

Important: Please print clearly using capitals and block letters. It is compulsory for fields marked with * to be completed.

FOR ADMINISTRATIVE USE ONLY

Member number	<input type="text"/>	Group	<input type="text"/>	Paypoint	<input type="text"/>
Interchangeability	<input type="text"/>				
Employer details	_____				
Name of employer	_____	Telephone number	CODE	_____	
Postal address	_____	E-mail address	_____	_____	

SECTION 1 Choice of plan / option • Indicate option with 'X' in the appropriate box

<input type="checkbox"/> New member	<input type="checkbox"/> New spouse/Additional dependant	<input type="checkbox"/> Newborn baby
Join scheme from	<input type="text"/>	
<input type="checkbox"/> PLATINUM COMPLETE	<input type="checkbox"/> GOLD COMPLETE	<input type="checkbox"/> PLATINUM PLUS
<input type="checkbox"/> PLATINUM FOCUS	<input type="checkbox"/> GOLD FOCUS	<input type="checkbox"/> SILVER CORPORATE NETWORK
		<input type="checkbox"/> GOLD PLUS
		<input type="checkbox"/> SILVER FOCUS

Please note that Silver options are linked to salary bands and you are required to provide proof of income with submission of the form

Silver Focus	<input type="checkbox"/> < R5 500	<input type="checkbox"/> >R5 500		
Silver Corporate Network	<input type="checkbox"/> < R3 800	<input type="checkbox"/> R3 801 - R5 500	<input type="checkbox"/> R5 501 - R8 000	<input type="checkbox"/> > R8 000

Payment from Medical Savings Facility (MSF) for day-to-day claims

Excess amounts (the difference between the Liberty Health Medical Scheme reimbursement rate and the amount charged by a healthcare provider), as well as amounts claimed in excess of benefit sub-limits for day-to-day claims, will automatically be paid from a positive balance in your Medical Savings Facility. Only the Liberty Health Medical Scheme rate will accumulate to your Threshold level. This may impact your Threshold Benefit and result in a higher Self-Funding Gap.

Contribution to Medical Savings Facility

Only the following options have a saving facility included in the total contribution:

Platinum Complete	15%
Gold Complete	15%
Platinum Plus	10%
Gold Plus	15%

SECTION 2 Details of Principal Member

• Please leave space between names

Surname* _____
 Maiden name (if applicable)* _____
 Title* _____ First name/s* _____
 Initials* _____
 Gender* M F Marital status* SINGLE MARRIED DIVORCED WIDOWED COMMON-LAW
 SA ID/passport number* _____ Date of birth Y Y Y M M D D
 Telephone (Home)* C O D E _____ (Work)* C O D E _____
 Fax C O D E _____ Cell* _____
 E-mail _____
 Postal address* _____
 _____ Postal code _____
 Physical address * Same as postal YES NO if NO _____
 _____ Postal code _____
 Date of employment D D M M Y Y Y Y
 Proposed date of joining D D M M Y Y Y Y

NOTE: Backdating will not be permitted

SECTION 3 Previous Medical Scheme Membership

PLEASE PROVIDE DETAILS OF PREVIOUS MEDICAL SCHEME MEMBERSHIP

Please attach Membership Certificates. Membership cards or copies thereof will not be accepted.

If not attached, the Late Joiner Penalty may apply.

Name(s) of Previous Medical Scheme	Membership number	Membership Period															
		Date Joined						Date Left									
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
		D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y

SECTION 4 Dependants to be registered

- It is compulsory to provide copies of supporting documentation such as Identification, Birth Certificate(s), Marriage Certificate, Legal Adoption or Foster care court order documents, etc. when applying for dependant registration. Please include a letter of motivation/ Affidavit for partners, fiances, common-law spouses and other special dependants.
- No passport numbers are accepted for South African citizens.
- If dependant is a full-time student please attach proof of registration.
- The granting of dependant membership is strictly subject to the rules and approval of the scheme.

1 Adult Child

Title _____ Initials _____

Surname _____

First name/s _____

Relationship to member _____

ID number or passport number
(Please include copy of ID or passport) _____

Date of birth _____ Gender M F

Marital Status _____

2 Adult Child

Title _____ Initials _____

Surname _____

First name/s _____

Relationship to member _____

ID number or passport number
(Please include copy of ID or passport) _____

Date of birth _____ Gender M F

Marital Status _____

3 Adult Child

Title _____ Initials _____

Surname _____

First name/s _____

Relationship to member _____

ID number or passport number
(Please include copy of ID or passport) _____

Date of birth _____ Gender M F

Marital Status _____

4 Adult Child

Title _____ Initials _____

Surname _____

First name/s _____

Relationship to member _____

ID number or passport number
(Please include copy of ID or passport) _____

Date of birth _____ Gender M F

Marital Status _____

5 Adult Child

Title _____ Initials _____

Surname _____

First name/s _____

Relationship to member _____

ID number or passport number
(Please include copy of ID or passport) _____

Date of birth _____ Gender M F

Marital Status _____

6 Adult Child

Title _____ Initials _____

Surname _____

First name/s _____

Relationship to member _____

ID number or passport number
(Please include copy of ID or passport) _____

Date of birth _____ Gender M F

Marital Status _____

If the physical or postal address for any of the dependants differ from the principal member, please complete the following:

Dependant no

Postal address _____

Physical address _____

Dependant no

Postal address _____

Physical address _____

SECTION 5 Underwriting Information

All sections below to be completed by applicant - Failure to do so will delay processing

Please give full details on the questions below

Questions pertain to all additional dependants

Current family doctor

Name and surname _____
 Telephone C O D E _____ How long has he/she been your doctor year(s)
 Postal address _____ code

HAVE YOU/YOUR SPOUSE OR ANY OF YOUR DEPENDANTS EVER EXPERIENCED ANY OF THE FOLLOWING CONDITIONS
 IN THE LAST 12 MONTHS?

		ANSWER	
		YES	NO
1. Heart & Circulation	Chest Pain/ Angina; Heart Attack; Heart Failure; Heart Valve defects; Rheumatic fever; High Blood pressure (Hypertension); High Cholesterol; Heart Murmurs; Circulatory problems/disorders; Varicose veins; Deep Vein Thrombosis (DVT) or any other heart or circulatory problems	YES	NO
2. Breathing & Respiratory	Asthma; Difficulty with breathing; Bronchospasm; Tuberculosis (TB); Coughing up blood; Emphysema; Pneumonia; Cystic Fibrosis; Phthisis; Chronic Bronchitis; Shortness of breath or any other breathing problems	YES	NO
3. Bladder & Kidneys	Blood in Urine; Kidney Failure; Polycystic Kidneys; Kidney or Bladder Infections; Kidney removal (Nephrectomy); Kidney Stones; Abnormal Kidney or Urine Tests or any other bladder or kidney problems	YES	NO
4. Reproductive Organs	Endometriosis; Infertility; Ovarian Cysts; Hysterectomy; Abnormal Pap Smears; Laser treatment; Cervix and Breast Biopsies; Fibro-adenosis of the Breast; Laparoscopies; Receiving Hormone Replacement Therapy (HRT); Prostate Infections or Surgery; Prostate enlargement or any other reproductive problems	YES	NO
5. Digestive System	Duodenal Ulcers; Gastric Ulcers; Peptic Ulcers; Hiatus Hernia; Colon Problems; Crohns's Disease; Ulcerative Colitis; Gall Bladder problems; Liver Problems or any other digestive system problems	YES	NO
6. Ear, Nose & Throat	Deafness; Ear Infections; Sinus Problems; Nasal Surgery; Throat surgery; Orthodontics; Dental Surgery; Speech Impairments; Harelip; Cleft Palate or any other nose or throat problems	YES	NO
7. Eyes	Blindness (Partial or full); Eye surgery; Lens implants; Cataracts; Glaucoma; Retinitis Pigmentosa; Retinal Detachment; Impaired Vision or any other eye or eyesight problems	YES	NO
8. Endocrine	Diabetes ("High Blood Sugar"); Underactive Thyroid; Overactive Thyroid; Thyroid Surgery; Cushing's Syndrome; Addison's Disease; Pituitary Gland Problems or any other glandular problems	YES	NO
9. Back & Muscles	Neck or Back Problems or Operations; Recurrent Back Pain; Osteoporosis; Ankylosing Spondylitis; Rheumatoid Arthritis; Osteo-Arthritis; Paget's Disease or any other bone or skeletal disorders	YES	NO
10. Neurological	Epilepsy; Stroke (CVA); Migraine; Brain Injuries; Spinal Cord Injuries; Paralysis; Cerebral Palsy; Multiple Sclerosis; Mental retardation; Narcolepsy; Motor Neurone Disease; Parkinson's Disease; Alzheimer's Disease or any other neurological problems	YES	NO
11. Psychological	Depression; Anxiety; Psychosis; Suicide Attempts; Bipolar Disorders; Manic Depression; "Stress"; Schizophrenia; Tourette's Syndrome; Anorexia Nervosa; Received Advice, counselling or hospitalisation for Alcohol or Drug Abuse; Attention Deficit Disorder; Bulimia or any other psychological problems	YES	NO
12. Tumours & Growths	Benign or Malignant Growths or Lumps or Tumours including: Melanoma; Lymph Gland Cancer; leukaemia and breast Cancer or any other tumours, growths and cancers	YES	NO
13. Blood	Blood or bleeding disorders e.g. Haemophilia; Christmas factor deficiency; Platelet or any other blood clotting disorders	YES	NO

		ANSWER									
		YES	NO								
14. Skin	Eczema; Acne; Dermatomyositis; Pemphigus; Psoriasis; Scleroderma or any other skin disorders	YES	NO								
15. Sexually Transmitted Diseases	Advice, treatment or counselling for any of the following: HIV/AIDS; Syphilis; Gonorrhoea; Herpes; Genital Ulcers; Pelvic Infectious Disease (PID); Genital Warts; Hepatitis B or any other sexually transmitted disease or disorder	YES	NO								
16. Hospitalisation	Have you, your spouse or any of your dependants, been hospitalised in the last five (5) years?	YES	NO								
17. Pregnancy	Are you/ your spouse/ any of your dependants currently pregnant If the answer to this question is "Yes", when is the expected date of delivery?	YES	NO								
		<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

If you answered "YES" to any of the questions above - please provide full details in the space below.

Questions pertain to Applicant and all dependants

Question Number	Name of person suffering from the condition	Nature and duration of condition or symptoms - Date of Diagnosis	Date symptoms were last experienced	Exact Dates of treatment/ Hospitalisation	Name(s) of Medication/ Treatment and the monthly cost thereof

Applicant's signature _____

Date _____

SECTION 6 Banking details of principal member

"I instruct Medscheme to electronically collect contributions and to deposit claims and savings funds, via the ACB electronic 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 reverse any erroneous transactions and/or rectify any electronic transfer of funds without prior notice."

- Use this account for ALL transactions : debit order instruction to collect contributions as well as to deposit claim refunds
- Use this account only for debit order contribution collections

Name of bank _____

Branch name _____ Branch code _____

Account type CHEQUE TRANSMISSION SAVINGS

Name of account holder _____

Account number _____

Account holder's signature _____

Date

- Use this account for savings/claim refunds only

Name of bank _____

Branch name _____ Branch code _____

Account type CHEQUE TRANSMISSION SAVINGS

Name of account holder _____

Account number _____

Account holder's signature _____

Date

SECTION 7 Declaration by principal member

1. I, the undersigned, hereby apply for myself and my dependants to join the Liberty Medical Scheme (the Scheme) and declare that this application and declarations together with the statements made by me, whether in my handwriting or not, are true and correct and agree that such statements together with any forms, reports or other information completed or supplied by me or any party on my behalf shall form the basis of the contract.
2. I agree to be bound and to abide by the Scheme rules, standard terms, conditions and any rules ordinarily used by Liberty Medical Scheme for the type of benefits for which I have applied, and that Liberty Medical Scheme shall not be bound in any way by any representations or undertakings made or given by any person or agent save as contained in the registered rules of the Scheme.
3. It is further agreed and understood that, notwithstanding any statement made to the contrary by any person, membership will not commence and no liability whatsoever will attach to Liberty Medical Scheme a result of this application, (complete in full with supporting documentation attached), unless and until the first contribution has been paid and received by Liberty Medical Scheme and express written notice of acceptance of the risk is given by Liberty Medical Scheme.
4. I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information which may be related to my own, or my dependants', past or future occupation, physical or mental health, including the results of any tests, to Liberty Medical Scheme, its administrator or managed health care agent and I agree that this authorisation shall remain in force after my/their death/s.
5. I indemnify Liberty Medical Scheme and its trustees, agents and administrator against any claim, of whatever nature, which may be made against them as a result of or arising out of the disclosure of any test results or medical information.
6. I further accept that the provisions of any previous declaration made in respect of the Scheme have been read and understood by me and will also apply mutatis mutandis to and form part of this application.
7. I accept that waiting periods or late joiner penalties may be applied, based on proof of prior medical scheme membership I supplied, as provided for in the Medical Schemes Act (Act No. 131 of 1998).
8. I acknowledge that it remains my responsibility to ensure that the monthly premium, or other amounts due, are received by the Scheme.
9. I accept that Liberty Medical Scheme has the right to amend monthly contributions and benefits from time to time.
10. I authorise Liberty Medical Scheme to debit my salary, or through the debiting of my bank account, all subscriptions or any other amounts that may become due by me in terms of the Scheme Rules.
11. I hereby authorise the Scheme to contact my bank, should it need to verify any of my bank account details.
12. I accept that should contributions, or other amounts due be unpaid, that this may result in the suspension of my own and my dependants' benefits and if they remain outstanding, that the Scheme may discontinue my membership. I also accept that I will be responsible for the legal costs associated with the recovery of arrears.
13. I undertake to promptly advise the Scheme of any change in status of health of myself or any of my dependants, that occurs prior to my receiving acceptance of this application. I acknowledge that not doing so may lead to the Scheme reconsidering the basis of my membership application.
14. I warrant that the information I have provided pertaining to me and my dependants is true, correct and complete and that I have not concealed, withheld or misstated any material facts. Should there be any non-disclosure or material misrepresentation, I accept that my membership may be terminated and that I may forfeit my contributions to the Scheme. Liberty Medical Scheme also has the right to claim damages in respect of any loss or damage it may suffer due to my nondisclosure or misrepresentation.
15. I declare that no material fact has been withheld, misstated or concealed by me and that I will disclose all material facts prior to acceptance of the risk and I agree that any misstatement and/or omission of any material information will render my membership null and void, and in such an event all monies paid in respect thereof shall be forfeited.
16. I hereby acknowledge that any credit extended by Liberty Medical Scheme to myself or my dependants whilst being members of Liberty Medical Scheme will become payable in full upon termination of my membership of the Scheme and that interest may be charged on all amounts due and owing to Liberty Medical Scheme.
17. I understand that Liberty Medical Scheme may provide written notification to my e-mail address, failing which, my broker's e-mail address as supplied by my broker, of change to its Rules.
18. I declare that my dependants and I are permanently resident in South Africa.
19. I consent to my telephone conversations with the Liberty Medical Scheme being recorded and forming part of the Scheme's records. I also agree that such records shall remain the sole property of Liberty Medical Scheme.
20. I understand that should there be any additional information required by the Scheme that is not received by it within 14 days, that the Scheme has the authority to suspend the application.
21. I consent to the use of all contact details given in Section 2 of this application, by Liberty Medical Scheme, or any appointed agent/s of the Scheme, to send me information of any nature (confidential or other).
22. I further acknowledge that on termination of membership, any amounts owing to the Scheme will be deducted from any amounts due to me from my Employer. For this purpose I hereby permit Liberty Medical Scheme to advise my employer of any amounts due to the Scheme where applicable.
23. I hereby appoint the financial adviser, who has submitted this application on my behalf, to be my nominated financial adviser.

Signed at _____ on this _____ day of _____ 20 ____

Signature of applicant . _____

SECTION 8 To be completed by Financial Advisor (Intermediary)

Financial Advisor's Commission code:

Are you accredited with the Council for Medical Schemes YES NO

Portion of Commission (%) _____

If "YES" please provide Accreditation number _____ Date accredited _____

Branch name _____ Cell _____

Office Tel. number _____ Other contact number _____

E-mail address _____

Secondary e-mail address (e.g. Broker Consultant) _____

Additional instructions by financial advisor (intermediary) to Liberty Health medical scheme administration

Financial Advisor's Signature

Date