PLEASE COMPLETE AND RETURN TO YOUR CFO/HR OFFICER

OFFICE USE
Member Number:

New Application and Medical Disclosure Form

Thank you for applying to become a member of SEDMED. This Medical Disclosure Form is to be completed by all new entrants to SEDMED.

Important to take note of:
In order to protect the interests of existing members of the SEDMED, the trustees have introduced a procedure whereby they reserve the right to restrict or exclude benefits for those new entrants with a ***known*** *prior existing condition, for a maximum period of 12 months. This questionnaire must be completed in order to assess your and your dependant's(s') eligibility for benefits under SEDMED. The information provided in this form will be available to SEDMED and will not be disclosed to any other person without the member's and/or beneficiary's (where over the age of 18 years) consent.*

A. About yourself (principal applicant):

Title:
Full name(s):
Surname:
Postal address:
Physical address:
Date of birth:
ID number:
E-mail address (for SEDMED to communicate with you):
Landline (daytime): **Cell phone no.:**
Date joining SEDMED (dd/mm/yyyy):
Is your spouse employed at any of the business units within the Group? **If Yes: Is he/she already a registered member of SEDMED?**

Principal Applicant's Banking Details:

Account holder (name and surname):
Bank:
Branch (name): **Branch code:**
Type of Account (eg: cheque, savings, transmission):
Account number:

B. About your spouse *(if you are applying for membership for him/her)*

Title:
Full name(s):
Surname:
Maiden name:
Date of birth:
ID number:
E-mail address (for SEDMED to communicate with you):
Landline (daytime): **Cell phone no.:**
Date joining SEDMED (dd/mm/yyyy):

Confirmation of marriage

If you are legally married then please attach a copy of your marriage certificate.

C. About your Child Dependant(s) *(if you are applying for membership for him/her/them)*

Please note:

A child may be registered as a dependant, provided:

a) The child is the natural child, legally adopted child, stepchild, legally fostered child (for the placement period only) of the principal applicant and/or spouse.
b) The child is under the age of 21 years AND not earning a regular income.
c) The child is a full time student under the age of 26 years (valid proof of registration as a full time student at a recognised institution is required)
d) The child is physically and/or mentally disabled (proof of such disability is required)

Child Dependant no. 1

Title:
Full name(s):
Surname:
Date of birth:
ID number:
Relationship to the Principal Applicant:
Date joining SEDMED (dd/mm/yyyy):

Child Dependant no. 2

Title:
Full name(s):
Surname:
Date of birth:
ID number:
Relationship to the Principal Applicant:
Date joining SEDMED (dd/mm/yyyy):

Child Dependant no. 3

Title:
Full name(s):
Surname:
Date of birth:
ID number:
Relationship to the Principal Applicant:
Date joining SEDMED (dd/mm/yyyy):

Child Dependant no. 4

Title:
Full name(s):
Surname:
Date of birth:
ID number:
Relationship to the Principal Applicant:
Date joining SEDMED (dd/mm/yyyy):

D. Health questionnaire and declaration

Please circle your answer

Has any proposal for life assurance ever been declined, deferred or accepted with certain restrictions, e.g. a premium loading, etc.? If so, state full particulars. _____	***YES***	***NO***

1. Medical history Do you or any of the dependants for whom you are applying for membership suffer from, been or being treated for, or have you ever had, any of the following? If YES, please state full details of each instance in the schedule following question 1.13.		***YES***	***NO***
1.1	Disorder of the heart, e.g. rheumatic fever, heart murmur, shortness of breath, palpitations, chest pain, angina pectoris or coronary thrombosis?	***YES***	***NO***
1.2	High blood pressure, disease of the blood vessels or circulatory disorder, e.g. cramps in the calves with exercise or walking, stroke, etc.?	***YES***	***NO***
1.3	Respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough, tuberculosis, etc?	***YES***	***NO***
1.4	Disorder of the digestive system, gall bladder, pancreas or liver, e.g. gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, rectal bleeding, piles or jaundice, etc?	***YES***	***NO***
1.5	Disease or disorder of the kidneys, bladder or reproductive organs, e.g. protein in urine, kidney stones, prostatitis, cystitis, etc?	***YES***	***NO***
1.6	Nervous or mental disorder, e.g. epilepsy, blackouts, paralysis, anxiety state or depression, etc?	***YES***	***NO***
1.7	Eye, ear, nose or throat disorder, e.g. defective vision, loss of hearing, ear discharge, hoarseness, etc?	***YES***	***NO***
1.8	Disorder or disease of skin, muscles, bones, joints, limbs or spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble, etc?	***YES***	***NO***
1.9	Diabetes, sugar in urine, thyroid or other glandular or blood disorders, cancer, growth or tumour of any kind?	***YES***	***NO***
1.10	Any tropical disease, e.g. bilharzia or malaria, etc?	***YES***	***NO***
1.11	Any other illness, disorder, operation, disability or accident relating to yourself?	***YES***	***NO***
1.12	Any specialist dental treatment, e.g orthodontic, periodontic, prosthodontic or maxillo-facial procedures or treatment for impacted wisdom teeth?	***YES***	***NO***
1.13	Are your and your dependants' teeth and mouth cavity healthy? If NO, please state full details below.	***YES***	***NO***

If you have answered YES (or no ito 1.13) to any of the questions above, please supply further details below:

If the space provided is insufficient, please attach the required information to the questionnaire.

Patient name	Nature, duration and severity of complaint or symptoms / medical diagnosis	Date first diagnosed	Name and telephone no. of attending doctor or hospital	When did you last have symptoms / treatment?

2. Tests and examinations *(mainly relating to the past 12 months)* Have you or any of the dependants for whom you are applying for membership suffer from, been examined for, been tested for or have you ever had, any of the following? If YES, please state full details of each instance in the schedule following question 2.7.		
2.1 HIV/AIDS or an AIDS-related condition?	***YES***	***NO***
2.2 Any sexually transmitted disease, including hepatitis B?	***YES***	***NO***
2.3 If not already stated, have you or any of the dependants during the past 12 months		
- had any X-rays, ECGs, other examinations or operations, or been hospitalised?	***YES***	***NO***
- taken any course of sedatives, tranquillisers or drugs for medical or other reasons? Please state present or past medication, dosage and reason for use.	***YES***	***NO***
- consulted any doctors or specialists, including regular general check-ups?	***YES***	***NO***
2.4 Recurrent headaches, colds, faintness, dizziness or any similar conditions?	***YES***	***NO***
2.5 Planning to undergo any form of medical treatment in the near future?	***YES***	***NO***
2.6 Received advice, counselling or treatment for alcoholism or drug dependency?	***YES***	***NO***
2.7 Been involved in an MVA (motor vehicle accident), sustained an injury on duty or contracted a work-related disease?	***YES***	***NO***

If you have answered YES to any of the questions above, please supply further details below:
If the space provided is insufficient, please attach the required information to the questionnaire.

Patient name	Exact nature of examinations, consultations and treatment	Date first diagnosed	Name and telephone no. of attending doctor or hospital	Results of examinations and date of last symptoms

3. Your usual Medical Attendant(s) details:

Name, address and contact telephone number of usual medical attendant:

_____

_____

State for how long he/she has been your/your dependants' doctor _____

4. Regular, on-going Medication:		
Have you or any of the dependants taken any medication prescribed on an ongoing or a recurrent basis in the last 12 months?	***YES***	***NO***

If you have answered YES, please supply full details below:

Patient name	Name of medication	Condition for which this is prescribed	Treating doctor's name and telephone number

5. Weight and height

	Principal Applicant	Spouse/partner	Child 1	Child 2	Child 3
5.1 Current weight? (kg)					
5.2 Current height? (m and cm)					

5.3 Has your or your dependants' weight been constant? If not, please provide reasons.

_____

6. Habits		
6.1 Do you or any of your dependants consume alcohol?	***YES***	***NO***

6.2 If you answered YES to 6.1 above, please provide details, as follows:

- who? (name of applicant)_____
- what kind of alcohol?_____
- Quantity consumed per day?_____
- Quantity consumed per week? _____

6.3 Have you or any of your dependants habitually taken more in the past or had an alcohol problem?
If YES, please state full details, including any treatment

_____

6.4 Have you or any of your dependants ever received medical advice to reduce or discontinue your liquor consumption?
If YES, please state full reasons_____

_____

6.5 Do you or any of your dependants smoke?
If YES,
- who? (name of smoker(s))_____
- what is the amount that you (each) smoke each day?_____

6.6 If you stopped smoking, what was the reason you stopped?_____

If you smoked in the past, when last have you smoked?_____

6.7 Have you ever received medical advice to reduce or discontinue smoking?
If YES, please state full reasons_____

_____

7. For female applicants/dependants only

Do you have, or have you ever had, any disorders of the female organs (breast, ovaries, uterus) or any abnormalities of pregnancy or confinement, e.g. Caesarean or miscarriage? If YES, please state full details including dates.

_____

Are you pregnant? | Yes | No | ____months. When was your last child born?_____

8. Previous medical aid membership details

1. Name of scheme(s): _____

   Duration of membership(s): From: _____until:_____

   Who was registered on the membership (if not all the applicants): _____

   Reason for leaving: _____

2. Name of scheme(s): _____

   Duration of membership(s): From: _____until:_____

   Who was registered on the membership (if not all the applicants): _____

   Reason for leaving: _____

3. Name of scheme(s): _____

   Duration of membership(s): From: _____until:_____

   Who was registered on the membership (if not all the applicants): _____

   Reason for leaving: _____

9. Permission and Declaration by applicant/new member

9.1 I _____ (full name and surname of the member) declare and warrant that this Personal Statement is complete and true and furthermore that I understand and agree that this statement and any other relevant documents shall be the basis of the proposed eligibility for benefits from SEDMED. I understand that my membership and claims processed to date may be cancelled without repayment of contributions if it is found that I have made a false declaration.

9.2 I hereby irrevocably authorise and request any medical practitioner, person or institution that is in possession of or may at a later stage obtain information (including results of any blood tests) regarding my physical and mental health/habits or those of any of my dependants, to disclose such information to SEDMED – also after my death.

9.3 I agree that the existing Rules of SEDMED, and amendments thereof, where applicable, are binding on me.

9.4 SEDMED will keep my information and the information about those whom I apply for confidential.

9.5 SEDMED may only share my personal and health information or the information of any dependant if it is requested by a third party who I have already given my consent to for the disclosure of this information. If SEDMED wants to share my information for any other reason, they will do so only with my permission.

9.6 SEDMED may collect, collate, process and store my and all my dependants' personal information, including health information, as provided in this application and any information SEDMED get about me and my dependants whilst a member:

- for the administration of my membership and benefits;
- for providing any managed care services that me or any dependant on my membership may need;
- for providing relevant information to a contracted third party who needs information to provide a healthcare service to me or any dependant on my membership; and
- to profile and analyse any risk to SEDMED.

Signed at _____ this _____ day of _____ 20____

Signature of the Applicant/Member _____

Signatures of all adult dependants (21 years and older): 1._____

2._____

3._____

4._____

TO BE COMPLETED BY THE CFO/HR OFFICER:

Name of the employer:
Applicant/new member's employee number:
Employer's address:
Employer contact person (name and surname):
Employer contact telephone no. (for person named directly above):
Authorised signatory (name and surname):
Signature: ***Date:***