

DETAILS OF DEPENDANT(S)

No person may be enrolled with different medical schemes simultaneously.

Surname	Full first name	Date of Birth	ID Number	Relationship	Gender

For any dependant other than your spouse, common-law spouse, partner or natural child under the age of 21 (including adopted child and foster child), please provide an affidavit stating:

- the relationship to the principal member
- that there is a legal duty of support
- that the dependant is unable to support himself/herself financially.

For natural children (including adopted child and foster child) who are full time students at an educational institution please include a tertiary institution registration certificate with this application.

INCOME CATEGORY

Please indicate your basic monthly salary/income. (Include payslip or proof of pension.) Member

Spouse/Partner

PREVIOUS MEDICAL SCHEME MEMBERSHIP

Were you a member or dependant of a registered medical scheme?

If 'yes', please attach certificates of membership from your current and previous medical schemes (membership cards are not sufficient). Please note that the onus is on you to ensure that your membership on your current medical scheme is cancelled.

1. Name of previous medical scheme _____

Member number: _____

Period of membership: From To

2. Name of previous medical scheme _____

Member number: _____

Period of membership: From To

Was membership subject to any restrictions, e.g. late-joiner penalty or waiting period/exclusions?

If 'yes', state particulars of restrictions _____

For applicants and/or dependants aged 35 years and older

Please supply full details and proof of all previous medical aid membership for the principal member and/or dependants who are aged 35 years and older (excluding membership as a child dependant). Use an additional sheet of paper if required.

MEDICAL HISTORY AND GENERAL HEALTH

This form must be completed by all principal members. Please complete all the required information by marking the relevant box.

Was medical advice, diagnosis, treatment or care received or recommended in respect of yourself or any of your dependants for the following in the last 12 months?

False answers will be regarded as fraud.

1. High cholesterol, stroke, high blood pressure, heart murmur, angina, heart attack, or any other cardiac or blood disorder? YES NO
2. Nephritis, kidney stone, congenital kidney disorders or any other urinary or related kidney disorder? YES NO
3. Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis, croup, or any other respiratory related disorder or ear problems? YES NO
4. Conditions of the joints or spine, including rheumatism, arthritis, neck or back disorders or any physical disability? YES NO
5. Diabetes, sugar in the blood or urine, glandular disorder, or any other related endocrine disorder? YES NO
6. Any lumps, growths, benign or malignant, or types of cancers, including Hodgkin's disease and leukaemia, skin cancer, etc.? YES NO
7. Epilepsy, migraine or any other neurological disorder? YES NO
8. Ulcers, hiatus hernia, gall bladder or liver disorders or any other digestive system disorder? YES NO
9. Any medical, major dental, chiropractic, optical or gynaecological treatment, advice, tests or hospitalisation? YES NO
10. Advice, counselling, treatment or therapy for alcoholism, drug dependence, mental or emotional disorders? YES NO
11. Medical advice, counselling or treatment in connection with HIV/AIDS or any sexually transmitted disease, e.g. hepatitis B, gonorrhoea or syphilis? YES NO
12. For other than routine treatment, do you, your spouse or any of your dependants expect to seek medical advice or treatment in the next six months? YES NO
13. Are you or any of your dependants pregnant? YES NO
 If so, what is the expected date of delivery?

D	D	M	M	Y	Y	Y	Y
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14. Height and weight (principal member) Height

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 Weight

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 Height and weight (spouse/partner) Height

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 Weight

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If you have answered "yes" to any of the above questions, please complete details below in full: include cause, nature, symptoms, date and duration of illness. State any investigations and the final diagnosis. State duration of any hospitalisation. State current treatment (name, dosage, frequency). If none, when were you last treated?

No.	Beneficiary	Consultation Date	Illness	Duration	Treatment

If more space is needed, please use an additional sheet of paper.

PAYMENT DETAILS

Banking account details: Required for the direct crediting of member refunds, and the direct debiting of amounts due to the Scheme. Claims paid by you can be credited to the banking account supplied below.

Bank account number _____ Name of account holder _____

Name of bank _____

Branch name _____ Branch number _____

Type of account Current Savings Transmission

I hereby instruct GEMS and/or its agents to credit/debit the above banking account.

Authorised signature _____ Name _____

CONSENT

My dependant(s) and I hereby give permission for the medical practitioner and/or staff member of the hospital in whose care I am/my dependants are to supply:

- i. Any information that GEMS and/or its agents need in order to settle any claim submitted by me or my dependant(s) to GEMS and/or its agents;
- ii. GEMS and/or its agents' case manager with any information the case manager needs in order to manage my case or that of my dependant(s);
- iii. The healthcare management with any information, on an anonymous and untraceable basis, that is required for administrative and statistical purposes.

It is important to give GEMS and/or its agents your consent to negotiate with your doctor(s), hospital or any other healthcare provider in order to ensure that you receive optimal care.

Signature of Principal Member _____ Date

D	D	M	M	Y	Y	Y	Y
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DECLARATION

I declare that:

- i. The content of this form is true, correct and complete;
- ii. I have made my option choice on page one and that I have satisfied myself with the benefit structure under this option;
- iii. The mentioned particulars concerning my dependant(s) are correct and he/she/they qualify/ies for admission as beneficiaries in terms of the Rules of the Scheme;
- iv. My mentioned dependent children are fully dependent on me;
- v. I am aware that general and condition specific waiting periods, as determined by Scheme rules and legislation, may be imposed on my membership with effect from date of registration;
- vi. I am aware that a late joiner penalty may be added to my monthly contributions and/or that of my dependants with effect from the date of registration, as determined by Scheme rules and legislation;
- vii. I am aware that my and my dependants' personal information may be used for research, statistical data, managed care and reporting purposes.

I undertake to submit myself and my dependant(s) to the GEMS rules. I herewith irrevocably authorise my employer to recover from my salary any amount I may legally owe GEMS and to pay over to GEMS or its agent all amounts thus recovered.

Signature of Principal Member _____ Date

D	D	M	M	Y	Y	Y	Y
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