Applying to become a member of Netcare Medical Scheme in 2025 (with underwriting)

Contact details
Tel: 0861 638 633 • PO Box 652509, Benmore 2010 • www.netcaremedicalscheme.co.za

Thank you for applying to join Netcare Medical Scheme. This document is an application for membership form. It also contains the conditions of application. Please make sure you read and understand the Rules of Netcare Medical Scheme which can be found at **www.netcaremedicalscheme.co.za**

Who we are
Netcare Medical Scheme, registration number 1584, is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as "the administrator") is a separate company and an authorised financial services provider (registration number 1997/013480/07), which takes care of the administration of your membership of Netcare Medical Scheme.

Once you submit your application form, here is what will happen:

1. If any details are missing or if we need more information for underwriting purposes, we will contact you.
2. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
3. We will send you or your employer a welcome letter, a notification or an email to let you know when your application is considered to have been fully and completely made.
4. Your welcome pack will be delivered to your employer.

When you sign this application, you confirm that you have read and understood the conditions of application and Rules of Netcare Medical Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the terms and conditions for membership (Section 11) and the Scheme Rules.
3. Please make sure the main applicant signs section 7, 10, and 11 as well as signs and dates any changes. Please submit the form to your HR who will complete the employer warranty and submit the application on your behalf. No direct applications will be accepted.
4. Please attach a copy of your Identity Document (ID) as well as each applicant to this form. We also accept passports and birth certificates for children.
5. If you do not hear from us within seven days after submission of your application form, please call **0860 100 345** or email **newbusiness_queries@netcaremedicalscheme.co.za** or contact your local HR office.

I consent to my spouse and/or adult dependant acting on my behalf and providing my personal information, including health information, for the purpose of this application. ☐

1. About yourself (main applicant)

Cover date D 0 D 1 M M Y Y Y Y

Title ☐☐☐☐ Initials ☐☐☐☐☐

Surname

First name(s) (as per identity document)

Previous or maiden name

ID or passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Preferred method of communication: Email ☐ Post ☐ By choosing email, you will receive your communication quicker and there is less of an impact on the environment.

Telephone (H) ☐☐☐ ☐☐☐☐☐☐☐ Telephone (W) ☐☐☐ ☐☐☐☐☐☐☐

Cellphone ☐☐☐ ☐☐☐☐☐☐☐

Email

Postal address (post collected from post box, suite or private bag)

PO Box | Private Bag | Box number

Suite | Postnet Suite | Number

Suburb | Postal code

If your post is delivered to your street address, please complete these details under physical address.

Physical address

Unit/Suite number | Complex name

Street number | Street name

Suburb

City | Postal code

Occupation

Your current salary **R** . | Tax number

2. About your spouse or partner (if applying for cover)

Title | Initials

Surname

First name(s) (as per identity document)

Previous or maiden name

ID or passport number

Gender M F | Date of birth D D M M Y Y Y Y

Race African | Coloured | Indian/Asian | White | Other | Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Telephone (H) | Telephone (W)

Cellphone

Email

Tax number

Partnership declaration

If you are not legally married and you cannot give us a marriage certificate, you have to complete the following section in full. If both parties have not signed and dated the below section, we will halt the application process until we receive the section signed and dated by both parties.

We declare we are in a long-term, committed relationship that is like a marriage and that we live together at the same residence. We understand that by signing this declaration, we agree to tell the Scheme about any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that if the information we give about our relationship or residency is false in any way, the Scheme reserves the right to end both our memberships.

Since when have you and your partner been in this relationship that is like a marriage D D M M Y Y Y Y

Signature of main applicant | Date D D M M Y Y Y Y

Signature of partner | Date D D M M Y Y Y Y

Please do not sign an incomplete application form

3. About your dependant/s (if applying for cover)1

Dependant 1

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (for example, mother, child)

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

*Disabled? Yes No A full-time student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R** .

Dependant 2

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (for example, mother, child)

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

*Disabled? Yes No A full-time student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R** .

Dependent 3

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Relationship to main member (for example, mother, child)

If your dependant is 21 years and older, are they:

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

*Disabled? Yes ☐ No ☐ A full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? **R** .

4. Your employer warranty (this section must be signed by the HR or payroll contact)

Name of employer | Employer or billing number

Employee number | Date of employment D D M M Y Y Y Y

Branch name | Branch number

Applicants monthly salary **R** .

The employer will reconfim the income stated above

Please make sure your employer completes this warranty. If this application form is sent without an employer warranty, we cannot process the application.

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. Netcare Medical Scheme may bill us for the amount due for this member in the same way as it does for our other employees as members of Netcare Medical Scheme.

Employer's authorised signature

Please do not sign an incomplete application form.

Name and surname of HR official

Designation

EMPLOYER STAMP

5. Your banking details

Please give us the details you would like to use for your claim refunds.

Please note: We cannot accept credit card account details. You may only use a South African bank account.

Bank name

Account number | Branch code - - -

Type of account Cheque ☐ Savings ☐

Account holder

By signing below, you agree that once claims have been refunded into the bank account you have chosen, Netcare Medical Scheme will not be responsible in any way for the amounts refunded, if these details are incorrect.

Signature of main applicant

If third party bank details, please insert the third party ID number.

ID Number

If the third party bank account is a Joint account ☐ Company account ☐ Trust account ☐

Please provide proof of bank account. Refer to **Section 10, banking details of a third party** for the proof of bank account required.

6. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you previously belonged to. Please give us proof in the form of a membership certificate.

Main applicant

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

If all dependant/s were on the same medical schemes as completed above, please tick here to confirm this. ☐

If any of your dependant/s applying for cover belonged to different medical schemes, please complete them below:

Dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

7. Your health questions

In the twelve months prior to your application, have any of your dependants in this application **ever** experienced, been treated/investigated for or currently suffer from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders.

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customised information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modelling, to assist the Scheme to better assess and mitigate its risk and other beneficial uses. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a within a 12-month period ending on the date on which this application is considered to be fully and properly made.

If any of your dependants have any symptom, condition or disorder not listed in the questions below, you should highlight and provide full details of this disorder, symptom or condition in response to question 6.18 below. An indication of existing medical conditions on this application does not automatically enrol you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Scheme's Disease Management enrolment visit www.netcaremedicalscheme.co.za.

We may be able to use certain previous medical information for you and your dependants(if applicable) we have from previous policies. By ticking this box you agree that we may utilise this information for the purposes noted below. ☐

7.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast **Yes** ☐ **No** ☐

Example: skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result or other skin conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.2 Heart and circulatory conditions Yes ☐ No ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, peripheral vascular disease, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.3 Gynaecological and obstetrics conditions Yes ☐ No ☐

Example: abnormal Pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed periods, ovarian cyst.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.4 Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or difficulty falling pregnant? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.5 Mental health Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, autism, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling, bulimia and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.6 Metabolic or endocrine conditions Yes ☐ No ☐

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.7 Abdominal conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gallbladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhoea, ascites (fluid in the abdomen).

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.8 Brain and nerve conditions **Yes** ☐ **No** ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt), intellectual disability, CVA, bleeding on the brain.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.9 Breathing and respiratory conditions **Yes** ☐ **No** ☐

Example: ventilator, oxygen therapy, CPAP, asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease/chronic cough > 3 months.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.10 Musculoskeletal (back, bone, injury and muscle pain) **Yes** ☐ **No** ☐

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, internal insertion of surgical implants, prosthesis, amputation.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.11 Kidney or urinary conditions including current or past dialysis **Yes** ☐ **No** ☐

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), bladder infections, other bladder or kidney problems.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.12 Blood conditions **Yes** ☐ **No** ☐

Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting disorders/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.13 Eye conditions **Yes** ☐ **No** ☐

Example: intra-ocular pressure, visual disturbances, night blindness, cataract, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.14 Ear, nose and throat (ENT) and dentistry conditions **Yes** ☐ **No** ☐

Examples: otitis media (middle ear infection), otitis externa, (ear canal infection) hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.15 Male urogenital conditions **Yes** ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), tumours, undescended testes, phimosis, urinary incontinence, retention, infertility.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.16 Are you or any of your dependant/s expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.17 Have you or any of your dependant/s received, or not yet received, medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

7.18 Have you or any of your dependants ever been diagnosed with or received treatment for, any condition/ symptoms or any allergic reactions or side-effects, not mentioned in the questions above, in the last 12 months before this application? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0861 638 633** within seven working days from the date we activate your Netcare Medical Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIV *Care* Programme. Netcare Medical Scheme

may have waiting periods that apply in certain circumstances. This means there may be a set time period before Netcare Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. We will not indicate the 12-month condition specific waiting on a counter offer letter, if the waiting period is applied prior to activation of membership due to the sensitivity of this information. We will not indicate the 12-month condition specific waiting period on a membership certificate if the waiting period is applied due to the sensitivity of this information. If you do not let us know about you or your dependant(s) HIV status within 7 days of your membership being active, we may end your Netcare Medical Scheme membership.

8. Privacy Statement for Netcare Medical Scheme administered by Discovery Health (Pty) Ltd

When you engage with Netcare Medical Aid Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants and beneficiaries, where applicable. To view and read our Privacy Statement, please follow this link: **https://www.netcaremedicalscheme.co.za/assets/medical-schemes/netcare/netcare-privacy-statement.pdf**

Signature of main applicant

Date D D M M Y Y Y Y

Please do not sign an incomplete application form

9. Terms and Conditions applicable to Netcare Medical Scheme membership

1. Who "we" are

Netcare Medical Scheme, registration no 1584, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Netcare Medical Scheme, an authorised financial services provider.

2. Rules for membership

The rules of Netcare Medical Scheme records your rights and responsibilities for your membership of Netcare Medical Scheme. They may change from time to time. You may ask Netcare Medical Scheme for a copy at any time. When you sign this application, you confirm that you have read and understood the rules and you agree that you and, those for whom you apply, will be bound by them. Where applicable you also acknowledge and confirm you or your employer appointed, may communicate with us on this application and your membership to Netcare Medical Scheme. The information will be shared so that he or she may contact us if necessary while we process your membership application. Please speak to your employer if there is anything you do not understand.

3. Acting for others

You may apply to join Netcare Medical Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Netcare Medical Scheme rules. For anyone to be treated as financially dependent for this application, you must be responsible for providing financially for that dependant. We might ask you to provide us with proof of financial responsibility. You will be referred to as the principal member or main member in our future communications to you.

You confirm you have the right to act for others

By signing this document, you confirm that:

- You have the right to apply for membership and to act for those for whom you are applying in any matter relating to this application;
- You have received permission from your spouse and any dependant/s over 18 to act on their behalf in any matter relating to this application; and
- In the event that you are signing on behalf of a minor (person younger than 18 years old) that you are a competent person and authorised to sign on their behalf.

4. Giving and getting information

You must give true, correct and complete information

To consider your application for membership, Netcare Medical Scheme must learn more about you and those for whom you apply. This information must be true, correct and complete. This includes the details you provide in this application form and in future dealings with us. It is important that you inform us of any medical condition, symptom or illness relating to you or those for whom you are applying, even if you do not consider it relevant to your application.

We may ask for more information about those for whom you are applying if they are 18 years of age or older.

Your legal address

We will send documents to you at the address you selected as the communication channel at which you prefer to be contacted. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have provided, or at any other address you have supplied. It is your responsibility to make sure we have the correct address for you.

Netcare Medical Scheme and the administrator may record telephone calls

Netcare Medical Scheme and the administrator may record telephone conversations with you and with those for whom you are applying. The recordings and all information we obtain during the recordings will be processed and retained as required by law.

We may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers), you agree that we may obtain information about you and those for whom you are applying from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you provide on this application and in respect of any matter pertaining to or that arises during your membership of Netcare Medical Scheme, is true, correct and complete. You give your permission that we may obtain any information that is relevant to your application and membership from your employer.

Inform us immediately if your information changes

You or your employer must inform us in writing should any of the information you have provided, in your application for membership, changes between the day you sign this document and the day your membership commences. This includes information regarding your health and the health of those for whom you apply. If at any stage you become a direct paying member, we require advance notice of any administrative changes such as cancellation of membership, as we cannot accept backdated changes.

5. When Netcare Medical Scheme may cancel your membership/s

Netcare Medical Scheme may suspend or cancel any membership immediately, if the member or dependant/s on the membership is found guilty of abuse of privilege of the Scheme. It is very important for the member and dependant/s to provide true, correct and complete information on the application form and in their dealings with the Scheme.

6. Becoming a member

Netcare Medical Scheme might not pay for certain expenses immediately after you become a member

Netcare Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before

Netcare Medical Scheme begins paying for any general or specific medical conditions. Please speak to your employer or one of our consultants to find out if waiting periods apply to your membership and the memberships of those for whom you are applying.

Resign from your current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those for whom you are applying must resign from your current medical scheme/s when you receive notice from Netcare Medical Scheme by letter, email or SMS informing you that you and those for whom you have applied have been accepted.

7. Contributions

As the main member of Netcare Medical Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time.

8. Repaying money owed to the Scheme

Netcare Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you should there be any such amount owed to the Scheme.

Signature of main applicant

Date D D M M Y Y Y Y

The main applicant must sign and date any changes.
Please do not sign an incomplete application form.
I confirm the information is accurate and complete.

10. Bank Details

Documents we need for a third-party bank account

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds.

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's account holder ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
  - State that the account can be used
  - State the membership details (including the membership or policy numbers) for which the bank account will be used
  - Include the details of the signatory
  - Be dated and signed by an authorised person on behalf of the company
- A copy of the company's certificate of registration.
- A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
  - Show the trustees
  - Be dated and signed by an authorised person on behalf of the trust
  - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.