bonitas medical fund

Serious about what you need

DEPENDANT REGISTRATION

P.O. Box 1101, Florida Glen 1708
Call Centre 0860 002 108
Fax 011 758 7171
E-mail bonitasmemmaintenance@medscheme.co.za

IMPORTANT

- **Section 1 *must be completed*** for dependant/s to be registered
- Please use block letters
- Complete blocks from left to right, one letter/number per block
- Registration and amendments are subject to the Rules of the Fund
- Please notify the Fund, within 30 days, of any change to the membership status of your dependant/s
- If you have any queries, please contact the Call Centre on **0860 002 108**

Section 1 MEMBERSHIP DETAILS *(must be completed)*

Title | Initials

First name/s

Surname

Membership number

Please ✓ appropriate block

☐	Change of address / contact details	***Complete Sections 1, 2 and 6***
☐	Change of bank details	***Complete Sections 1, 3 and 6***
☐	Change of marital status	***Complete Sections 1, 4 and 6***
☐	Termination of dependant membership	***Complete Sections 1, 5 and 6***

Section 2 CONFIRMATION OF ADDRESS / CONTACT DETAILS

Telephone (H) code

Telephone (W) code

Postal address

code

E-mail address

Cell

Fax code

Street address

code

Section 3 BANK DETAILS OF PRINCIPAL MEMBER – Refund of claim and savings payments / debt order instruction Please provide the following documents:

If Account Holder differs from that of Principal Member, an Affidavit is required.

- **Copy of the account holders ID**
- **Copy of the bank statement / cancelled cheque / letter from the bank / bank letterhead confirming the account holder's details**
- **Account holders signature**

☐ **Use this account for contribution collections and refunds**

☐ **Use this account for contribution collections**

Bank name

Branch name

Bank branch code

Type of account: Cheque | Transmissions | Savings *please* ✓

Name of account holder _____

Bank account number

☐ **Use this account for claims and savings refunds only**

Bank name

Branch name

Bank branch code

Type of account: Cheque | Transmissions | Savings *please* ✓

Name of account holder _____

Bank account number

Account holder's signature _____

Date signed d d m m y y y y

Section 4 REGISTRATION OF SPOUSE / PARTNER / NEWBORN / ADDITIONAL ADULT OR CHILD DEPENDANT

An adult dependant is anyone who is 21 years of age or older. Child rates apply to full–time students 21-24 years of age provided the student proof (registration details) is attached to the application for the current academic year. You are able to register adult or child dependants on this form. Provide valid ID numbers and/or passport numbers for all beneficiaries. Acceptance of the dependants will be in accordance with the Rules of the Fund. Please attach copies of ID / passport, marriage certificates, birth certificates, legal adoption or foster care court order documents and previous membership certificates with the terminated date.

1

Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname *(if different from principal member)*

First name/s

Relationship to principal member

Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name *(if applicable)*

ID / passport number

Tax number *(if applicable)*

2

Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname *(if different from principal member)*

First name/s

Relationship to principal member

Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name *(if applicable)*

ID / passport number

Tax number *(if applicable)*

3

Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname *(if different from principal member)*

First name/s

Relationship to principal member

Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name *(if applicable)*

ID / passport number

Tax number *(if applicable)*

4

Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname *(if different from principal member)*

First name/s

Relationship to principal member

Gender M F Date of birth d d m m y y y y

Marital status Single Married Divorced Widowed Cohabiting

Maiden name *(if applicable)*

ID / passport number

Tax number *(if applicable)*

Section 5 MEDICAL DETAILS

Failure to disclose existing medical conditions could limit and / or exclude you from receiving certain benefits, or result in the termination of your membership.

1. Do you or any of your dependants suffer from a chronic illness (e.g. raised cholestrol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and / or thyroid disorders)? If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

2. Do you or any of your dependants suffer from any gastro-intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative coilitis, diverticuilitis and / or a spastic colon)? If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

3. Do you or any of your dependants suffer from muscle, bone, skin or nerve illnesses or disorders (e.g. back- and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc.)? If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

4. Do you or any of your dependants suffer from urinary or genital disorders (e.g. kidney stones, prostate, endometriosis, ovarian cysts, menstrual disorders)? If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

5. Do you or any of your dependants suffer from ear, nose or throat disorders (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics)? If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

Section 5 MEDICAL DETAILS – *continued*

6. Do you or any of your dependants suffer from any blood disorders, immune deficiency state, HIV / Aids, cancer, etc.?
If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

7. Are you or any of your dependants pregnant?
If yes, provide details.

Yes | No

Name of beneficiary	Expected delivery date	Attending doctor
	d d m m y y y y	
	d d m m y y y y	
	d d m m y y y y	

8. Have you or any of your dependants had surgery in the past, or are you planning to have a surgical procedure in the next 12 months?
If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

9. Is there any other condition or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months? If yes, provide details.

Yes | No

Name of beneficiary	Condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	
			Yes	No	d d m m y y y y	

Current doctor

Name and surname

Telephone c o d e He / she has been your doctor for y y m m years

Section 6 PREVIOUS MEDICAL SCHEME INFORMATION

Please attach copy of the previous certificate of membership with the terminated date.

Have you as the principal member, or any of your dependants had previous medical aid cover? Yes | No **If yes, please give full details of you and / or your spouse / partner / adult dependants' membership of previous registered medical aid schemes and attach a copy of previous Membership Certificate. Should you need additional space to provide the necessary information, please make a copy of this section and attach it to your application. It is important that you specify exact membership join and termination dates for each medical scheme.**

Name of beneficiary	Name of scheme	Membership number	Date joined	Date terminated
			d d m m y y y y	d d m m y y y y
			d d m m y y y y	d d m m y y y y
			d d m m y y y y	d d m m y y y y
			d d m m y y y y	d d m m y y y y

Are you changing your medical scheme due a change in your employment? If yes is selected please provide a letter from previous employer confirming termination of employment or letter from new employer or new employment. Yes | No

Have condition-specific waiting periods, exclusions or late-joiner penalties ever been imposed by a previous medical scheme/s on medical scheme applications by your partner / spouse or any of your dependants? Yes | No

Section 7 TO BE COMPLETED BY EMPLOYER – *(must be completed)*

Company name

Scheme code | Pay-point code | Group | Dependant/s subsidised

The above details have been noted and contributions will be adjusted in terms of the Scheme Rules on d d m m y y y y and include arrears, if applicable.

Total current contribution R

Total new contribution R

Arrears *(if applicable)* R

COMPANY STAMP

Company representative's signature and designation

Date d d m m y y y y

Section 8 ACKNOWLEDGEMENT AND DECLARATION BY PRINCIPAL MEMBER – *(must be completed)*

1. I warrant that the information I have provided pertaining to me and my dependants is true and correct. Should there be any non-disclosure or material misrepresentation, I understand that my membership may be terminated and that I may forfeit my contributions to Bonitas. Bonitas also has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation.

2. Should any of my or my dependants' circumstances alter subsequent to the date of filling in this application, prior to or after the acceptance of my membership by Bonitas Medical Fund, I shall promptly notify Bonitas Medical Fund of the change. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership, and Bonitas shall also be entitled to reclaim any amounts it may have erroneously paid to any service provider on my or my dependants' behalf.

3. I warrant that I have been advised that the Rules will be made available on request and I understand that I am responsible to read the Rules and any amendments to the Rules. I agree that I will read the Rules and the amendments to the Rules and be bound by them.

4. I authorise and instruct my employer to deduct and pay over any amounts (that may become due and owing on my behalf) to Bonitas from time to time and I also authorise any persons, bodies or institutions who may hold retirement funds for my benefit, to deduct and pay to Bonitas all amounts that may become due and owing to Bonitas from time to time. I agree that should Bonitas incur any legal costs or expense to recover any contributions, I shall be responsible for such costs and expenses on the attorney/client scale.

5. Notwithstanding the above, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by Bonitas.

6. Should any contribution be unpaid, it may result in me and my dependants being suspended from Bonitas until all arrear contributions have been settled. Should two months' contributions be outstanding, Bonitas shall have the right to immediately cancel my Bonitas membership. I also understand that should my membership be suspended or terminated, I shall not be entitled to any benefits arising from my membership whatsoever.

7. I shall inform the scheme of any changes to my dependants' health or personal status, as required by the scheme rules, within 30 days of the change in circumstances.

8. I authorise my healthcare provider to disclose information to the scheme and it's contracted third parties, provided such information is treated as confidential at all times.

9. I agree to provide Bonitas with any medical or historical information or grant Bonitas access to medical information reasonably requested pertaining to a particular ailment, disease, disorder, condition or disability.

10. I agree that should I be accepted as a member of Bonitas, I shall provide Bonitas with all information including medical information that Bonitas may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Bonitas Rules. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.

11. I declare that my dependants are not beneficiaries of another registered medical scheme.

12. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

    12.1 a 3 (three) month general waiting period in respect of all benefits;

    12.2 a 12 (twelve) month exclusion in respect of a pre-existing condition;

    12.3 a late-joiner contribution penalty.

13. I authorise and permit Bonitas to take all reasonable steps to verify information provided by me in this application form.

14. I agree to submit proof of identification to Bonitas on demand.

15. I consent to my telephone conversations with Bonitas being recorded and forming part of Bonitas' records. I also agree that such records shall remain the sole property of Bonitas.

16. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any monies owing to Bonitas.

17. I warrant that the information provided above is true and accurate and should my application be accepted by Bonitas, the contents of this application form shall constitute the basis of my agreement with Bonitas.

18. As a government employee, I acknowledge that Bonitas Medical Fund will strictly adhere to Persal policies and procedures.

19. As a direct paying member, I acknowledge that monthly contributions are payable in advance in accordance with the Rules of Bonitas Medical Fund.

Section 8 ACKNOWLEDGEMENT AND DECLARATION - *continued*

20. I hereby consent that all contact details given in Section 5 of this application and any amendments to those contact details, may be used by Bonitas or any appointed agent of Bonitas for sending any information of any nature (confidential or other).

21. I warrant that none of my beneficiaries are members of beneficiaries of another medical scheme.

Section 9 MEDICAL FUND ACKNOWLEDGEMENT AND DECLARATION

1. Member's/dependant's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential.
2. Member/dependant information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes.
3. The Fund has granted access, to certain persons within the organisation and its contracted third parties, to a member's/dependant's personal and health information.
4. The Fund has data security measures in place, i.e. access control to members and dependants' information to authorised individuals, disaster and data recovery plans.
5. Confidentiality agreements between the Fund, its staff and its contracted third parties who will use the medical/health/diagnosis/procedure information provided for the purpose of processing the application for membership, reimbursment of claims, determining member/dependant entitlement to benefits, risk management practises, data transfer and management, scheme administration and managed care arrangements.
6. All staff within the Fund, its administrator and third party service providers is bound by internal confidentiality agreements.
7. In the event of a breach in confidentiality, the Fund assumes reponsibility and the breach will be managed according to the Fund's internal protocols.

I acknowledge that I have read and understood the content of this application form. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

All information declared on the application form will be kept confidential by the medical scheme.

Signed at _____

on this _____ day of _____ 20 _____

Signature of principal member _____

Chronic Medication Management

To apply for chronic authorisation, the member, doctor or pharmacist can call Chronic Medicine Management on 0860 100 608.

Alternatively, members, doctors or pharmacists may apply for chronic medication on-line by logging onto the Medscheme website (https://www.medscheme.co.za)