RESOLUTION health Medical Scheme

MEMBER ACKNOWLEDGEMENT AND DECLARATION

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General

1. *I, the undersigned applicant:*
   - 1.1 Hereby apply for myself and my dependants to be registered on the Resolution Medical Scheme ("the Scheme") and agree to abide by and undertake to familiarise myself with the Rules of the Scheme;
   - 1.2 Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and, should there be any change in the state of health or change in personal status by myself or any of my dependants from the date of signing this application form and the date of acceptance of risk by the Scheme, notification of such change will be provided to the Scheme in writing with full details of such condition / ailment within 30 days from the change in circumstances;
   - 1.3 Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null and void and all contributions paid shall be forfeited;
   - 1.4 Understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary, including the result of such medical examinations and tests that they may require me or my dependants to undertake;
   - 1.5 Consent to the Scheme addressing any requests for information, tests or examinations directly to any dependants of mine over the age of 18, with the same legal consequences as if the request had been addressed to me in my capacity as a member;
   - 1.6 Acknowledge that it is my responsibility as a member to ensure that claims are submitted within the 4 month submission period (Rule 15.2).
   - 1.7 Acknowledge that it is my responsibility as a member to ensure that the monthly contribution is received by the Scheme in terms of the Rules of the Scheme;
   - 1.8 Acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any contribution is not paid on the due date; and
   - 1.9 Undertake to inform the Scheme within 30 days should the situation change (Rule 7.2.1).
   - 1.10 Is familiar with and has full knowledge of the irrefutable conditions and benefits of the option elected, notwithstanding misrepresentation by any other party;
   - 1.11 That neither myself or my dependants are dependants of another medical scheme;
   - 1.12 Hereby consent to all conversations between myself, the Scheme or any party as being recorded;

Authority

2. Accepting that I am curtailing my and my dependants' right to privacy, but in order to facilitate the assessment of the risk and the consideration of any claim, I irrevocably authorise:
   - 2.1 The Scheme to obtain from any person, whom I hereby so authorise and direct to give, any information which the Scheme deems necessary.
   - 2.2 I further authorise and instruct the Scheme and any hospital concerned to give any information relating to myself and my dependants to the Medical Case Managers appointed by the Scheme, for the purposes of ensuring that the members of the Scheme receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources.
   - 2.3 I understand and accept that the above authorisation constitutes a partial waiver of my and my dependants' right to privacy.
3. *declare that:*
   - 3.1 My dependant(s) is / are residing with me.
   - 3.2 I am liable for his/her family care.
   - 3.3 The dependant(s) is / are my immediate family (Must be blood related).
   - 3.4 My dependant(s) is / are not in receipt of remuneration of more than the maximum social pension per month.
   - 3.5 My dependant(s) is / are not a member(s) or dependant(s) of another medical scheme.
     (Evidence / affidavit to prove the above must be submitted with this application).

Termination

4. On termination of my membership of the Scheme:
   - 4.1 I undertake to repay the Scheme any amount by which claims paid out of or from my Medical Current Account exceed contributions and other net credits paid into such account, where applicable.
   - 4.2 I understand that should contributions and other net credits to my Medical Current Account exceed claims paid from this account, this excess will be paid to me subject to the approval in terms of the Medical Schemes Act 131 of 1998, where applicable.
   - 4.3 One month written notice (Rule 12.2.1).

SCHEME DECLARATION

1. *We hereby confirm:*

1.1 that the applicant and his / her dependants' personal and medical information, (obtained from healthcare providers with applicant's consent) will be kept confidential

1.2 that both personal and medical information obtained will not be used or sold commercially

1.3 that data security measures are in place

1.4 that staff of RHMS as well as its contracted third parties are bound by confidentiality agreements

1.5 that the Scheme and its contracted third parties use application information for the processing of the application, re-imbursement of claims to determine benefits and access levels of care in respect of managed health care principles

1.6 that the Scheme's contractual agreements ensure the confidentiality of data management, scheme administration and managed health care agreements

1.7 that should the Scheme assume responsibility for breach in confidentiality, the management thereof will be in accordance to Scheme Rules and Protocols

INTERMEDIARY DECLARATION

1. *I, the undersigned applicant hereby confirms:*
   - 1.1 that the appointed intermediary is accredited at date of signing the application form
   - 1.2 that the appointed intermediary is licensed by the FSB in terms of the FAIS Act
   - 1.3 that the appointed intermediary has made his / her name, physical, postal address and contact number available
   - 1.4 that I am aware of commission payable by the Scheme on this transaction to the appointed intermediary
   - 1.5 that the appointed intermediary is contractually bound to the Scheme
   - 1.6 that there has been no material misrepresentation of facts by the appointed intermediary and that in such an event the appointed intermediary undertakes to refund all monies paid to the Scheme
   - 1.7 that I have been given all the relevant information with regards to the application information from the appointed intermediary
   - 1.8 that the advice given to me by the appointed intermediary was in my best interest and unprejudiced

INTERMEDIARY DETAILS

Name of Brokerage ____________________ Brokerage Code ____________

Address ____________________ Consultant / Agent Sub-code ____________

____________________ Code ________

Full Name of Consultant / Agent ____________________

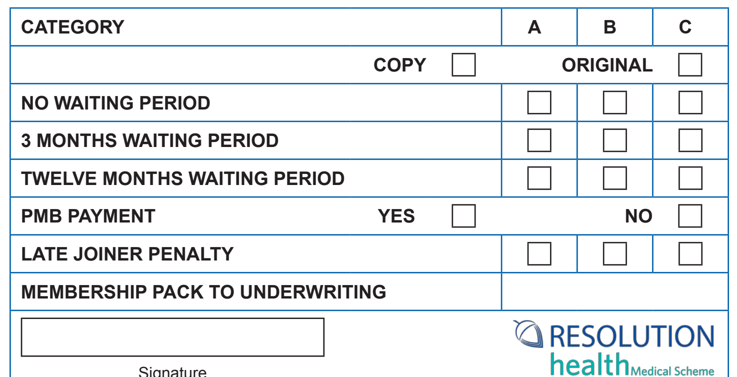
Telephone Number ____________ Email Address ____________________

Fax Number ____________

SIGNATURE	SIGNATURE	SIGNATURE
Signature of Broker	**Signature of Consultant**	**Signature of Applicant**

Signed at ____________________ on this ________ day of ____________ / ________

DISEASE MANAGEMENT - ICD10



OFFICE USE ONLY

CATEGORY	A	B	C
COPY ☐	ORIGINAL ☐		
NO WAITING PERIOD	☐	☐	☐
3 MONTHS WAITING PERIOD	☐	☐	☐
TWELVE MONTHS WAITING PERIOD	☐	☐	☐
PMB PAYMENT YES ☐	NO ☐		
LATE JOINER PENALTY	☐	☐	☐
MEMBERSHIP PACK TO UNDERWRITING			
Signature	RESOLUTION health Medical Scheme		