MAKOTI
MEDICAL SCHEME

MEMBER APPLICATION FORM

NAME OF COMPANY | DIVISION

BUSINESS UNIT CODE | SITE / BRANCH

FOR OFFICE USE ONLY

COMPANY CODE

LANGUAGE	SUBS TABLE

MEMBERSHIP NO.

1. APPLICATION FOR MEMBERSHIP

DATE OF COMMENCEMENT (D D M M Y Y Y Y)

DATE OF EMPLOYMENT (D D M M Y Y Y Y)

EMPLOYEE NO.

FIRST NAME/S

SURNAME

INCOME TAX NUMBER

RACE

ID/PASSPORT NUMBER **(Attach copy of document)**

MARITAL STATUS

GENDER M F

OCCUPATION

BASIC MONTHLY SALARY **(Attach proof of income)** R

RESIDENTIAL ADDRESS

POSTAL CODE

POSTAL ADDRESS

POSTAL CODE

TELEPHONE NUMBERS (HOME) (WORK)

(CELL)

EMAIL

Please attach supporting documents: ID/Passort, Birth Certificate, Marriage Certificate, Student Proof of Registration and Proof of Income.

2. DEPENDANTS TO BE ADDED (INCLUDING SPOUSE / PARTNER)

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

Please indicate and provide details of any medical treatment, including acute conditions, you or any of your dependants have received during the last twelve months, or anticipate receiving within the next twelve months.

Have received during the last twelve months.	Yes	No
Anticipate receiving within the next twelve months.	Yes	No

If you indicated “Yes” to any of the above statements, please provide details below:

Name	Details of condition	Date of treatment	Degree of recovery

3. CHOSEN DOCTOR DETAILS

NAME OF DOCTOR OF CHOICE

DOCTOR'S ADDRESS

DOCTOR'S CONTACT NUMBER ( )

PRACTICE NUMBER (OFFICE USE)

4. DECLARATION

APPLICANT

1. I hereby apply for membership to Makoti Medical Scheme (Makoti) for myself and my listed dependants and agree to abide by the Rules of the Scheme.
2. I understand that false information could result in my application for membership being rejected or my membership being cancelled. Should this occur, I agree to refund Makoti all relevant payments which was made on my behalf.
3. Contributions due to Makoti are due MONTHLY. Failure to pay contributions due will result in my membership being suspended or terminated as per the Rules of the Scheme.
4. 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.
5. I hereby warrant that as the principal member of Makoti, to the extent that 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.
6. I understand that I will be liable for any legal costs incurred in the recovery of any amount owing to the Scheme.
7. For the purpose of considering applications for membership, as well as any claim for benefits, the Scheme and any medical personnel authorised by the Scheme has the right to obtain any medically relevant information which it may deem necessary from any medical practitioner or institution or nominee that possesses such information, and that party may disclose such information to the Scheme and any party duly authorised by the Scheme.
8. Makoti and any medical personnel duly authorised by the Scheme may request and acquire from service providers any relevant information that may be required for the fulfilment of any of its obligations. The Scheme and any party duly authorised by the Makoti Medical Scheme may keep such information in their databases and use it for statistical purposes.
9. The information may be requested and supplied at any time, including after the death of the member, and will include accounts from service providers, indicating diagnoses, and medical or clinical reports when indicated. Such information will, however, be treated as confidential at all times by the party to whom its supplied.
10. By agreeing to sign the application form(s) the applicant/member thereby waives his/her right to privacy to the extent implied by the above clauses 7, 8 and 9.
11. Note that if you omit to submit a copy of your ID/Passport document, your details will be confirmed with your HR department.
12. In the event of any refund due to you, your banking details will be confirmed by your HR department and your current banking details on file as per your payroll department will be used for such refund.
13. Contribution amount R

I DECLARE THAT I HAVE DISCLOSED ALL PARTICULARS RELEVANT TO THIS APPLICATION, AND THAT I AM AWARE THAT ANY FALSE STATEMENT WILL RENDER MY MEMBERSHIP NULL AND VOID.

SIGNATURE OF APPLICANT

D D M M Y Y Y Y

DATE

5. EMPLOYER

This application has been scrutinised, and we are not aware of any facts other than those stated which should be made known to the Scheme.

DATE D D M M Y Y Y Y

EMPLOYER'S NAME

DESIGNATION

EMPLOYER'S SIGNATURE

6. BROKER DETAILS

BROKERAGE NAME

BROKER CODE

BROKER'S NAME

BROKER'S TELEPHONE NUMBERS (CELL)

(OFFICE)

7. BROKER CONSULTANT

BROKER CONSULTANT NAME

BC CODE

SIGNATURE OF BROKER CONSULTANT

D D M M Y Y Y Y

DATE

Universal Administrators

Administered by: Universal Healthcare Administrators (Pty) Ltd

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