

Section 4 GOVERNMENT EMPLOYEES – Attach a current copy of your salary advice
 Peral number
Section 5 EMPLOYER INFORMATION – This section MUST be completed and signed by your employer

If you are an employee of a Private Company, submit your Application Form to your Human Resources/Salaries Department.
No Application Form will be processed without your Employer's Stamp.

 Name of employer

 Division number

 Dept. name

 Bonitas pay-point code

 Employee number

 Medical scheme start date

 Employment date

Dependants	Adult	Child	Non-subsidised
Total contribution	R	R	R

COMPANY STAMP

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the Scheme Rules and Plan chosen. All sections of the application form have been completed.

 Employer telephone number

 Employer fax number

 Employer e-mail address

 Name of medical scheme / salary administrator

 Designation

 Signature

 Date signed
Section 6 DETAILS OF PRINCIPAL MEMBER – Please leave a block between names
 Title Initials First name/s

 Surname

 Marital status

 Maiden name (if applicable)

 ID / passport number Gender Date of birth

 Telephone (H) Telephone (W)

 Cell Fax

 E-mail address

 Postal address

 Postal code

 Street address

 Postal code

 Tax number

 Number of dependants to be registered (include spouse, dependants and adult dependants)

 I wish to join the Scheme from
Please complete for statistical purposes
 Language

 Ethnic group

Section 7 DEPENDANTS YOU WISH TO REGISTER

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. Child rates will apply until the day the dependant turns 24 years of age. You are able to register six 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 certified copies of ID documents, marriage certificates, birth certificates and legal adoption or foster care court order documents.

1	Adult	<input type="checkbox"/>	Child	<input type="checkbox"/>	Title	<input type="text"/>	Initials	<input type="text"/>														
	Surname <i>(if different from principal member)</i>	<input type="text"/>																				
	First name/s	<input type="text"/>																				
	Relationship to principal member	<input type="text"/>				Gender	<input type="text"/> M <input type="text"/> F	Date of birth	<input type="text"/> d <input type="text"/> d <input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y													
	Marital status	<input type="text"/> Single <input type="text"/> Married <input type="text"/> Divorced <input type="text"/> Widowed <input type="text"/> Cohabiting																				
	Maiden name <i>(if applicable)</i>	<input type="text"/>																				
	ID / passport number	<input type="text"/>																				
	Tax number <i>(if applicable)</i>	<input type="text"/>																				
	Contact details <i>(if different from principal member)</i>																					
	Telephone	Home	<input type="text"/> c <input type="text"/> o <input type="text"/> d <input type="text"/> e <input type="text"/>			<input type="text"/>			Work	<input type="text"/> c <input type="text"/> o <input type="text"/> d <input type="text"/> e <input type="text"/>			<input type="text"/>									
	Fax	<input type="text"/> c <input type="text"/> o <input type="text"/> d <input type="text"/> e <input type="text"/>			<input type="text"/>			Cell	<input type="text"/>													
	E-mail	<input type="text"/>																				
	Postal or street address	<input type="text"/>																				
		<input type="text"/>											Postal code	<input type="text"/>								
Please complete for statistical purposes																						
	Language	<input type="text"/> English			<input type="text"/> Afrikaans			<input type="text"/> Other: specify _____			Ethnic group	<input type="text"/> Black			<input type="text"/> Coloured		<input type="text"/> Indian		<input type="text"/> White		<input type="text"/> Asian	

2	Adult	<input type="checkbox"/>	Child	<input type="checkbox"/>	Title	<input type="text"/>	Initials	<input type="text"/>														
	Surname <i>(if different from principal member)</i>	<input type="text"/>																				
	First name/s	<input type="text"/>																				
	Relationship to principal member	<input type="text"/>				Gender	<input type="text"/> M <input type="text"/> F	Date of birth	<input type="text"/> d <input type="text"/> d <input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y													
	Marital status	<input type="text"/> Single <input type="text"/> Married <input type="text"/> Divorced <input type="text"/> Widowed <input type="text"/> Cohabiting																				
	Maiden name <i>(if applicable)</i>	<input type="text"/>																				
	ID / passport number	<input type="text"/>																				
	Tax number <i>(if applicable)</i>	<input type="text"/>																				
	Contact details <i>(if different from principal member)</i>																					
	Telephone	Home	<input type="text"/> c <input type="text"/> o <input type="text"/> d <input type="text"/> e <input type="text"/>			<input type="text"/>			Work	<input type="text"/> c <input type="text"/> o <input type="text"/> d <input type="text"/> e <input type="text"/>			<input type="text"/>									
	Fax	<input type="text"/> c <input type="text"/> o <input type="text"/> d <input type="text"/> e <input type="text"/>			<input type="text"/>			Cell	<input type="text"/>													
	E-mail	<input type="text"/>																				
	Postal or street address	<input type="text"/>																				
		<input type="text"/>											Postal code	<input type="text"/>								
Please complete for statistical purposes																						
	Language	<input type="text"/> English			<input type="text"/> Afrikaans			<input type="text"/> Other: specify _____			Ethnic group	<input type="text"/> Black			<input type="text"/> Coloured		<input type="text"/> Indian		<input type="text"/> White		<input type="text"/> Asian	

Section 7 DEPENDANTS YOU WISH TO REGISTER – continued

5

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)

Contact details (if different from principal member)

Telephone Home c o d e Work c o d e

Fax c o d e Cell

E-mail

Postal or street address

Postal code

Please complete for statistical purposes

Language English Afrikaans Other: specify Ethnic group Black Coloured Indian White Asian

6

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)

Contact details (if different from principal member)

Telephone Home c o d e Work c o d e

Fax c o d e Cell

E-mail

Postal or street address

Postal code

Please complete for statistical purposes

Language English Afrikaans Other: specify Ethnic group Black Coloured Indian White Asian

Section 8 MEDICAL DETAILS

*Please note:
Failure to disclose 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
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

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
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

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
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

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
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Name of beneficiary	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

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	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

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	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

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

Yes	No
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Name of beneficiary	Expected delivery date	Attending doctor

Section 8 MEDICAL DETAILS – continued

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	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

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	Name of condition	Name of medication	Are you currently receiving treatment?		Date of treatment	Attending doctor
			Yes	No		
			Yes	No		
			Yes	No		

CURRENT DOCTOR

Name and surname

Telephone How many months / years has she / he been your doctor?

Please note

If you, or any of your dependants, have been prescribed chronic medication, contact Chronic Medicine Management on telephone number 0860 100 608; fax number 0800 223 670/680, or e-mail cmm@medscheme.co.za to register as a member on the chronic medicine management programme. Alternatively, visit www.medscheme.co.za to download a chronic medicine application form.

Section 9 BANK DETAILS OF PRINCIPAL MEMBER – Refund of claim and savings payments / debt order instruction

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

I instruct Medscheme to electronically collect contributions and to deposit claim and savings refunds, via the Electropay system, using the information provided below. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorise Medscheme to adjust any incorrect transactions and / or correct any electronic transfer of funds errors without prior notice.

<input type="checkbox"/> Use this account for member refunds	<input type="checkbox"/> Use this account for member refunds
<input type="checkbox"/> Use this account for contribution collections only	
Bank name _____	Bank name _____
Branch name _____	Branch name _____
Bank branch code <input type="text"/>	Bank branch code <input type="text"/>
Type of account <input type="button" value="Cheque"/> <input type="button" value="Transmission"/> <input type="button" value="Savings"/>	Type of account <input type="button" value="Cheque"/> <input type="button" value="Transmission"/> <input type="button" value="Savings"/>
Name of account holder _____	Name of account holder _____
Bank account number <input type="text"/>	Bank account number <input type="text"/>
Account holder's signature _____	Date <input type="text"/>

Section 10 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 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

Are you changing your medical scheme due to a change in your employment?

Yes No

Have condition-specific waiting periods, exclusions or late-joiner penalties ever been imposed by previous medical scheme/s on medical scheme applications by you, your partner / spouse or any of your dependants?

Yes No

Section 11 ACKNOWLEDGEMENT AND DECLARATION

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, 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.
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.
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).

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 _____

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