



RESOLUTION

health Medical Scheme

MEMBERSHIP APPLICATION FORM

Name & Surname

ID Number

This application form must be received at the Scheme within one month following the date on which it was signed. Failure to do so will result in this application being null and void. Incomplete application forms will not be accepted.

FOR OFFICE USE ONLY

Members Number

Group Reference Number

Region

Date of Commencement

Applicable Option

- Hospital
- Progressive Flex
- Progressive Saver
- Prestige

Foundation

Income Category

- R0 - R3750
- R3751 - R5800
- R5801 - R8000
- R8001 - R9500
- R9501 +

Underwriting Decision:

Authorisation:

Name

Signature

Date:

CATEGORY	A	B	C
COPY <input type="checkbox"/>	ORIGINAL <input type="checkbox"/>		
NO WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 MONTHS WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TWELVE MONTHS WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PMB PAYMENT	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
POST MEMBERSHIP GUIDE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
LATE JOINER PENALTY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEMBERSHIP PACK TO UNDERWRITING			
<input type="text"/>			
Signature			

F. DETAILS OF CURRENT MEDICAL PRACTITIONER

1	Name of Principal Member's Doctor	<input type="text"/>	Date of first Consult	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	Name of Dependant/s' Doctor	<input type="text"/>	Date of first Consult	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

NOTE: Please ensure that above details are correct and completed in full as this may delay application and authorisation processes.

DETAILS FOR NOMINATION OF MEDICAL PRACTITIONER – FOUNDATION PLAN ONLY

Dependant Type	1	Principal member	2	Spouse / Partner / Dependant 1
Name of practice or name and surname of doctor:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tel Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Region:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Suburb:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dependant Type	3	Dependant 2	4	Dependant 3
Name of practice or name and surname of doctor:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tel Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Region:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Suburb:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

G. SPECIFIC HEALTH QUESTIONS

State whether you or any of your dependants have ever suffered from, been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including but not limited to:

1. Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia, clotting disorders.	YES	NO
2. Cancer, growths, abscess or tumours of any kind, whether benign or malignant.	YES	NO
3. Cardiovascular (heart and blood vessels) disorders e.g. congenital heart conditions, chest pain, coronary artery disease / ischaemic heart disease, high blood pressure, valvular disease, arrhythmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever, shortness of breath, palpitations, angina, deep vein thrombosis, pulmonary embolism, atherosclerosis lymphatics.	YES	NO
4. Ear, nose and throat disorders e.g. hearing/speech impairment, ear infections, sinus problems, nasal/throat surgery, ear discharge, hoarseness, mouth disorders, tonsils, adenoids, grommets, previous nasal injuries, upper airway infections, cleft lip/palate, epistaxis, hayfever / rhinitis, blocked nose.	YES	NO
5. Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities, sugar in urine, nutritional disorders, metabolic syndrome, hypo/hyperglycaemic coma.	YES	NO
6. Eye related disorders e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts, lens implants, infections, refractive and laser surgery, short or far sightedness, pterygium.	YES	NO
7. Gastro-intestinal disorders e.g. recurrent indigestion, heartburn, reflux, ulcers, bowel disorders, gallbladder disorders, liver disorders and pancreas disorders, hiatus hernia, piles, anal fissures, rectal bleeding, ulcerative colitis or have you or any of your dependants ever had a gastroscopy or colonoscopy, spleen disorders, Crohn's disease.	YES	NO
8. a. Gynaecological and obstetrical disorders e.g. ectopic pregnancy, caesarian section, fibroids, endometriosis, menstrual irregularities, abnormal papsmear, receiving hormone treatment, vaginal bleeding, laparoscopic surgery, dilatation and curettage, miscarriages, pregnancy related problems, cysts, infertility, breast disorders.	YES	NO
8. b. Pregnancy - expected date of delivery.	<input type="text"/>	<input type="text"/>
9. Male genito-urinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system.	YES	NO
10. Musculo-skeletal disorders e.g. osteo-arthritis, rheumatoid arthritis, back problems, gout, osteoporosis, all joint problems e.g. knee, shoulder, bones, limbs, spine, fractures, carpal tunnel syndrome, bunion, spondylosis, hernia, kyphosis.	YES	NO
11. Neurological disorders e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue, headache, migraine, polio, paralysis, Guillian-Barre, meningitis, Parkinson's Disease, Alzheimer Disease, dementia.	YES	NO
12. Psychological disorders e.g. insomnia, anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit disorder, post traumatic stress, schizophrenia, bi-polar disorders, mood swings, attempted suicide, anorexia/bulimia nervosa.	YES	NO
13. Renal (kidney) disorders e.g. blood in the urine, urinary tract stones, recurrent infections, kidney failure, bladder problems, dialysis, Addisons Disease, nephritis.	YES	NO

14. Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema or cigarette smoking related disorders, tuberculosis, persistent cough, allergies, chronic obstructive pulmonary disease, pneumoconiosis.	YES	NO
15. Skin disorders e.g. eczema, psoriasis, melanoma, skin cancer, burns, acne, scars, keloids, growths, warts, ingrown toe nails.	YES	NO
16. State whether you or any of your dependants have received medical advice or treatment for any infectious and tropical disease e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitis, bilharzia, malaria, cholera.	YES	NO
17. Do you or any of your dependants have any birth defects or hereditary disorders?	YES	NO
18. Have you or any of your dependants ever sought counselling or treatment for HIV or AIDS related infections or ever tested positive for HIV or AIDS?	YES	NO
19. Have you or any of your dependants ever been diagnosed and/or treated for an immune system problem?	YES	NO
20. Previous injuries and trauma including sports injuries?	YES	NO
21. Have you or any of your dependants ever been told to improve your adherence to medical treatment?	YES	NO
22. Have you ever required rehabilitation following an event i.e. stroke or motor vehicle accident?	YES	NO

If "yes" answered to any of the questions above, please supply full details below.

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current Condition

If the space provided is insufficient please complete addendum.

Addendum attached YES NO

SURGERY AND HOSPITAL ADMISSIONS

1. Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past, and/or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future.

Applicant	Surgical Procedure/Hospital Admission	Date	Reason	Doctor	Current Condition

CHRONIC MEDICATION

1. Please supply details of any chronic medication (prescribed medicines used continuously for more than 3(three) months) currently prescribed for you or any of your dependants.

2. Do you or any of your dependants expect chronic medication to be prescribed in the next 12 months? YES NO

If so please supply details below.

Applicant	Prescribed Medication	Medical Condition	Date Started/To be Started

H. GENERAL HEALTH QUESTIONS

1. Do you or any of your dependants expect to receive any treatment in the next 12 months and do you or your dependants expect to be, or are currently hospitalised?	YES	NO
2. Has any close blood relative (excluding dependants named in this application form) ever been diagnosed with heart disease, high blood pressure, high cholesterol, diabetes or any other hereditary disease?	YES	NO
3. Do you or any of your dependants have incomplete dental treatment plans, dental implants, orthodontic treatment, dentures, wisdom teeth problems or do you or any of your dependants currently receive, or expect to receive dental treatment in the next 12 months?	YES	NO
4. Are you or any of your dependants currently involved in any third party claim or WCA claim that may include medical treatment? If so please provide below, FULL details of injuries, surgery, investigative procedures for which claims will be or have been lodged.	YES	NO
5. Do you or any of your dependants smoke, or did you or any of your dependants receive medical advice to reduce the quantity of tobacco used? If so, specify whether cigarettes, cigars or a pipe and how many are or were smoked per day.	YES	NO
6. Do you or any of your dependants consume alcohol? If so, specify what type of alcohol and quantity consumed per week.	YES	NO
7. Have you or any of your dependants ever received medical advice, counselling or treatment to reduce alcohol consumption for alcohol abuse or alcoholism?	YES	NO
8. Do you or any of your dependants use stimulants, any illegal drug substances, or ever been treated for illegal drug substance abuse or addiction?	YES	NO
9. Investigations and/or specialised treatment. In and out of hospital.		
a. Are you or any of your dependants currently undergoing, or expect to undergo investigations for any medical condition and/or symptoms not yet diagnosed?	YES	NO
b. Are you or any of your dependants currently receiving or expect to receive specialised treatment (i.e. chemotherapy, radiotherapy, bone marrow transplant, mechanical ventilation, oxygen therapy, dialysis, psychotherapy or counselling)?	YES	NO
10. In the past 2 years, have you or any of your dependants had any x-rays, electrocardiogram or other examinations including genetic testing, or tumour markers, operations or been hospitalised?	YES	NO

If "yes" answered to any of the questions above, please supply full details below.

Question	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and consulting doctor's details)

If the space provided is insufficient, please provide additional information to this application.

HEIGHT AND WEIGHT

Applicant	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg
Spouse / Partner / Dependant 1	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg
Dependant 2	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg
Dependant 3	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg
Dependant 4	Initials <input type="text"/>	Height <input type="text"/> cm	Weight <input type="text"/> kg

N.B. Any misrepresentation or non-disclosure of medical material or factual information will render all benefits granted by the Scheme null and void. In addition, any payment made due to such actions will be recovered from the member by the Scheme.

I. PAYMENT METHOD

Payment Method Debit Order Persal Via Employer

J. CONTRIBUTION COLLECTION DETAILS

Claim refunds can only be paid by direct credit to your bank account. All claims will be reimbursed at scheme rate, unless otherwise indicated.

Name of Bank

Account Type: Cheque: Transmission: Savings:

Name of Account Holder

Account Number

Branch

Branch Code

Monthly Debit Order 1st 5th

K. CLAIM REIMBURSEMENT DETAILS

Cheque: Transmission: Savings:

Resolution Health Medical Scheme ("the Scheme") hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted, and similarly I authorise my bank to debit my account with amounts drawn against it by the Scheme.

I understand that the withdrawals hereby authorised will be processed by computer through a system known as ABSA Link Direct Service / Debit Order / Multidata and I also understand that the details of each withdrawal will be printed on my bank statement or on an accompanying voucher.

I agree to pay any bank charges relating to this, ABSA Link Direct Service / Debit Order / Multidata, instruction.

The authority may be cancelled by myself giving the Scheme / Agility Global Health Solutions Africa (Pty) Ltd thirty (30) days notice in writing, sent by prepaid registered post, but I understand that I shall not be entitled to any refund of amounts which the Scheme has withdrawn while this authority was in force if such amounts were legally owing to the Scheme. Receipt of this instruction by the Scheme / Agility Global Health Solutions Africa (Pty) Ltd shall be regarded as receipt thereof by my bank.

I further agree to advise the Scheme / Agility Global Health Solutions Africa (Pty) Ltd in writing of any changes which may occur.

Signature of Account Holder

SIGNATURE

L. MEMBER ACKNOWLEDGEMENT AND DECLARATION

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 inception of the membership, notification of such change will be provided to the Scheme immediately upon occurrence of the change, in writing with full details of such condition / ailment as soon as I become aware of the circumstances. Such notification is to include all available medical reports relating to any health conditions in order to enable the Scheme to investigate the circumstances causing and/or contributing to such change;
- 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 regarding the dependency of any of my dependants change (Rule 7.2.1).
- 1.10 Am familiar with and have 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 I am liable for his/her family care.
 - 3.2 Dependant children or other members of immediate family in respect of whom the member is liable for care and support.
 - 3.3 My dependant(s) is/are not in receipt of remuneration of more than the maximum social pension per month.
 - 3.4 My dependant(s) is/are not a member(s) or dependant(s) of another medical scheme.
4. By their signature hereto any of my dependants who have reached or are over the age of 18 declare themselves bound to the above terms

Termination

4. On termination of my membership of the Scheme:
 - 4.1 One month written notice (Rule 12.2.1).

Signed at _____ on this _____ day of _____ / _____

SIGNATURE

Signature of Applicant

M. INTERMEDIARY DECLARATION

- 1. I, the undersigned hereby confirm:
 - 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 to the appointed intermediary
 - 1.8 that the advice given to me by the appointed intermediary was in my best interest and unprejudiced

N. 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

O. 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

Signed at on this day of /

SIGNATURE

Signature on behalf of Scheme

WHAT TO EXPECT WITH YOUR APPLICATION:

Upon receipt of the application:

- 1. We capture and check your details.
- 2. If any details are missing, you will be contacted in writing or telephonically.
- 3. We will advise you or your intermediary in writing, SMS or an E-mail to inform you of your acceptance to join Resolution Health Medical Scheme.

This correspondence may contain certain conditions:

- 1. You sign these terms of acceptance to confirm that you accept any waiting period/s or late joiner penalties (if we apply any) and return it to us.
- 2. You will receive a membership pack in the post.
- 3. This will contain details about your plan selection to get you started.

If you do not hear from us 7 (seven) days after submission, please contact your financial advisor or call us on 0861 796 6400.