

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 cholesterol, 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	
			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 colitis, diverticulitis 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	
			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	
			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	
			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	
			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		
			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		
			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		
			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 He / she has been your doctor for years

Section 6 PREVIOUS MEDICAL SCHEME INFORMATION

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 your and / or your spouse / partner / adult dependants' membership of previous registered medical aid schemes. 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	d	d	m	m	y

Are you changing your medical scheme due a change in your 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 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 **Section 8 DECLARATION BY PRINCIPAL MEMBER – (must be completed)**

- 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.
- Should any of my or my dependants' circumstances after subsequent to the date of filling in this application, but prior to acceptance of my membership by Bonitas, I shall promptly notify Bonitas 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.
- 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.
- 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.
- Notwithstanding the above, I understand that it is my res-ponsibility as a member to ensure that the monthly contributions are received by Bonitas.
- 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' con-tributions 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 mem-bership whatsoever.
- 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.
- 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.
- 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.
- 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.

- I declare that my dependants are not beneficiaries of another registered medical scheme.
- I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:
 - 3 (three) month general waiting period in respect of all benefits;
 - 12 (twelve) month exclusion in respect of a pre-existing condition;
 - a late-joiner contribution penalty.
- I authorise and permit Bonitas to take all reasonable steps to verify information provided by me in this application form.
- I agree to submit proof of identification to Bonitas on demand.
- 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.
- 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.
- 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.
- As a government employee, I acknowledge that Bonitas Medical Fund will strictly adhere to PERSAL policies and procedures.
- As a direct paying member, I acknowledge that monthly contributions are payable in advance in accordance with the Rules of Bonitas Medical Fund.
- I hereby consent that all contact details given in Section 2 of this registration form 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).

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 registration form and the implications thereof have been read and explained to me.

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

Principal member's signature _____

Date