

APPLICATION FORM

Attention: Profmed Membership Department
Fax: 012 679 4439 E-mail: applications@profmed.co.za



UNDERWRITING

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 _____ / _____ / _____
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1. ELIGIBILITY

Profession _____ Are you retired? Yes No

Are you a member of PPS Limited? 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 ✓ ProActive ProActive Plus ProSecure ProSecure Plus ProPinnacle

3. PERSONAL DETAILS (A copy of ID document must be attached for processing)

Language preference Eng Afr

Title: e.g. Mr/Ms _____

Surname _____

Maiden name _____

First Names _____

Known as _____ Gender: Male Female ID No. _____

Street address domicilium citandi et executandi _____ Postal address _____

Postal Code _____ Postal Code _____

Telephone Code Work _____ Code Home _____ Cell _____

E-mail address _____ Fax No. Code _____

Gross salary of principal member per month **R** _____

Billing frequency: Monthly Quarterly Half-yearly Annually Quarterly, half-yearly and annual payments only available for cash, cheque and electronic transfers

4. REFUNDS

I hereby authorise Profmed to deposit any credits due to me into my bank account. (Please complete your banking particulars.)

Name of bank _____ Branch name _____ Branch code _____

Type of account Cheque Transmission Savings Account number _____

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.

Name of account holder _____ Name of bank _____ Branch name _____
 Branch code _____ Type of account Cheque Transmission Savings Account number _____

Deduct my membership contributions monthly on the 1st of each month.

Date _____ Signature of account holder _____

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

5. DEPENDANT DETAILS

SURNAME	FULL NAMES	ID NUMBER	RELATIONSHIP	Male	Female

6. 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 symptom 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? MARK WITH A "✓"

	YES	NO		YES	NO
1. Any blood disease or condition (eg. Anaemia, haemophilia)?			13.2 Diabetes mellitus?		
2. Any psychological or psychiatric disease or condition (eg. Depression, anxiety, neurosis, tension)?			13.3 High cholesterol?		
3.1 Any neurological disease or condition (eg. Epilepsy, fainting, paralysis, stroke, Alzheimer's, Parkinson's, multiple sclerosis, attention deficit disorder)?			13.4 Any condition of the thyroid gland?		
3.2 Any migraines?			14. Any cancer / malignant / pre-malignant tumours?		
4. Any transmissible disease (eg. Hepatitis B, hepatitis C)?			15. Any other physical disease/condition, irrespective of whether it is congenital or developed later (eg. Spasticity, cleft palate)?		
5. Any disease / affection of the skin (eg. Acne, eczema, psoriasis)?			16. Do you suffer from chronic sinusitis?		
6. Any affection of the bone system and/or joints (eg. Osteoporosis, rheumatism, gout, arthritis, back problems, hip problems, knee problems)?			17. Any affection of the female organs (eg. Womb, ovaries, abnormal pap smears, breasts, endometriosis)?		
7. Any affection of the muscular system (eg. Muscular dystrophy)?			18. Varicose veins?		
8. Any affection of the heart or blood circulation system (eg. Hypertension, coronary heart disease, chest pains, irregular heartbeat, rheumatic fever, heart failure, valve lesions)?			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?		
9. Any affection of the chest or respiratory system (eg. Asthma, bronchitis, chronic cough, TB or other lung diseases)?			20. Is any female member/dependant currently pregnant? If "YES", provide expected date of confinement.		
10. Any affection of the digestive system, liver and gallbladder (eg. Gastric ulcers, hernia, poor digestion, gallstones, spastic colon)?			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?		
11. Any affection of the urinary system and/or sex organs (eg. Bladder infection, nephritis, kidney stones, prostatitis)?			22.1 Are you aware of any existing condition(s) that may require medical or surgical treatment within the next 12 months?		
12.1 Any affection/disorder of the eyes (eg. Cataracts, glaucoma)?			22.2 Are you or any of your dependants currently undergoing any other medical and/or surgical treatment?		
12.2 Any affection of the ears, nose or throat, irrespective of whether it is congenital or developed later (eg. Deafness)?			22.3 Did you or any of your dependants undergo any medical and/or surgical treatment during the past 12 months?		
12.3 Any affection/disorder of the teeth or gums?			23. Were you or your dependants subjected to any waiting periods, exclusions or penalties by your previous medical scheme?		
13.1 Any metabolic condition (eg. Gaucher's disease, porphiria)?					

If you answered YES to any of the questions in the medical questionnaire (6), please give full details. 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/YYYY	DD/MM/YYYY	
			DD/MM/YYYY	DD/MM/YYYY	
			DD/MM/YYYY	DD/MM/YYYY	
			DD/MM/YYYY	DD/MM/YYYY	



PROFMED

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TO BE COMPLETED BY GOVERNMENT EMPLOYEES ON PERSAL

Deduction and pay-over authorisation

Employee's Name
(Title, First Name/s, Surname)

Persal/Salary No. Identity No.:

Occupation

Name of Employer Department

Dept./Org. Code Pay point No.

Total Monthly Contributions R

(Note claims will not be paid out until the first premium is received)

Starting date (for salary deductions)

Medical Aid Number (Issued by PROFMED)

I, the undersigned, hereby authorise my above-mentioned employer/department to deduct my share of the total monthly contribution and any future adjustment thereto that may be due by me in terms of the Scheme's rules, and pay it over to the PROFMED (Deduction Code: 0118/Table 057) on my behalf until such time that I cancel this authorisation in writing or substitute it with a new one. I hereby accept that a written notice of three months must be given for the termination of my membership.

Employee's Signature: _____ Date: _____

MUST BE ACCOMPANIED BY A HANDWRITTEN CANCELLATION REQUEST FROM MEMBER

**Request by Government Employee to PROFMED
to cancel membership of previous medical scheme**

The Paymaster

Dear Sir/Madam, I hereby request that PROFMED cancels my membership of the following Medical Scheme on my behalf:

Medical Scheme Name

Membership No.

Resignation Date
(Last date of benefits)

Full Names and Surname

ID Number

PERSAL No

Thank you for your assistance.

Signature: _____ Date: _____