APPLICATION FORM

Profmed is an Authorised Financial Services Provider: FSP no. 43918
Attention: Profmed Membership Department
Fax: 012 679 4439 E-mail: applications@profmed.co.za

UNDERWRITING

PROFMED

INSTRUCTIONS
A copy of the principal member's identity document must be attached. Any incomplete or illegible information will result in further enquiries which could delay your application for membership. Membership is subject to the conditions, exclusions or limitations of benefits in accordance with the Medical Schemes Act and the Rules of the Scheme.

Requested inception date _____ / / (YYYY MM DD)

1. ELIGIBILITY

Profession _____ Are you retired? Yes ☐ No ☐

Are you a member of PPS Holdings Trust? Yes ☐ No ☐ If "Yes", state member number _____

If "No", please provide the following information: Degree(s) obtained _____

Name of university _____

Minimum duration of degree(s) _____

Other qualifications _____

NOTE: If your profession has a registering body or authority with which you are required to register before you may practice, please provide the following information:

Name of the registering body or authority _____ Are you registered? Yes ☐ No ☐ Your registration number _____

2. BENEFIT OPTION

Indicate with a ✓

ProPinnacle	ProSecure Plus	ProSecure	ProActive Plus	ProActive
☐	☐	☐	☐	☐

3. PERSONAL DETAILS (Please attach a copy of your ID document)

Language preference: English ☐ Afrikaans ☐

Title _____

Surname _____

Maiden name _____

First names _____

Gender: Male ☐ Female ☐ ID no. _____

Street address _____

_____

_____ Postal code

Postal address _____

_____

_____ Postal code

Telephone Work _____ Home _____ Cell _____

E-mail address _____ Fax no. _____

Gross salary of principal member each month R _____

Are you a government employee? Yes ☐ No ☐ If "Yes", please provide us with a copy of your latest salary slip.

4. REFUNDS

I hereby authorise Profmed to deposit any credits due to me into my bank account, as follows:

Name of bank _____ Branch name _____ Branch code _____

Account number _____ Type of account | Cheque | Transmission | Savings |

4.1 DEBIT ORDER INSTRUCTIONS FOR CONTRIBUTIONS

Debit order instruction is not necessary if the employer pays over the TOTAL membership fee from the member's salary. Contributions are deducted on the 1st of each month.

Name of account holder _____ Name of bank _____ Branch name _____

Branch code _____ Account number _____ Type of account | Cheque | Transmission | Savings |

Date _____ Signature of account holder _____

Please note: If your membership date is confirmed after the monthly debit order contributions have been raised, a double contribution will be deducted the following month.

5. DEPENDANT DETAILS

Surname	Full Names	Id Number	Relationship	Male	Female

6. DETAILS OF PREVIOUS MEDICAL SCHEME(S)

Please provide below the details of previous medical scheme membership and attach membership certificates of all previous medical schemes.

Name	Surname	Date of birth	Scheme & membership no.	Date from	Date to
				DD/MM/Y Y Y Y	DD/MM/Y Y Y Y
				DD/MM/Y Y Y Y	DD/MM/Y Y Y Y
				DD/MM/Y Y Y Y	DD/MM/Y Y Y Y
				DD/MM/Y Y Y Y	DD/MM/Y Y Y Y
				DD/MM/Y Y Y Y	DD/MM/Y Y Y Y

Attach additional information if space is insufficient.

7. WAITING PERIODS/LATE JOINER PENALTIES

Late joiner penalties will be applied in respect of persons over the age of 35 years who were without medical scheme cover for the period indicated hereunder:

1 — 4 years @ 5% x the relevant contribution
5 — 14 years @ 25% x the relevant contribution
15 — 24 years @ 50% x the relevant contribution
25+ years @ 75% x the relevant contribution.

To avoid a late joiner penalty, please provide proof of your membership of all previous medical schemes. General and/or condition-specific waiting periods will be imposed if you do not have proof of sufficient medical cover over the previous 24 months.

NOTE: It is illegal to belong to more than one medical scheme simultaneously.

8. DETAILS OF YOUR GENERAL PRACTITIONER

Name _____ Telephone _____

9. MEDICAL QUESTIONNAIRE

The following section is extremely important. Any misstatement in, or omission from this form, may lead to refusal to admit any claims for treatment given, suspension or termination of membership. It is essential to declare all conditions/illnesses/symptoms, no matter how insignificant they may seem. If the space provided below is insufficient, please attach additional information to the application form. Disclosure is not limited to the example conditions cited below. Related, consequent and suspected conditions and symptoms must also be disclosed. Should a new medical condition arise or be diagnosed between the time of completing this form and inception date of membership, please inform the Scheme accordingly.

Did you or any of your dependants suffer from any of the following diseases or medical conditions or disorders during the past 12 months, or receive treatment, advice and/or medication for any of them? (*Please tick the applicable box(es).*)

1. Any blood disease or condition (e.g. anaemia, haemophilia)?	
2. Any psychological or psychiatric disease or condition (e.g. depression, anxiety, neurosis, tension)?	
3.1 Any neurological disease or condition (e.g. epilepsy, fainting, paralysis, stroke, Alzheimer's, Parkinson's, multiple sclerosis, attention deficit disorder)?	
3.2 Any migraines?	
4. Any transmissible disease (e.g. Hepatitis B, Hepatitis C)?	
5. Any disease/affection of the skin (e.g. acne, eczema, psoriasis)?	
6. Any affection of the bone system and/or joints (e.g. osteoporosis, rheumatism, gout, arthritis, back problems, hip problems, knee problems)?	
7. Any affection of the muscular system (e.g. muscular dystrophy)?	
8. Any affection of the heart or blood circulation system (e.g. hypertension, coronary heart disease, chest pains, irregular heartbeat, rheumatic fever, heart failure, valve lesions)?	
9. Any affection of the chest or respiratory system (e.g. asthma, bronchitis, chronic cough, TB or other lung diseases)?	
10. Any affection of the digestive system, liver and gallbladder (e.g. gastric ulcers, hernia, poor digestion, gallstones, spastic colon)?	
11. Any affection of the urinary system and/or sex organs (e.g. bladder infection, nephritis, kidney stones, prostatitis)?	
12.1 Any affection/disorder of the eyes (e.g. cataracts, glaucoma)?	
12.2 Any affection of the ears, nose or throat, irrespective of whether it is congenital or developed later (e.g. deafness)?	
12.3 Any affection/disorder of the teeth or gums?	
13.1 Any metabolic condition (e.g. Gaucher's disease, porphyria)?	

13.2 Diabetes mellitus?	
13.3 High cholesterol?	
13.4 Any condition of the thyroid gland?	
14. Any cancer, malignant or pre-malignant tumours?	
15. Any other physical disease/condition, irrespective of whether it is congenital or developed later (e.g. spasticity, cleft palate)?	
16. Do you suffer from chronic sinusitis?	
17. Any affection of the female organs (e.g. womb, ovaries, abnormal Pap smears, breasts, endometriosis)?	
18. Varicose veins?	
19. A disease or condition for which you or any of your dependants have received a gratuity, pension, pay-out and/or guaranteed medical treatment from the Compensation Commissioner, Department of War Pensions or arising from the Motor Vehicle Insurance Act during the past 24 months?	
20. Is any female member/dependant currently pregnant? If so, provide expected date of confinement below.	
21. Do you or any of your dependants suffer from any chronic disease for which you and/or your dependants have to use chronic medication?	
22.1 Are you aware of any existing condition(s) that may require medical or surgical treatment within the next 12 months?	
22.2 Are you or any of your dependants currently undergoing any other medical and/or surgical treatment?	
22.3 Did you or any of your dependants undergo any medical and/or surgical treatment during the last 12 months?	
23. Were you or your dependants subjected to any waiting periods, exclusions or penalties by your previous medical scheme?	

If you ticked any of the questions in the medical questionnaire above, please provide full details below. Attach additional information if this space is insufficient.

Question number	Name of patient	Type of illness	Date diagnosed	Date of last treatment	Treatment and/or medication used
			DD/MM/Y Y Y Y	DD/MM/Y Y Y Y	
			DD/MM/Y Y Y Y	DD/MM/Y Y Y Y	
			DD/MM/Y Y Y Y	DD/MM/Y Y Y Y	
			DD/MM/Y Y Y Y	DD/MM/Y Y Y Y	
			DD/MM/Y Y Y Y	DD/MM/Y Y Y Y	
			DD/MM/Y Y Y Y	DD/MM/Y Y Y Y	
			DD/MM/Y Y Y Y	DD/MM/Y Y Y Y	

10. DECLARATION BY APPLICANT

I am applying for benefits from Profmed and warrant and declare that the information given and statements made herein, whether entered on the form by me or on my behalf, are correct and complete in every respect.

I declare that in the event of any amount being paid by the Scheme arising out of injuries which may involve a claim against any other party, I undertake to refund the Scheme the whole amount relevant to medical expenses incurred by the Scheme as may be recovered from any other source.

I hereby authorise any medical practitioner or other person and/or the administrator of Profmed, who may be in possession of or may acquire any information concerning my health or that of my dependants, to disclose the information to Profmed, and agree that compliance with this authorisation shall be a condition precedent to payment of any benefits by the Scheme.

I hereby consent to the disclosure by Profmed from time to time of any information including, without restriction, the generality thereof, personal, commercial, medical or general information provided by me to Profmed from time to time and any information obtained pursuant to this application. Any disclosure shall only be made in fulfillment of the legal obligations of Profmed and its administrator, managed healthcare providers or any organisation acting on behalf of Profmed.

I acknowledge that acceptance of this application shall be conditional upon there having been no deterioration in the state of my health or that of my dependants between the date of completion of the application and the date of acceptance of membership. I undertake, on acceptance of my application, to advise Profmed of any such deterioration.

I agree that this declaration shall be the basis of the contract for benefits from Profmed. I also agree that should any information be incorrect, inexact or incomplete, the contract shall be null and void and all money paid to the Scheme shall be forfeited. I agree to abide by the rules of the Scheme, as amended from time to time.

I understand that acceptance of my membership of Profmed is subject to the eligibility criteria.

Profmed may deal with me electronically and may treat electronic communication (e-mail, fax, telephone, etc.) as being the same as written authority and confirmation. I agree further that where I choose to use electronic methods to transact with Profmed, that I will carry the risk of such use.

Should Profmed not apply underwriting conditions to my application, I accept membership of Profmed without further notification.

10.1 FINANCIAL ADVICE

My decision to join Profmed, and my choice of benefit option, is based on:
Please tick the appropriate box.

☐ The advice received from a Profmed consultant, (name) _____ ; or

☐ The advice received from my independent broker, (name) _____ ; or

☐ My own consideration of my personal requirements, and those of my dependants. I have not received advice from or been influenced in any way by a Profmed consultant or independent broker. I acknowledge the risk that my decision could be inappropriate to my circumstances, needs or objectives without having obtained a full healthcare needs analysis.

_____	_____	_____
Signature of applicant	Witness	DD / MM / YYYY Date

11. DETAILS OF LICENSED PROFMED BROKER

Surname _____ Initials _____

Profmed broker number _____ Business/company name _____

Signed at _____ this _____ day of _____ 20_____

_____
Signature of Profmed broker