Because Your Health Matters

ALLIANCE-MIDMED MEDICAL SCHEME

Application for Registration on the Alliance Midmed Mental Wellness Programme

Membership Number		**Date**	
Surname			
First Name/s			
Is this registration for yourself or a family member?	**Myself** ☐	**Family** ☐	**Both** ☐

Please complete a separate form for each person in your family if applicable

Please specify your condition:				
When were you diagnosed?		**Do you take chronic medicines?**	**Y**	**N**

Please provide us with your contact details in the spaces below so that we can keep in touch

Home Phone	code		
Work Phone	code		ext
Shop/Department			
Cell Phone (yours)		**Cell Phone (alt)**	
e-mail Address			
Postal Address **Where we can send you information**			
Doctor's Name & Phone Number			

N.B. **In order to register you on the programme and/or consider chronic medication benefits, we need your doctor to confirm your diagnosis and complete a treatment plan document that includes the DSM IV (Diagnostic and Statistical Manual of Mental Disorders™) multiaxial assessment system criteria together with your latest prescription and treatment history.**

May we contact your doctor directly for information?	**Yes**		**No**	
Please sign here:				

ALL THE INFORMATION YOU GIVE US WILL BE KEPT STRICTLY CONFIDENTIAL AND WILL NOT BE SHARED WITH YOUR EMPLOYER OR ANYONE OTHER THAN YOUR DOCTORS AND PHARMACY WITHOUT YOUR PERMISSION.