for information, tests or examinations directly to any dependant of mine over the age of 21 (twenty one), with the same legal consequences as if the request had been addressed to me in my capacity as a principal member.
9. On termination of my membership with Alliance-MidMed Medical Scheme as per the agreed termination period, I shall repay any amount by which claims paid out of savings exceed contributions paid into such account, on demand. I further agree/acknowledge that termination of membership does not entitle me to any refunded contributions and any indebtedness due to Alliance-MidMed Medical Scheme which have been deducted while my membership was active.
10. I hereby authorise the deduction of my monthly contribution and any other indebtedness due to Alliance-MidMed Medical Scheme as per the deduction amount agreed upon and understand it is my sole responsibility as a member of Alliance-MidMed Medical Scheme, to ensure that the monthly contribution is received by Alliance-MidMed Medical Scheme. I accept that non-receipt of two consecutive month's contributions will result in the termination of my membership. I further acknowledge/agree that my authorisation to deduct my monthly contributions will be treated as payment instruction issued personally by me as the account holder. Membership may not be ceded.
11. In the event that the payment day falls on a Sunday, or recognised South African public holiday, the payment day will automatically be the preceding ordinary business day.
12. My membership number serves as my reference number.
13. 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.
14. I accept that in the case of new Alliance-MidMed Medical Scheme members, the following may apply:
    - A three month general waiting period
    - A twelve-month exclusion on a pre-existing condition
    - Late-joiner contribution penalty.
15. I acknowledge that should this application be submitted via the internet or facsimile, it is solely for the purposes of convenience and neither I nor the Administrator (subject its sole discretion) nor Alliance-MidMed Medical Scheme will rely on the information herein contained without my first providing Alliance-MidMed Medical Scheme with a signed hard copy of this application.
16. I agree that this application submitted to the Administrator will constitute an offer on my part for membership with Alliance-MidMed Medical Scheme.
17. Alliance-MidMed Medical Scheme shall be entitled to obtain credit and related information concerning myself at any time and lodge, exchange and disclose such information with any credit bureau without any further notice to me. Alliance-MidMed Medical Scheme shall be entitled to verify such information and to make any queries it deems necessary. I understand that in the event of a negative credit record, Alliance-MidMed Medical Scheme will not advance saving benefits for non-essential healthcare without my lodging of a bank guarantee with Alliance-MidMed Medical Scheme.

18. I consent to all conversations between myself and Alliance-MidMed Medical Scheme and the administrator being recorded and regard all information obtained through these conversations as part of Allliance-MidMed Medical Scheme and the administrator being recorded and regard all remaining the sole property of Alliance-MidMed Medical Scheme.
19. I warrant that the contents of this application are true, correct and complete.
20. Online Access
    - I accept that Alliance-MidMed Medical Scheme will not in any way be responsible or liable for any claims of any nature whatsoever made by anyone (myself excluded) which arise as a result of my failing to keep my password and username secure and confidential to myself.
    - Online Access - I indemnify Alliance-MidMed and hold it harmless against any such claims.
    - Online Access - I understand that this service may not be available 24 hours a day.

Signed at _____ this _____ day of _____ 20 _____

Signature of Principal Applicant: _____

To avoid a delay in the processing of your application; please utilise the following checklist and ensure all important sections of your application are completed and all relevant documentation is attached.

IMPORTANT SECTIONS - COMPLETED		IMPORTANT DOCUMENTS - ATTACHED	
Start date		Copy of Identity document	
Personal details		Birth certificates/affidavits (where dependants surnames differ)	
Identity number (age)		Previous Medical Aid membership certificates	
Employment date		Original documents of a traditional wedding from internal affairs (proof of customary marriage (proof of customary marriage	
Contact details		Certified copy of internal affairs proof of customary marriage	
Company members - employer signature and stamp		Proof of shared common households	
Completed statement of health		Original or certified copy of your bank statement or signed and stamped letter from the bank confirming your bank account details	
Signed section 9 - rules		Disability details: Copy of Disability certificate	

Banking Details of Alliance-MidMed Medical Scheme
Name: Alliance-MidMed
First National Bank - Account Number: 6211 670 8259