MEDSHIELD
medical scheme

MEDSHIELD MEMBER APPLICATION

Email: newapplication@medshield.co.za

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary. All sections must be completed.

Selection of Benefit Option: _____

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Start Date of Membership: | D | D | M | M | Y | Y | Y | Y |

Applicant Signature: _____ Date: | D | D | M | M | Y | Y | Y | Y |

CONSULTANT DECLARATION

Brokerage Name:	I	R	A	C	E	M	A		F	O	N	S	E	C	A					
Broker Code:	6	2	3	7	0	7	4	8												

DOCUMENT CHECKLIST

In order to avoid rejection of your application please provide the following documents:	Please Tick
ID document copy(ies) for all beneficiaries (e.g. ID/birth certificate/passport)	
Student certificate (child dependant age 21-27 that is studying or turning 21 in the next 3 months)	
Proof of previous medical scheme (certificate of membership reflecting an end date)	
Mem02 - Member Record Amendment (for Special Dependants: e.g. parents, foster child, niece, nephew, brother, sister, grandchild)	
Stamped bank statement or stamped confirmation letter from the bank or copy of cancelled cheque and signed letter of authority for 3rd Parties	
ID copy(ies) of the nominated 3rd Party(ies) Consent (To whom we may provide specified information)	

I, _____ hereby understand that it is an offense to submit fraudulent business and have explained Non-disclosure, General and condition specific waiting periods, Late Joiner Penalty, PMB and proration of benefits to the applicant. I further declare that I have attached all documents as per the document checklist above to this application form, and that the application form is submitted to the Scheme within 14 days of the member declaration sign date.

Consultant's Signature: _____ Date: | D | D | M | M | Y | Y | Y | Y |

SECTION A PERSONAL DETAILS (attach copy of ID document)

Title: Initials:

First Name/s:

Surname:

ID/Passport Number:

Date of Birth: D D M M Y Y Y Y

Postal Address:

Postal Code:

Residential Address:

Please provide at least one email address

Personal Email Address:

Business Email Address:

Telephone Number (W): C O D E

Telephone Number (H): C O D E

Cell Number:

Fax Number: C O D E

Tax Number:

Please complete for marketing purposes:

Gender: (Mark with an X) M F Marital Status: Single Married Divorced Widowed

Please complete for statistical purposes. If you do not wish to disclose your race, please mark the relevant box with an X.

Race: African Caucasian/ White Coloured Indian Asian Other

I do not wish to disclose:

SECTION B DEPENDANTS YOU WISH TO REGISTER (attach copy of ID document)

Spouse or Partner: Spouse Life Partner Divorced Spouse

Title: Initials:

First Names:

Surname:

Previous Surname:

ID/Passport Number:

Date of Birth: D D M M Y Y Y Y

Country of Residence:

Dependant Email Address:

Dependant Tel Number (W): C O D E

Dependant Cell Number:

Please complete for marketing purposes:

Gender: (Mark with an X) M F Marital Status: Single Married Divorced Widowed

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race: African Caucasian/ White Coloured Indian Asian Other

I do not wish to disclose:

Please complete a MEM02 form for Special Dependants (e.g. parents, foster child, niece, nephew, sibling, grandchild). Acceptance of dependants will be in accordance with the Rules of the Scheme. Affidavits are required for Special Dependants. Please attach copies of the dependants' ID or birth certificate or passport.

Dependant 1

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number:

Dependant Email Address:

Dependant Cell Number:

Relationship to Principal Member:

Gender: (Mark with an X) M F Adult Over 21: (Mark with an X) Y N

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race: African Caucasian/ White Coloured Indian Asian Other

I do not wish to disclose:

Dependant 2

Name of Dependant:

Surname: (If Different to Principal Member)

ID Number:

Dependant Email Address:

Dependant Cell Number:

Relationship to Principal Member:

Gender: (Mark with an X) M F Adult Over 21: (Mark with an X) Y N

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race: African Caucasian/ White Coloured Indian Asian Other

I do not wish to disclose:

Dependant 3

Name of Dependant:																		
Surname: (If Different to Principal Member)																		
ID Number:																		
Dependant Email Address:																		
Dependant Cell Number:																		
Relationship to Principal Member:																		
Gender: (Mark with an X)	M		F			Adult Over 21: (Mark with an X)							Y		N			

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 4

Name of Dependant:																		
Surname: (If Different to Principal Member)																		
ID Number:																		
Dependant Email Address:																		
Dependant Cell Number:																		
Relationship to Principal Member:																		
Gender: (Mark with an X)	M		F			Adult Over 21: (Mark with an X)							Y		N			

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 5

Name of Dependant:																		
Surname: (If Different to Principal Member)																		
ID Number:																		
Dependant Email Address:																		
Dependant Cell Number:																		
Relationship to Principal Member:																		
Gender: (Mark with an X)	M		F			Adult Over 21: (Mark with an X)							Y		N			

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

SECTION C FAMILY PRACTITIONER (FP) NOMINATION – MediPhila, MediCurve, MediValue Compact and MediPlus Compact

If you have selected MediPhila, MediCurve or one of the Compact options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP). If you do not nominate a FP as per the criteria listed per option below, your application form will not be processed by the Scheme.

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediCurve: Each Beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

MediValue Compact and MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where a FP was nominated from the FP Network & Day-to-Day benefit is depleted the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION D PREVIOUS MEDICAL AID HISTORY

Where applicable, please provide details and proof of all previous registered South African medical schemes you and your dependants belonged to (proof in the form of membership certificates reflecting the join and end dates, must be attached to this application form). This information is used to determine whether waiting periods and or late joiner penalties are applicable.
Where late joiner penalties have already been imposed and evidence of credible cover is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the following month. No backdate will be allowed unless evidence of previous submission is provided to the Scheme.

Select relevant box with a tick:

Principal Member:									Dependant:										
Name & Surname:																			
Name of Scheme:																			
Membership Number:																			
Date Joined:	D	D	M	M	Y	Y	Y	Y	Date Terminated:				D	D	M	M	Y	Y	Y	Y

Principal Member:								Dependant:												
Name & Surname:																				
Name of Scheme:																				
Membership Number:																				
Date Joined:	D	D	M	M	Y	Y	Y	Y	Date Terminated:	D	D	M	M	Y	Y	Y	Y			

Principal Member:								Dependant:												
Name & Surname:																				
Name of Scheme:																				
Membership Number:																				
Date Joined:	D	D	M	M	Y	Y	Y	Y	Date Terminated:	D	D	M	M	Y	Y	Y	Y			

Principal Member:								Dependant:												
Name & Surname:																				
Name of Scheme:																				
Membership Number:																				
Date Joined:	D	D	M	M	Y	Y	Y	Y	Date Terminated:	D	D	M	M	Y	Y	Y	Y			

SECTION E — MEDICAL HISTORY (yes or no)

To be completed by each applicant in respect of himself/herself and all his/her dependants. All questions must be answered with a "Yes" or "No".

All conditions, symptoms and or disorders have to be declared, no matter how insignificant they may seem. Incomplete, inaccurate information or information that is withheld may result in the termination of your membership effective from date of registration.

If additional space is required, please complete a separate sheet of paper and attach it to the application.

1. Have you or any of your dependants sought advice, been diagnosed or treated for any condition within the past 12 months? Y | N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		
Any additional information:						

2. Do you, or any of your dependants take chronic medication or are you expecting to take medication on an ongoing basis? Y | N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.
Your doctor or pharmacist can contact Chronic Medicine Management on 086 000 2120 to telephonically register you for chronic medication.
Any additional information:

3. Have you or any of your dependants been admitted to hospital or undergone any procedure (other than routine medical or dental treatment) in the past 12 months? Y N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		
Any additional information:						

4. Are you or any of your dependants planning or reasonably expecting to be hospitalised or to have a procedure or treatment in the next 12 months - including pregnancy? Y N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		
Any additional information:						

5. Are there any other conditions or symptoms not mentioned above for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months that you would like to disclose? Y N

Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		
Any additional information:						

IMMUNE DEFICIENCY STATUS (Confidential Disclosure)

If you, or any of your dependants, have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Programme on 086 050 6080 to register on the HIV/AIDS Disease Management Programme. Failure to do so within 21 days of joining the Scheme will be considered as non-disclosure of information and may result in termination of your membership.

SECTION F BANK DETAILS

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account.
A stamped bank statement or cancelled cheque or a stamped confirmation letter from the bank in the name of the Principal Member is required.
Should contributions be paid by a 3rd party, a stamped bank statement or cancelled cheque or a stamped confirmation letter from the bank together with a signed letter of authorisation from the account holder must accompany this form. For Companies/Groups a signed letter of authorisation needs to be on a company letterhead.

Use this account for: **Contributions only** ☐ **Contributions and Claim Refunds** ☐

Bank Name:

Branch Name:

Branch Code:

Type of Account: (Mark with an X) Current | Transmission | Savings

Name of Account Holder:

Bank Account Number:

Date: D D M M Y Y Y Y

Signature of Account Holder: _____

Use this account for: **Claims Refunds Only** ☐

Bank Name:

Branch Name:

Branch Code:

Type of Account: (Mark with an X) Current | Transmission | Savings

Name of Account Holder:

Bank Account Number:

Date: D D M M Y Y Y Y

Signature of Account Holder: _____

SECTION G EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date: D D M M Y Y Y Y

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section G have been completed:

Employer's Email Address:

Employer's Representative's Name:

Employer's Representative's Designation:

Date: D D M M Y Y Y Y

Signature of Employer's Representative: _____

SECTION H — CONSENT (Consent for Medshield Medical Scheme to process personal information)

The Scheme understands that your personal information and that of your dependants is important to you. Medshield undertakes to keep this information confidential and shall take all reasonable steps to comply with the provisions of legislation protecting your personal information.
We require your consent to obtain, process and disseminate your personal information so we can provide you with the services stipulated in our contractual agreement, as detailed for your chosen benefit option and in compliance with the Medical Schemes Act 131/1998. These services include but is not limited to:

a. Treatment Authorisations;
b. Claims Assessment;
c. Claims Payment;
d. Communication;
e. Disease Management; and
f. Wellness Initiatives.

While your consent is voluntary, it is a requirement for the administration of your Medshield membership. **If you object to the processing of your personal information, the Scheme will not be able to activate and service your membership.**

I, the Principal Member, _____ (Name & Surname),

ID number _____, do hereby:

Please read the items of consent below carefully. All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

☐ Give permission, with the consent of my dependants, that Medshield Medical Scheme may collect, process, store and share our personal information, including health information with the Scheme's contracted service providers to perform their functions for the administration and/or managed care of my membership which include the assessment and processing of my application, eligibility, underwriting, risk assessment, assessment and payment of claims, the provision of managed healthcare services, assessments of non-disclosures, validation and allocation of benefits, reporting to statutory bodies, fraud prevention and detection, member surveys and communication, collection and refund of contributions, members portions and savings and credit reporting.

☐ Authorise Medshield Medical Scheme to obtain from any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my or any of my dependants' health, whether such information relates to the past or future, to disclose such information to the Scheme and it's contracted third parties and agree that this request shall remain in force after my / their death, as well as prior thereto.

☐ Confirm that I am duly authorised to apply for membership and to act for those for whom I am applying for under the age of 18 in any matter relating to this application and the administration of our Medshield membership.

☐ I hereby acknowledge and declare that as the Principal Member of the Scheme, to the extent that it may be required by law, that I have received the necessary consent from my dependant(s) over the age of 18 to act on their behalf in any matter relating to this application and the administration of our Medshield Membership and to access and view their healthcare claims.

☐ Consent that all conversations between me, or any of my dependant(s), and the Scheme or its contracted service providers may be recorded.

☐ Acknowledge that my and my dependants' personal information, shall be retained as part of the records of the Scheme for as long as it is required by the Scheme for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of the applicable law. Medshield Medical Scheme are required to collect and keep personal information in terms of the allowable statutory limits.

☐ Confirm that if I (Principal Member) am part of a group membership by virtue of employment, I grant permission to Medshield Medical Scheme to share information relating to my membership with my employer. This will be limited to information that is relevant to my application, collection of contributions and information that is required for the ongoing servicing of my membership, but will not include any health information unless I have given Medshield permission to do so.

☐ Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Planner, if any, who is an accredited Medical Aid Broker of my choice.

☐ Consent to receive Scheme communication as it pertains to my membership and any information from the Scheme which could enhance my benefits, health and the management of my health.

☐ I have the right to request my personal information and that of my dependant(s), which is in the possession of Medshield Medical Scheme, provided that I furnish adequate identification and written consent from my dependant(s) over the age of 18.

☐ I have the right to request Medshield Medical Scheme where necessary, to correct, or delete my, or any of my dependant(s), personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.

☐ I shall inform the Scheme of any changes relating to my or any of my dependant(s) personal information within 30 days of the change, as required by the Scheme rules, as it may impact the administration of my membership and communication from the Scheme.

☐ I agree that should I have a complaint relating to the processing of my and my dependant(s) personal information, I will refer it to the Scheme to resolve. If I am not satisfied with the outcome of the complaint, I may refer the complaint to the Information Regulator.

Principal Member Signature: _____ Date: | D | D | M | M | Y | Y | Y | Y |

SECTION I MEMBER DECLARATION

All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

Please read the declarations below carefully.

1. ☐ I the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree that my dependants and I shall abide by its Rules as amended from time to time which are available on Medshield's website www.medshield.co.za

2. ☐ I understand that the Scheme's brochures are a summarised version and do not supersede the rules of the Scheme.

3. ☐ I acknowledge that I have familiarised myself with the benefits covered on my benefit option of choice and that I may only change my benefit option during year-end for an effective date of 01 January.

4. ☐ I am aware of the fact that on joining the Scheme during the course of a calendar year, the maximum benefits to which I may be entitled shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular calendar year

5. ☐ I certify that all the information given is true and correct, whether completed by me or on my behalf, and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void, effective from date of registration. In such event, the Scheme will have the right to offset applicable costs against contributions paid and refund the difference, if any.

6. ☐ I understand that should a period greater than three (3-month) lapse since contributions were paid to Medshield, that my membership will not be reinstated and that I have to re-apply subject to full underwriting.

7. ☐ I undertake to give notice to the Scheme to terminate my membership in accordance with the Rules of the Scheme.

8. ☐ Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

If applicable:

9. ☐ I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

If applicable:

10. ☐ As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

11. ☐ Notwithstanding point 9 and 10, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

If applicable:

12. ☐ As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

13. ☐ I hereby authorise the Scheme, or any of its nominated representatives, to verify my bank details.

14. ☐ I acknowledge and agree that it's my responsibility to advise the Scheme in writing of any change in banking details. The Scheme will not be liable should an incorrect account be credited under any circumstances

15. ☐ The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi or by any agreed electronic means unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi or by any agreed electronic means shall be deemed to have been received by me on the 7th day after the date of posting.

16. ☐ I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:
- a 3 (three) month general waiting period in respect of all benefits;
- a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
- a late joiner contribution penalty.

17. ☐ I agree to inform the Scheme of any deterioration or change in my state of health or in that of my dependant(s) before the commencement date of membership, or the date of acceptance of this application form by the Scheme, or the date of receipt of the first subscription, whichever date is the latest shall entitle Medshield to reconsider the application and propose new terms of admission.

18. ☐ It is illegal to be a member of more than one medical scheme at the same time. I acknowledge that it is my responsibility to resign from my existing medical scheme and agree that neither me, nor any of my dependants, will be registered on both Medshield and another medical scheme simultaneously.

19. ☐ I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: _____ Date: D D M M Y Y Y Y

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form be submitted to the Scheme within 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

SECTION J THIRD PARTY CONSENT (To allow disclosure of information to a third party)

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words.
Mark with a tick where required. All sections must be completed.

ABOUT THE INFORMATION WE PROVIDE TO THE THIRD PARTY

This section needs to be completed if you want to nominate someone to manage your medical aid membership on your behalf. For instance your financial adviser/broker or a family member or a friend who you trust to administer your membership. We call this giving a Third Party Consent by nominating them on this form, which provides us with your approval that the Scheme may share specific personal information and/or discuss your membership with the specific Third Party you nominated below.

Additonally, please specify what type of information may be accessed by your financial adviser, employer representative and/or nominated Third Party, and for how long (if no date is specified, the consent will be in effect from the signature date until you revoke the consent in writing).

PRINCIPAL MEMBER DETAILS (attach copy of ID)

Membership Number:																				
Title:					Initials:															
Principal Member Name/s:																				
Principal Member Surname:																				
Principal Member ID number:																				
E-mail Address:																				

FINANCIAL ADVISER/BROKER (If applicable)

Your Financial Adviser/Broker																			
Broker code:																			
Financial Adviser/Brokerage Name:																			
Financial Adviser Email address:																			
Financial Adviser Telephone Number (W):																			

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my Financial Adviser/Broker as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

EMPLOYER REPRESENTATIVE (If applicable)

Your employer representative (if you form part of a group membership by virtue of employment) ☐

Company Name:

Employer Representative Name and Surname:

Employer Representative Email address:

Employer Representative Telephone Number (W):

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my employer representative as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

THIRD PARTY NOMINEE (Another adult that you choose to administer your membership on your behalf.

DOCUMENT CHECKLIST

For third party nomination and consent, please attach the below documents	Please Tick
ID copy(ies) of Principal Member and/or person giving consent	
ID copy(ies) of your nominated Third Party	

Third Party Nominee 1 ☐

Relationship to Principal Member:

Title: Initials:

First Name/s:

Surname:

ID Number:

Date of Birth: D D M M Y Y Y Y

Email Address:

Telephone Number (W):	C	O	D	E							
Telephone Number (H):	C	O	D	E							
Cell Number:											
Gender: (Mark with an X)	M		F								

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my nominated Third Party as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

Third Party Nominee 2 ☐

Relationship to Principal Member:																			
Title:					Initials:														
First Name/s:																			
Surname:																			
ID Number:																			
Date of Birth:	D	D	M	M	Y	Y	Y	Y											
Email Address:																			
Telephone Number (W):	C	O	D	E															
Telephone Number (H):	C	O	D	E															
Cell Number:																			
Gender: (Mark with an X)	M		F																

YOUR LEGAL DECLARATION

1. I acknowledge and understand that this document authorises Medshield Medical Scheme and its outsourced providers to disclose and/or distribute the above information to the nominated third party(s)/employer representative/financial adviser, if any indicated herein.
2. I agree that by making this information available, Medshield Medical Scheme and its outsourced providers accepts no liability whatsoever for any loss, including direct, indirect and consequential loss, that may arise from the use of this information other than where it is due to, or attributable to, gross negligence or fraudulent conduct by the Scheme.
3. I understand that the consent provided to Third Party(s) will be in force during the specified time periods. If I have not specified the dates, the consent will be in effect from the signature date below until I revoke the consent in writing.

4. Confirm that if I am part of a group membership by virtue of employment, the consent granted to my employer representative will cease when my employment with the company comes to an end. I hereby agree to inform Medshield Medical Scheme immediately of any employment changes.
5. The consent granted to my financial adviser (if applicable) will become null and void in the event that I appoint a new financial adviser.
6. This consent will become null and void in the event of the death of a member or person providing consent, and a new consent form should be completed by the appointed executor of the deceased estate.
7. I may choose to change or revoke my consent at any time by informing the Scheme in writing.

Signed at: _____ Date: | D | D | M | M | Y | Y | Y | Y |

Signature of Person Giving Consent: _____

Name of Person Giving Consent: | | | | | | | | | | | | | | | | | | | |