GEMAS Grintek Electronics Medical Aid Scheme

APPLICATION FOR MEMBER AND NEW DEPENDANT

New application: ☐ New dependants: ☐

First name/s: Membership number of individual:

Surname: Join date for dependant: D D / M M / 2 0 Y Y

Membership number:

Company employee number:

Date employment commenced: D D / M M / 2 0 Y Y

Date to be admitted to the Scheme: D D / M M / 2 0 Y Y

Please attach a certificate of membership from the previous Medical Scheme(s) to this application

SECTION 1 - EMPLOYER DETAILS

Group name: Group reference number:

SECTION 2 - PRINCIPAL MEMBER DETAILS

Member's surname: Gender: M F Race:

First name/s:

Title: Marital status: Nationality: Present age:

Date of birth: D D / M M / 2 0 Y Y ID/Passport number:

Member's postal address: Postal code:

Member's physical address: Postal code:

Member's contact details: Work: Home: Cell:

Email:

Occupation:

Monthly income (mark applicable column):

Group	A	B	C	D	E	F
Monthly income	R0 - R4 500	R4 501 - R6 000	R6 001 - R8 000	R8 001 - R10 000	R10 001 - R15 000	R15 000 +

SECTION 3A - DEPENDANT DETAILS (INCLUDING SPOUSE/ PARTNER)

No.	Gender	Race	First names & surname	Identity/Passport number	Relationship	Income p.m. R

Universal House,
15 Tambach Road, Sunninghill Park,
Sandton. Tel: 011 208 1000

Administered by:
UNIVERSAL HEALTHCARE ADMINISTRATORS (PTY) LTD
Reg. No. 1974/001443/07

Private Bag X1897,
Rivonia, 2128
Fax: 011 208 1028

SECTION 3B - ELECTRONIC TRANSFER INFORMATION

PERSONAL BANKING DETAILS
Electronic transfer of payments to you and collection of members portion's (co-payment's) where applicable.
CREDIT CARD ACCOUNTS NOT ACCEPTED

	PAYMENTS (Claims refunds)	COLLECTIONS (Members portions)
Name of account holder		
Account holders ID no		
Name of Bank		
Branch		
IBT number	- -	- -
Account number		
Type of account	Current Savings Transmission	Current Savings Transmission

DISCLAIMER: It is the member's responsibility to advise the administrator in writing of any change in banking details. Neither the scheme nor its administrators will be held liable should an incorrect account be credited under any circumstances.

I / We hereby authorise the Scheme to debit my / our bank account, the amount necessary for amounts owed by the member to the scheme to the maximum value of R500 or as arranged with the scheme.

Authorised signature / s	Date	Authorised signature / s	Date
Member's signature / s (if different from the authorised signature)	Date	Member's signature / s (if different from the authorised signature)	Date

SECTION 4A - MEDICAL DETAILS

Please complete all questions in full as non-disclosure of material information could prejudice future claims made by you and/or any of your dependants.

Please give the name of your general practitioner and/or specialist, you or any of your dependants have consulted recently.

Name of General Practitioner/ Specialist	Telephone number	Number of years consulted
	Code ( )	
	Code ( )	
	Code ( )	
	Code ( )	
	Code ( )	

SECTION 4B - MEDICAL HISTORY QUESTIONNAIRE

It is most important that the questions on the following page be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit. Please advise whether you or any of your dependants suffer from, or have suffered from, or received treatment/consultation for any of the following conditions. Please ensure that you underline the appropriate condition, tick and complete the appropriate block/s.Group reference number:

			Yes	No	Name of member/dep
1.	**Heart & Vascular System**	High blood pressure, high cholesterol, angina, heart attack, angiogram, previous coronary artery bypass, rheumatic fever, heart murmurs, valve problems/replacement, arrhythmias - insertion of pacemakers, heart failure, stroke, varicose veins, DVT's (deep vein thrombosis), pulmonary emboli.			
2.	**Lungs**	Asthma, emphysema, chronic bronchitis, TB, chronic infections - bronchitis & pneumonia.			
3.	**Digestive System, Gallbladder, Liver (psychological, psychosomatic problems)**	Dyspeptic disease (heartburn, hiatus hernia, peptic ulcers, reflux), irritable bowel syndrome (spastic colon, inflammatory bowel disease e.g. Crohn's & ulcerative colitis, chronic diarrhoea/ constipation), gallstones & jaundice, hepatitis, pancreatitis, haemorrhoids, incontinence, bowel prolapse.			
4.	**Nervous System**	Persistent headaches, epilepsy, paralysis, degenerative diseases - Alzheimer's, Parkinson's, multiple sclerosis, stroke, neuralgias, ADD (attention deficit disorder).			
5.	**Bone, Muscle & Joints**	Arthritis, rheumatism, gout, back or neck problems, fibromyalgia, previous fractures, deformities, degenerative muscle disease, osteoporosis, previous amputations/artificial limbs, birth defects, joint replacements.			
6.	**Urinary Tract**	Infections, stones, albumin/blood in urine, urinary incontinence, prolapsed bladder.			
7.	**Gynaecological System**	Menopause, female hormone replacement, irregular menses, infertility, breast tumours (benign/malignant), ovarian tumours, cysts, prolapsed uterus/rectum/bladder, miscarriage, caesarian section.			
8.	**Male Genital System**	Prostate problems (hypertrophy/cancer or infections), infertility, hernias - groin, scrotal swellings, testicular tumours, abnormalities of the penis.			
9.	**Gland/Hormonal**	Over/under active thyroid, diabetes mellitus, Cushings syndrome, Addison's disease, pituitary gland abnormality.			
10.	**Blood**	Anaemia, bleeding disorders (haemophilia), leukaemia, Hodgkin's disease.			
11.	**Ear, Nose & Throat**	Allergies (rhinitis, sinusitis), chronic infections (otitis, tonsillitis), nasal reconstruction, snoring, sleep apnoea, deafness - hearing aids.			
12.	**Eyes**	Poor vision, birth defects, degenerative disease (glaucoma, retinitis pigmentosa, cataracts, keratoconus), allergies - pteryguims, anticipated/previous laser surgery, artificial eyes.			
13.	**Emotional (psychological, psychosomatic problems)**	Depression, bipolar disorder, anxiety, stress, previous treatment for post traumatic stress syndrome, eating disorders - bulimia & anorexia, mental retardation, alcoholism, drug abuse.			
14.	**Infections/ Tropical Diseases**	Sexually transmitted diseases, genital warts, HIV/AIDS, hepatitis, ME-Virus (Yuppie Flu), malaria, bilharzias, cholera, typhoid.			
15.	**Skin Disorders**	Acne, eczema, psoriases, lesions (keloid hypertrophic scars), skin rashes, shingles, kaposi sarcoma - tumours.			
16.	**Connective Tissue Disorders**	Systemic lupus erythromatosis, scleroderma.			
17.	**Teeth & Gums**	Impacted molars (wisdoms), previous/current orthodontic treatment, braces, crowns, recurrent infections - gums.			
18.	**Cancer**	Cysts, growths, tumours of any kind.			
19.	**Allergies**	Are you or any of your dependants allergic to any specific type of medication (e.g. penicillin, asprin, sulphas, morphine, NSAIDS), pollen dust, animals, specific food types (e.g. nuts).			
20.	**Immuno-Suppressive Treatment**	Have you or any of your dependants ever had or expecting to undergo an organ transplant? Have you or any of your dependants ever suffered from any condition requiring Immunosuppressive treatment?			
21.	Have you or any of your dependents ever received any form of physiotherapy, occupational therapy or chiropractic treatment?				
22.	Are you or any of your dependants pregnant? If "yes" - how many weeks? Please give expected date of delivery.				
23.	Have you or any of your dependants had any previous or pending claims for which any other party may be liable e.g. MVA (Motor Vehicle Accident) claims? If "yes", please give details.				
24.	Are you or any of your dependants expecting to undergo any medical treatment, e.g. hospitalisation, operation, specialised dentistry etc, within the next twelve months?				
25.	Do you or any of your dependants have a chronic condition requiring ongoing medication? If "yes", please give the name and dosage of all the medication you or any of your dependants are currently taking.				
26.	Have you or any of your dependants ever received any medical attention of any nature, e.g., hospitalisation, operation, specialised dentistry etc, not mentioned above?				
27.	Have you or any of your dependants ever appeared before a medical board in view of early retirement and declared medically unfit?				

SECTION 4B - MEDICAL HISTORY QUESTIONNAIRE (continued)

If any of the questions on the previous page have been answered "Yes", please supply details below. If there is not enough space, please attach an additional page.

No	Member/ Dependant	Full details of the disorder, consulting doctor, type of medication and dosage used	Date of treatment	Degree of recovery

SECTION 5 - PREVIOUS MEMBERSHIP (COVERING PREVIOUS 2 YEARS)

To ensure continuous benefits, please attach a certificate of membership (from the previous medical scheme/s) to this application.

Name of previous medical scheme/s	Membership number	Date joined	Date terminated

SECTION 6 – GRINTEK ELECTRONICS MEDICAL AID SCHEME DECLARATION

1. Grintek Electronics Medical Aid Scheme, hereafter referred to as "the Scheme", confirms that your and your dependants' personal details and medical information shall be kept confidential and the Scheme shall take all reasonable steps to comply with the provisions of any legislation applicable to the protection of your and your dependants' personal information.

2. The Scheme confirms that your and your dependants' identifiable information (personal and health information) will neither be used for purposes of related company business nor sold for commercial purposes.

3. The Scheme confirms that it has data security measures in place, including restricted access to your and your dependants' data, data back-up systems and data recovery systems.

4. The Scheme shall take all reasonable steps to ensure that all staff within the Scheme and all third parties who have access to beneficiary information for the purpose of data transfer and management, scheme administration, managed care agreements and compliance with applicable legislation, keep the personal information of beneficiaries confidential and comply with applicable legislation.

5. The Scheme confirms it has granted access to certain persons within the Scheme and its contracted third parties to your and your dependants' personal and health information. The use of relevant personal information and/or personal health information provided is for the following purposes: verifying your identity; processing your application for membership; administration of your medical scheme membership; membership verification and eligibility checking; assessment, processing and reimbursement of claims for medical expenses; determining your entitlement to benefits; underwriting or risk assessments; providing relevant information to a healthcare provider who requires this information to provide a healthcare service to you or any of your dependants; providing managed care services to you or any of your dependants; sharing your information with service providers, including electronic switching houses, for the purpose of processing it and rendering services to you such as electronic submission of claims to us; risk management practices; fraud prevention and detection, audit and record keeping purposes; compliance with applicable legal and regulatory requirements; population of the beneficiary registry as required by the Council for Medical Schemes and the Department of Health; collection of monies owed by you or healthcare providers to us; statistical analysis (this will always be on an anonymous basis, which means that data about you that is relevant to the analysis is used but it is not linked to your name or membership number).

6. In the event of a breach of confidentiality, the Scheme shall assume responsibility if the Scheme is at fault and will manage the breach according to its internal protocols and disciplinary procedures.

7. The Scheme will ensure that underwriting is applied to all members in a consistent and equitable manner.

SECTION 7 - MEMBER ACKNOWLEDGEMENT AND DECLARATION

Please read the declarations below carefully. These contain acknowledgements of fact that may impact on your rights. These declarations must be read in conjunction with the rules of Grintek Electronics Medical Aid Scheme (hereafter referred to as "the Scheme"), and the Medical Schemes Act No. 131 of 1998 (hereafter referred to as "the MSA"), and all these provisions shall be binding on you and your dependants. **Please tick the boxes to acknowledge that you have read each declaration:**

1. I, the undersigned hereby apply for membership of Grintek Electronics Medical Aid Scheme and agree that all answers and information contained in this application completed by me or by any other person / s will be the basis of the proposed agreement. ☐
2. I warrant that the contents of this application are true, correct and complete. No cover will be granted unless Grintek Electronics Medical Aid Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void. ☐
3. I agree to abide by and undertake to familiarise myself with the rules of the scheme as amended from time to time and grant my employer the right to deduct from my remuneration any amounts (including members portions) outstanding by myself to Grintek Electronics Medical Aid Scheme. I further grant my employer the right to pay such monies over the scheme. ☐
4. I understand that the scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998). ☐
5. I agree to notify the scheme within 30 days in the event that any alternation in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk. ☐
6. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the scheme. Furthermore, I understand that I will be liable for any legal costs incurred in the recovery of any amount owing to the Scheme on the attorney and own client scale. ☐
7. I declare that neither the applicant nor any of his / her dependant / s are beneficiaries of another registered medical scheme, on the date of registration with Grintek Electronics Medical Aid Scheme. ☐
8. I understand that once I am enrolled as a member I may not terminate my membership voluntarily and that membership may only be terminated once I leave my current employment, or I am eligible to become a member of another medical scheme of which my spouse is a principal member. ☐
9. I hereby give the scheme permission to communicate to me by SMS or Email. ☐
10. I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the scheme from liability and subject my membership to cancellation. I warrant that I am authorised to sign on behalf of my dependant/s. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me. ☐
11. I also authorise any doctor or other person, who may be in possession of or hereafter acquire information about my health or the health of my dependants, to disclose the information to the Scheme and its contracted third parties, provided such information shall be treated as confidential at all times. I confirm that I have the required consent of my dependants to share information of such dependants with the Scheme and its contracted third parties. ☐
12. I understand that my confidential health and personal information will only be used for the purposes as outlined by the Scheme on the application form and any deviation from this constitutes a breach of confidentiality. ☐
13. In the event that the Scheme wishes to use my (or my dependants') confidential information for purposes other than those outlined in the application form, the rules of the Scheme and the MSA, the Scheme is required to obtain further consent from me (or my dependants). ☐
14. I agree to inform the Scheme of any changes in my or my dependants' personal status, as required by the Scheme rules, within 30 days of the change in circumstances. ☐

SECTION 7 - MEMBER ACKNOWLEDGEMENT AND DECLARATION (continued)

15. I shall ensure that the Scheme is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of my application for membership, the administration of my membership, payment of claims and communication by the Scheme with me. ☐
16. I acknowledge that my dependants and I may have access to our personal information held by the Scheme and request the Scheme to correct any inaccurate information as prescribed by applicable legislation. ☐
17. I further acknowledge that the personal information of my dependants and I shall be retained as part of the records of the Scheme for as long as it is required by the Scheme for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of applicable law. ☐
18. If any of my dependants or I have any concern about the processing of our personal information, we can raise the matter with the Scheme by contacting the Principal Officer. ☐
19. I agree that contribution late joiner penalties may apply to my adult dependants 35 years and older if they have not been a member or a dependant of any previous medical scheme(s) or existing dependant at time of registration. ☐
20. I consent to all conversations between myself and the Scheme or its contracted third parties being recorded. ☐
21. I confirm that I have received a copy of the current Member Benefit Guide and understand the contents therein. ☐
22. I confirm that I am familiar with the terms of this agreement, being the conditions, limits and benefits of the Scheme. ☐
23. I hereby guarantee that as the main member of the Scheme, to the extent that it may be required by law, that I have received the necessary consent from my dependants to access and view their healthcare claims made on my membership and deal with all matters relating to their claims on my membership as set out in this section. ☐

Signature of applicant _____ Date _____

SECTION 9 - EMPLOYER

We certify that the Applicant is on our permanent staff.

Contribution group: | D | D | / | M | M | / | 2 | 0 | Y | Y |

Employer's name:

_____ Employer's signature

_____ Date

Company stamp

This application form has been scrutinised, and we are not aware of any facts other than those stated which should be made known to the Scheme.