HORIZON MEDICAL SCHEME

Administered by Medscheme Holdings (Pty) Ltd: PO Box 1101, Florida Glen, 1709.
Tel: 0860 101 103, Email: horizonmembership@medscheme.co.za

Application for Membership

PLEASE COMPLETE DIGITALLY

INSTRUCTIONS: It is imperative that all sections of the application form be completed fully. Failure to ensure that all information is reflected on the form will cause unnecessary delays in the processing of the document as incomplete forms will be returned.

Ensure that you include a completed Medical History Form with this application, if applying more than 30 days after date of employment.

A. APPLICANT'S INFORMATION

Surname:

First names:

Identity number: *(Copy of ID is required)*

Passport number: Country of issue:

Nature of person: ☐ Individual ☐ Foreign individual ☐ Individual estate (Including late estate)

Date of birth: *(DD/MM/YYYY)* SARS tax number:

Gender: ☐ Male ☐ Female

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Other – Please specify:

Marital status: ☐ Single ☐ Married ☐ In life partnership

Contact details: Home Work

Cell

Email

Postal address:

Residential address:

B. EMPLOYMENT DETAILS (TO BE COMPLETED BY EMPLOYER)

Employer name:

Employee number: Date of employment: **(COMPULSORY)** *(DD/MM/YYYY)*

HR/Payroll name: E-mail address:

Contact details:

Date of entry: *(DD/MM/YYYY)*

Date completed: *(DD/MM/YYYY)* Signature:

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C. PLAN OPTION (Please consult your Employer before indicating your Plan option)

Select Plan of your choice from the list below

- ☐ **461** Hospital Core Plan
- ☐ **462** Hospital plus Network Plan
- ☐ **463** Hospital plus Savings Plan

D. BANK DETAILS FOR DIRECT CREDIT OR REFUND

Bank name:

Branch name & town:

Branch number: Account type: ☐ Current ☐ Savings ☐ Transmission

Account number:

Account holder name:

I hereby request and authorise you to credit any Medical Aid benefits which may accrue to me to the account mentioned above.

Signature: Date: *(DD/MM/YYYY)*

E. DEPENDANT INFORMATION

SEE ANNEXURE E1 FOR DEPENDANT CLASSIFICATION AND PROOF REQUIRED.

Please complete the MEDICAL HISTORY ANNEXURE and attach it to your Application Form.

Surname	**First name(s)**	**ID number or Date of birth**	**Gender M / F**	**Relationship to the applicant** (e.g. wife, child)
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	

Medical History Annexure

PLEASE COMPLETE IN BLOCK LETTERS

MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please complete all the required information by ticking the correct box. If the answer to any question is "YES", please provide details in Section B in respect of you and your dependants. I understand that if I do not provide full details about all the medical conditions known to me at the time of this application, or before acceptance of this application, my membership will be declared null and void.

		YES	NO
1	Are you or any of your proposed dependants currently pregnant? If so how many months?	☐	☐
	Number of months ☐ Name and surname of person ☐		
2	Have you or any of your dependants ever had any of the following?		
2.1	Any disorder of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	☐	☐
2.2	High blood pressure or disease of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder)?	☐	☐
2.3	Any respiratory or lung trouble (e.g. asthma, bronchitis, persistent cough, tuberculosis)?	☐	☐
2.4	Any disorder of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, Hepatitis B or persistent diarrhoea)?	☐	☐
2.5	Any disease or disorder of kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)?	☐	☐
2.6	Any nervous or mental complaint (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety state or depression)?	☐	☐
2.7	Any ear, eye, nose or throat disorder (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment, chronic sinusitis)?	☐	☐
2.8	Any disorder or disease of muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)?	☐	☐
2.9	Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder?	☐	☐
2.10	Any lumps, growths (benign or malignant), types of cancers (including Hodgkins and Leukaemia), skin cancers or skin disorders?	☐	☐
2.11	Any tropical disease (e.g. bilharzia, malaria, cholera)?	☐	☐
2.12	Any other condition, illness, disease, disorder, disability or accident which required medical, radiological, surgical, pathological or dental investigations during the past twelve months?	☐	☐
2.13	Been tested for or received or expect to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or any AIDS-related condition or any sexually transmitted disease (e.g. Hepatitis B, Gonorrhoea or Syphilis)?	☐	☐
3	Have or are you or your dependants receiving surgical, medical, major dental (implants), chiropractic, optical or gynaecological treatment, procedures, advice or tests?	☐	☐
4	Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause?	☐	☐
5	Do you or any of your dependants currently use medication on a daily basis?	☐	☐
6	Has your weight or the weight of your dependents changed by more than 5kg in the last 12 months? If so, why?	☐	☐
7	Do you or any of your dependants suffer from any other ailment or disease at present?	☐	☐
8	Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire relating to past or present diseases, accidents, operations or other conditions including pregnancy for which advice has been sought or treatment has been received or recommended during the past 5 years?	☐	☐
9	Are you or any of your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months?	☐	☐

ADDITIONAL MEDICAL INFORMATION		1	2	3
Question number:				
Name of person suffering from the illness:				
Type of illness/condition (diagnosis):				
Date on which the illness began:				
Frequency of attacks (hourly/daily/weekly/monthly):				
Date of last attack:				
If hospitalised, when and for how many days:				
Duration of illness or condition:				
Treatment and/or type of medication received in the past:	Treatment			
	Medication			
Current treatment and/or type of medication received:	Treatment			
	Medication			
Approximate monthly cost of treatment/ medication:	Treatment			
	Medication			
Details of operation(s) previously performed:				
Operation(s) and/or treatment needed in future:				
Name of attending doctor:				

PREVIOUS MEDICAL SCHEME HISTORY (Please attach copies of all previous Medical Scheme Certificates)

Are or were you or any of your nominated dependants, beneficiaries of a registered Medical Scheme(s)?

☐ Yes ☐ No

If "YES", a certificate(s) of membership per beneficiary (not membership cards) from the previous medical scheme(s) must accompany this application. The entry date as well as the cancellation date must be indicated on the certificate.

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ANNEXURE E1. DEPENDANT CLASSIFICATION AND PROOF REQUIRED

Definition of Dependant	Document(s) required
Spouse	Marriage certificate and I.D.
Natural child	I.D. or Birth certificate required (If > 21 and a student, proof of study)
Stepchild	Affidavit required and I.D. or Birth certificate (If > 21 and a student, proof of study)
Adopted child	Affidavit required and I.D. or Birth certificate (If > 21 and a student, proof of study)
Grandchild	Affidavit required and I.D. or Birth certificate (If > 21 and a student, proof of study)
Foster child	Affidavit required and I.D. or Birth certificate (If > 21 and a student, proof of study)
Traditional spouse	Affidavit required and I.D.
Polygamous spouse	Affidavit required and I.D.
Parents of Principal Member	Affidavit required and I.D.
Siblings	Affidavit required and I.D.
Common law partner	Affidavit required and I.D.
Same sex partner	Affidavit required and I.D.

F. PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION

Horizon Medical Scheme, hereafter referred to as "the Scheme", subscribes to the protection of all beneficiary's personal and health information provided to the Scheme for the administration of your medical aid. You are required to understand how and what the Scheme will use your personal and health information for as a beneficiary of the Scheme.

In order to provide you and your dependants with optimal healthcare, we require your consent and the consent of your dependants, to access, collect, process, store and retain your personal information. Upon signing this Application Form, you are providing the Scheme with your consent to use your personal and health information and you acknowledge that you have read and understood the Terms and Conditions available on the Scheme website.

a) Purpose

Horizon Medical Scheme, upon your consent, will:

- Share your personal and health information with contracted third parties, healthcare providers contracted to the Scheme, the Scheme's administrator and managed healthcare organization, partners of the Scheme and service providers of the Scheme;
- Store your personal and health information in a secure facility, which may include a secure cloud based storage facility;
- Process your personal and health information for the purposes of maintaining your information, providing your medical scheme services, providing the additional services and sharing your information, where required;
- Use your de-identified personal and health information for medical research purposes;
- Use your personal and health information to optimize your medical scheme benefits;
- Use your personal and health information to facilitate the medical scheme benefits in emergency medical situations;
- Retain your personal and health information in terms of the allowable statutory limits.

b) Collection and Processing of Personal Information

- The Scheme collects your personal information when you become a member of Horizon Medical Scheme and will process your personal information for the applicable services and benefits.
- Every dependant over 18 years must consent to use the services and benefits. If you are giving consent for a person under 18 (a minor) you confirm that you are the parent or legal guardian of that person and that you have authority to give their consent for them.

c) Correction of Personal Information

- You have an obligation to notify the Scheme if any of your personal information has changed or is no longer valid. To ensure your records are up to date, you can e-mail the Scheme at horizonmembership@medscheme.co.za or you can phone the member contact centre on 0860 101 103.
- You have the right to ask the Scheme to update, correct or delete your personal information, upon termination of your membership from the Scheme. Where your personal information cannot be deleted, the Scheme will take all steps to make it anonymous.
- If you want to know what personal information the Scheme holds about you, you will have to complete the Promotion of Access to Information form that is included in the PAIA Manual, which can be accessed on www.medscheme.com, your identity will be verified before providing any of your personal information.

d) Security of your Personal Information

- The Scheme has taken the appropriate security measures to protect your personal information from loss, misuse or unauthorized alteration. Your personal information is stored in secure databases that have the appropriate safeguards to ensure the privacy and protection of that information.
- The intended recipients of your personal information are yourself, selected healthcare providers, the Scheme, its administrator and researchers.

PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION *(Continued)*

e) Retention of Personal Information

The personal information of each member will be retained by the Scheme, administrator and managed healthcare organization, for the duration of your membership with the Scheme. After you have left the Scheme, your personal information will be retained within the allowable statutory limits.

f) Changes by the Medical Scheme

In the event of there being any changes to these terms and conditions, the Scheme will advise you within 30 days of these changes being made. It is the member's responsibility to ensure what the Scheme's registered rules are regularly reviewed in order to ensure all changes are acknowledged.

g) Right to withdraw Consent

The consent provided for the purpose of accessing, using, transferring, sharing, storing and collecting the personal information of you or your beneficiaries can be revoked at any time. You can revoke consent for a specific purpose or from the Scheme at any time by contacting the Scheme. If you revoke your consent in totality, the Scheme will not be able to provide you and your dependants with the necessary medical scheme and related healthcare services.

G. DECLARATION BY THE APPLICANT (Must be completed by all members applying)

1. I, the undersigned, hereby make application to be admitted as a member of the Horizon Medical Scheme (hereafter referred to as the Scheme) and to register my dependant/s (where applicable) as per Section E.
2. If admitted, I agree to abide by the Rules of the Scheme and the Medical Schemes Act as amended from time to time.
3. As per the Medical Schemes Act, a person cannot belong to more than one medical scheme at the same time. I therefore declare that I, or any dependant applied for, are not a member or dependant of another medical scheme.
4. I declare that any false statement in the above application or the non-disclosure of any material information will render my membership null and void, and that any monies paid towards the Scheme shall be forfeited to the Scheme.
5. I warrant that the above answers are true, correct and complete in every aspect.
6. I undertake to advise the Administrator of any change in my state of health or that of my dependants which may occur prior to my receiving written acceptance of this application, and that such notification shall give the Scheme the right to reconsider the application and to propose new terms of acceptance.
7. I hereby authorise any hospital, physician or any other person who has attended or examined me or any of my registered dependants to furnish the Scheme or its authorised employer group with all information in respect of any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photo copy or facsimile of this Authorisation shall be considered as effective and valid as the original.
8. I agree that my and my dependants' healthcare data may be used for the purposes of health risk assessment in order to be registered on managed care programmes for the better management of our health and to activate our personal health records.
9. I confirm that as the main member on the Scheme, I have received permission from my dependants to access and view their healthcare claims made on my membership and to deal with all matters relating to the claims on my membership.
10. I guarantee to the extent that it may be required by law that I have the necessary consent from my dependants to provide the authorization as set out in this section.
11. I acknowledge that I may access the information the Scheme holds about myself and my dependants and may request the Scheme to correct any errors or delete it.
12. I am aware of the fact that on joining the Scheme during the course of a calendar year, the maximum benefits to which I may be entitled shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular benefit year.
13. I am aware of the fact that if I am 35 years or older and did not belong to any medical aid, the late joiner penalty will apply.
14. I also agree that any amounts due by me may be offset against any amount due to me by the Scheme. I hereby authorise my employer to deduct from my salary and pay the Scheme all amounts that may be due by me to the Scheme directly or on my behalf.
15. Upon termination of my membership of the Scheme, I agree that any amount due to the Scheme by me may be deducted from any monies due to me by my employer group.

☐ I confirm that I am familiar with the terms and conditions and benefits of the Scheme.

☐ I acknowledge that I have read and understood the protection of personal and health information **Terms and Conditions** noted on the Scheme's website.

Signed at _____ on _____ of _____

Signature: _____