CompCare
Medical Scheme

CompCare Medical Scheme
Administered by Universal Healthcare Administrators (Pty) Ltd
Universal House, 15 Tambach Road, Sunninghill Park, Sandton 2191
PO Box 1411 Rivonia 2128
Tel: 0861 222 777 **Email:** membership@universal.co.za
www.compcare.co.za

MEMBER AND DEPENDANT APPLICATION FORM

Please ensure that when completing this form you provide complete, up to date and accurate information at all times. Any non-disclosure of material information or any other fraudulent act may result in cancellation or suspension of your membership. You may also be guilty of an offence as provided for in the Medical Schemes Act 131 of 1998 and liable on conviction to a fine or imprisonment or both.

Name of employer

Join date Y Y M M D D

Name of individual

Membership number

Option (please select the appropriate box)

- ☐ **ExecuCare Plus**
- ☐ **UltraCare Plus**
- ☐ **ExtraCare**
- ☐ **SaverCare Plus**
- ☐ **ExecuCare**
- ☐ **UltraCare**
- ☐ **SelfCare Plus**
- ☐ **HospiCare**

CHECKLIST DOCUMENTATION TO ACCOMPANY THIS APPLICATION

- ☐ Membership certificate/s from previous medical aid/s*
- ☐ Copy of Identity Documents/copy of passport
- ☐ Adult dependant 21 years and over – Proof of registration/Affidavit of dependency
- ☐ Proof of adopted/Foster/Child status – legal documents

***PLEASE ATTACH CERTIFICATES OF MEMBERSHIP FROM THE PREVIOUS MEDICAL SCHEME TO THIS APPLICATION**

FOR OFFICE USE ONLY

Member number

Company code

Persal number

Code

SECTION 1 - EMPLOYER DETAILS

Name of employer

Employee number

Contact person

Postal address

Postal code

Email address

Telephone details Tel Code ( ) Cell

SECTION 2 - PRINCIPAL MEMBER DETAILS

Surname

First name/s

Title Marital status Nationality Present age

Date of birth ID/Passport number

Tax number Race African Coloured Indian/Asian White

Postal address Postal code

Physical address

Email address

Telephone details (W) Code ( ) (H) Code ( )

Cell

Occupation Date employed Y Y M M D D

Gross monthly earnings (all income including salary, commission, fringe benefits, interest, dividends etc) R

(Please note that if no proof of income is attached, members will be billed on the maximum income category)

Name of GP GP Telephone No GP Practice No

SECTION 3 - SPOUSE/PARTNER DETAILS

Surname

First name/s

Title Marital status Nationality Present age

Date of birth ID/Passport number

Tax number Race African Coloured Indian/Asian White

Telephone details (W) Code ( ) (H) Code ( )

Cell

Occupation Date employed Y Y M M D D

Gross monthly earnings (all income including salary, commission, fringe benefits, interest, dividends etc) R

(Please note that if no proof of income is attached, members will be billed on the maximum income category)

Name of GP GP Telephone No GP Practice No

SECTION 4 - DEPENDANT DETAILS (INCLUDING SPOUSE/PARTNER)

No	Gender	Race	First name/s and Surname	Identity or Passport Number	Relationship	Living-in	Income p.m.
							R

PLEASE NOTE: For any dependant/s other than your direct family, please provide affidavits/legal documents.

SECTION 5A - MEDICAL DETAILS

Please complete all questions in full, as non-disclosure of material information could prejudice future claims made by you and/or any of your dependants.

	Principal member	Spouse/Partner	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Height (cm)							
Weight (kg)							
Smoker/Non smoker							

Please give the name of your General Practitioner and/or specialist whom you or any of your dependants have consulted recently.

Name of General Practitioner/Specialist	Telephone details	Number of years consulted
	Code ( )	
	Code ( )	
	Code ( )	
	Code ( )	

In the event that I am hospitalised and the Scheme will need to communicate with someone on my behalf, I hereby nominate the following person and warrant that I have obtained their consent to share their personal details with the Scheme for this purpose:

Name and Surname _____ Relationship _____

Telephone details Code ( ) _____ Cell _____

SECTION 5B - MEDICAL HISTORY QUESTIONNAIRE

It is most important that the questions listed below be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition of which you are aware, which is not disclosed in this application, can be excluded from benefits. Please advise whether you and any of your dependants suffer from, or have suffered from, or received treatment/consultation for any of the following conditions. Please ensure that you **underline** the appropriate condition, select and complete the appropriate block/s.

			YES	NO	Name of member/dependant
1.	**Heart and Vascular System**	High blood pressure; high cholesterol; angina; heart attack; angiogram; previous coronary artery bypass; rheumatic fever; heart murmurs; valve problems/replacement; arrhythmias – insertion of pacemakers; heart failure; stroke; varicose veins; DVTs (deep vein thrombosis); pulmonary emboli.			
2.	**Lungs**	Asthma; emphysema; chronic bronchitis; TB; chronic infections - bronchitis and pneumonia.			
3.	**Digestive System, Gallbladder, Liver**	Dyspeptic disease (heartburn; hiatus hernia; peptic ulcers; reflux); irritable bowel syndrome (spastic colon; inflammatory bowel disease e.g. Crohn's disease and ulcerative colitis; chronic diarrhoea/ constipation); gallstones and jaundice; hepatitis; pancreatitis; haemorrhoids; incontinence; bowel prolapse.			
4.	**Nervous System**	Persistent headaches; epilepsy; paralysis; degenerative diseases – Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).			
5.	**Bone, Muscle and Joints**	Arthritis; rheumatism; gout; back, knee or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease; osteoporosis; previous amputations/artificial limbs; birth defects; joint replacements.			
6.	**Urinary Tract**	Infections; stones; albumin/blood in urine; urinary incontinence; prolapsed bladder.			
7.	**Gynaecological System**	Menopause; female hormone replacement; irregular menses; infertility; breast tumours (benign/malignant); ovarian tumours; cysts; prolapsed uterus/rectum/bladder; miscarriage; caesarean section.			
8.	**Male Genital System**	Prostate problems (hypertrophy/cancer or infections); infertility; hernias – groin; scrotal swellings; testicular tumours; abnormalities of the penis; problems with urination.			
9.	**Gland or Hormonal**	Over/under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.			
10.	**Blood**	Anaemia; bleeding disorders (haemophilia); leukaemia; Hodgkin's disease.			
11.	**Ear, Nose and Throat**	Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness – hearing aids.			
12.	**Eyes**	Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus); allergies – pterygiums; anticipated/previous laser surgery; artificial eyes.			
13.	**Emotional (psychological, psychosomatic problems)**	Depression; bipolar disorder; anxiety; stress; previous treatment for post traumatic stress syndrome; eating disorders – bulimia and anorexia; mental retardation; alcoholism; drug abuse. Have you or any of your dependants ever been on sleeping tablets or antidepressants?			
14.	**Infections or Tropical Diseases**	Sexually transmitted diseases; genital warts; HIV/AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzia; cholera; typhoid fever.			
15.	**Skin Disorders**	Acne; eczema; psoriases; lesions (keloid hypertrophic scars); skin rashes; shingles; Kaposi sarcoma – tumours.			

SECTION 5B - MEDICAL HISTORY QUESTIONNAIRE – continued

			YES	NO	Name of member/dependant
16.	**Connective Tissue Disorders**	Systemic lupus erythromatosis; scleroderma; rheumatoid arthritis.			
17.	**Teeth and Gums**	Impacted molars (wisdom teeth); previous/current orthodontic treatment; braces; crowns; recurrent infections - gums.			
18.	**Cancer**	Cysts; growths; tumours of any kind.			
19.	**Allergies**	Are you or any of your dependants allergic to any specific type of medication (e.g. penicillin, aspirin, sulphas, morphine, NSAIDS); pollen; dust; animals; specific food types (e.g. nuts).			
20.	**Immuno-Suppressive Treatment**	Have you or any of your dependants ever had or expecting to undergo an organ treatment transplant? Have you or any of your dependants ever suffered from any condition requiring Immunosuppressive treatment?			
21.	Have you or any of your dependants ever received any form of physiotherapy, occupational therapy or chiropractic treatment?				
22.	Are you or any of your dependants pregnant? If **yes** - how many weeks? Please give expected date of delivery.				
23.	Have you or any of your dependants had any previous or pending claims for which any other party may be liable e.g. MVA (Motor Vehicle Accident) claims? If **yes,** please give details.				
24.	Are you or any of your dependants expecting to undergo any medical treatment, e.g. hospitalisation, operation, specialised dentistry etc, within the next twelve months?				
25.	Do you or any of your dependants have a chronic condition requiring ongoing medication? If **yes,** please give the name and dosage of all the medication you or any of your dependants are currently taking.				
26.	Have you or any of your dependants ever received any medical attention of any nature, e.g. hospitalisation, operation, specialised dentistry etc, not mentioned above?				
27.	Have you and any dependants ever appeared before a medical scheme review board in view of early retirement and declared medically unfit?				
28.	Are you or any of your dependants organ donors?				

If any of the questions above have been answered yes, please supply full details below. If there is not enough space, please attach an additional page.

No	Member/Dep	Full details of the disorder, consulting Doctor, type of medication and dosage used	Date of treatment	Degree of recovery

IMPORTANT! The Scheme may exclude from benefits or terminate the membership of a member or dependant whom the Scheme finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making misrepresentation or the non-disclosure of factual information. In such an event, the member may be required by the Board to refund the Scheme any sum which, but for his abuse of the benefits or privileges of the Scheme, would not have been disbursed on his behalf.

SECTION 6 - LIVING WILL

At CompCare Medical Scheme we strive for your rights to good health, and will protect and fight for that right. However, we also respect your right to dignity, and respect your right to a living will. Do you have a living will?

☐ Yes ☐ No

SECTION 7 - PREVIOUS MEMBERSHIP

Please attach certificates of membership (from previous medical scheme/s) to this application. If no certificate/s is attached, interchangeability could be forfeited.

Name of previous medical scheme/s	Membership number	Date joined	Date terminated

SECTION 8 - ELECTRONIC TRANSFER INFORMATION

PERSONAL BANKING DETAILS

Electronic transfer of payments to you and collection of member's portions (co-payments) where applicable.

CREDIT CARD AND TRANSMISSION ACCOUNTS ARE NOT ACCEPTED

	PAYMENTS (Claims refunds)	COLLECTIONS (Member's portions)
Name of account holder		
Account holder's ID no		
Name of bank		
Branch		
Branch number	- -	- -
Account number		
Type of account	Current ☐ Savings ☐	Current ☐ Savings ☐

DISCLAIMER: It is the member's responsibility to advise the Scheme in writing of any change in banking details. Neither the Scheme nor its administrators will be held liable should an incorrect account be credited under any circumstances.

I/We hereby authorise the Scheme to debit my/our bank account, the amount necessary for amounts owed by the member to the Scheme to the maximum value of R500 or as arranged with the Scheme.

Authorised Signature/s	Date (Y Y M M D D)	Authorised Signature/s	Date (Y Y M M D D)
Member's Signature (if different from the authorised signature)	Date (Y Y M M D D)	Member's Signature (if different from the authorised signature)	Date (Y Y M M D D)

SECTION 9 - METHOD OF PAYMENT OF CONTRIBUTION

Please note that credit card and transmission accounts are not accepted.

Please select method of payment (please tick) Debit order ☐ Employer deduction ☐

If paying by debit order, please fill in the following:

I/We hereby authorise the Scheme to debit my/our banking account (wherever it may be), the amount necessary for any contributions and changes in relation to this agreement, incorporating the contribution rate changes.

Name of account holder			
Name of bank		Branch	
Type of account		Branch code	
Account number		Type of account - please tick	Current ☐ Savings ☐
Authorised signatory		Monthly preferred debit order date	1st ☐ 15th ☐ 26th ☐

SECTION 10 - COMPCARE MEDICAL SCHEME DECLARATION

1. CompCare Medical Scheme, hereafter referred to as "the Scheme", confirms that your and your dependants' personal details and medical information shall be kept confidential and the Scheme shall take all reasonable steps to comply with the provisions of any legislation applicable to the protection of your and your dependants' personal information.
2. The Scheme confirms that your and your dependants' identifiable information (personal and health information) will neither be used for purposes of related company business nor sold for commercial purposes.
3. The Scheme confirms that it has data security measures in place, including restricted access to your and your dependants' data, data back-up systems and data recovery systems.
4. The Scheme shall take all reasonable steps to ensure that all staff within the Scheme and all third parties who have access to beneficiary information for the purpose of data transfer and management, Scheme administration, managed care agreements and compliance with applicable legislation, keep the personal information of beneficiaries confidential and comply with applicable legislation.
5. The Scheme confirms it has granted access to certain persons within the Scheme and its contracted third parties to your and your dependants' personal and health information. The use of relevant personal information and/or personal health information provided is for the following purposes: Verifying your identity; processing your application for membership; administration of your medical scheme membership; membership verification and eligibility checking; assessment, processing and reimbursement of claims for medical expenses; determining your entitlement to benefits; underwriting or risk assessments; providing relevant information to a healthcare provider who requires this information to provide a healthcare service to you or any of your dependants; providing managed care services to you or any of your dependants; sharing your information with service providers, including electronic switching houses, for the purpose of processing it and rendering services to you such as electronic submission of claims to us; risk management practices; fraud prevention and detection, audit and record-keeping purposes; compliance with applicable legal and regulatory requirements; population of the beneficiary registry as required by the Council for Medical Schemes and the Department of Health; collection of monies owed by you or healthcare providers to us; statistical analysis (this will always be on an anonymous basis, which means that data about you that is relevant to the analysis is used but it is not linked to your name or membership number).
6. In the event of a breach of confidentiality, the Scheme shall assume responsibility if the Scheme is at fault and will manage the breach according to its internal protocols and disciplinary procedures.
7. The Scheme will ensure that underwriting is applied to all members in a consistent and equitable manner.

SECTION 11 - MEMBER ACKNOWLEDGEMENT AND DECLARATION

Please read the declarations below carefully. These contain acknowledgements of fact that may impact on your rights. These declarations must be read in conjunction with the rules of CompCare Medical Scheme (hereafter referred to as "the Scheme"), and the Medical Schemes Act No. 131 of 1998 (hereafter referred to as "the MSA"), and all these provisions shall be binding on you and your dependants.

1. I, the undersigned, hereby apply for membership of CompCare Medical Scheme and agree that all answers and information relating to my dependants and I, contained in this application completed by me or by any other person, will be the basis of the proposed agreement.
2. I warrant that the contents of this application are true, correct and complete, whether the information is relating to myself or any of my listed dependants. No cover will be granted unless the Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
3. I agree to abide by and undertake to familiarise myself with the rules of the Scheme as amended from time to time and grant my employer the right to deduct from my remuneration any amounts (including member's portions) outstanding by myself to the Scheme. I further grant my employer the right to pay such monies over the Scheme.
4. I agree that contribution late joiner penalties may apply to my adult dependants 35 years and older if they have not been a member or a dependant of any previous medical scheme(s) or existing dependant at time of registration.
5. I understand that the Scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition-specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998).
6. I agree to notify the Scheme within 30 days in the event that any alternation in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk.
7. I declare that neither the applicant nor any of his/her dependant/s are beneficiaries of another registered medical scheme, on the date of registration with CompCare Medical Scheme.
8. I hereby give the Scheme permission to communicate to me by SMS or Email.
9. I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the Scheme from liability and subject my membership to cancellation. I warrant that I am authorised to sign on behalf of my dependant/s. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

SECTION 11 - MEMBER ACKNOWLEDGEMENT AND DECLARATION – continued

10. I also authorise any doctor or other person, who may be in possession of or hereafter acquire information about my health or the health of my dependants, to disclose the information to the Scheme and its contracted third parties, provided such information shall be treated as confidential at all times. I confirm that I have the required consent of my dependants to share information of such dependants with the Scheme and its contracted third parties.
11. I understand that my confidential health and personal information will only be used for the purposes as outlined by the Scheme on the application form and any deviation from this constitutes a breach of confidentiality.
12. In the event that the Scheme wishes to use my (or my dependants') confidential information for purposes other than those outlined in the application form, the rules of the Scheme and the MSA, the Scheme is required to obtain further consent from me (or my dependants).
13. I agree to inform the Scheme of any changes in my or my dependants' personal status, as required by the Scheme rules, within 30 days of the change in circumstances.
14. I shall ensure that the Scheme is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of my application for membership, the administration of my membership, payment of claims and communication by the Scheme with me.
15. I acknowledge that my dependants and I may have access to our personal information held by the Scheme and request the Scheme to correct any inaccurate information as prescribed by applicable legislation.
16. I further acknowledge that the personal information of my dependants and I 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 applicable law.
17. If any of my dependants or I have any concern about the processing of our personal information, we can raise the matter with the Scheme by contacting the Principal Officer.
18. I consent to all conversations between myself and the Scheme or its contracted third parties being recorded.
19. I confirm that I am familiar with the terms of this agreement, being the conditions, limits and benefits of the Scheme.
20. I hereby guarantee that as the main member of the Scheme, to the extent that it may be required by law, that I have received the necessary consent from my dependants to access and view their healthcare claims made on my membership and deal with all matters relating to their claims on my membership as set out in this section.
21. I agree that in the event that I, or my Employer have appointed an accredited broker to provide intermediary services, the Scheme shall be entitled to pay over to the broker the agreed fee for such services.
22. Failure to provide proof of income on an annual basis when required by the Scheme, will result in my contributions to default to the highest income category, which will not be backdated when proof is submitted.
23. I accept that penalties may be applied in terms of the Medical Schemes Act. I understand that these penalties include a 3-month general waiting period, a 12-month waiting period on pre-existing conditions and, where applicable, a late joiner penalty fee.
24. I confirm that once I am enrolled as a member who has not joined as part of an employer group, that I may terminate membership of the Scheme by giving 1 month's written notice in terms of the Scheme Rules.
25. If you have appointed a broker to provide a healthcare service to you or your registered dependants, you hereby consent for the Scheme and the Administrator to share your personal information with your chosen broker as needed.
26. If the broker requests any information from the Scheme or Administrator to provide a healthcare service to you or your registered dependants, you confirm that the necessary consent for this disclosure to your broker is in place.
27. It remains your responsibility to inform the Scheme and Administrator of any changes to your appointed broker. Should you withdraw the consent to disclose information to the appointed broker, if you change brokers, or if you terminate the services of the appointed broker and fail to inform us, the Scheme and Administrator will not accept responsibility for disclosing any information to the said broker.

I confirm that I have read and understood the above acknowledgements and declarations. I have had the opportunity to question and consider these and I agree to them. My signature below confirms that I voluntarily give consent to the above on behalf of myself and my dependants.

SIGNATURE OF APPLICANT _____ Date Y Y M M D D

SECTION 12 - EMPLOYER

This application form has been scrutinised, and we are not aware of any facts other than those stated which should be made known to the Scheme. We certify that the applicant is on our permanent staff and confirm the salary details are correct.

Contribution amount **R** _____ Date Y Y M M D D

Employer's name _____

Employer's signature _____ Capacity _____

SECTION 13 - BROKER DECLARATION

WHERE A BROKER HAS BEEN USED, THE BROKER MUST COMPLETE THE FOLLOWING BROKER DECLARATION SECTION:

1. I hereby confirm that I have been appointed by the member applicant, and acknowledge that the member applicant may terminate my services at any time.
2. I confirm that I am fully accredited in terms of relevant legislation, on date of my signature, of this document.
3. Financial Services Board: Accreditation number _____ Council for Medical Schemes: Accreditation number _____
4. I confirm that I have provided the member applicant with my full name, physical and postal address and telephone number.
5. The commission payable upon completion of the transaction by the: Member applicant R _____ Scheme R _____
6. I confirm that I have a valid contract with the Scheme.
7. I confirm that the information provided by me, to the member applicant and the Scheme is true and correct to the best of my knowledge.
8. I confirm that where I have completed this application form on behalf of the applicant member, the applicant member is familiar with the information requested and responses provided.
9. The advice and assistance provided to the applicant member was impartial and in his/her best interests.
10. In the event of a material misrepresentation being made by me or engagement in unlawful conduct I undertake to refund all monies paid by the applicant member and/or the Scheme in consequence of such misrepresentation or conduct.
11. I confirm that the member applicant has personally signed the form.

DISCLAIMER: The Scheme shall not be held responsible for any misrepresentation made by any of its agents/representatives/consultants.

SECTION 14 - BROKER DETAILS

Brokerage name _____ Broker code _____

Broker's name _____

Broker's cell _____ Broker's Tel Code ( ) _____

SIGNATURE OF BROKER _____

SECTION 15 - BROKER CONSULTANT

Broker consultant name _____ BC code _____

SIGNATURE OF BROKER CONSULTANT _____ Date Y Y M M D D