Resolution Health Medical Scheme

FOR OFFICE USE ONLY

Members Number

Group Reference Number

Date of Commencement D D M M Y Y Y Y

APPLICATION FOR THE REGISTRATION OF ADDITIONAL DEPENDANTS

(Note: Please complete all sections in **BLACK** ink and attach copy of SA ID document / Passport)

Tel: 0861 796 6400 **Fax: 086 513 1438**

ID Number | Membership Number

A. REMARKS

The following information must also be furnished separately in writing where application is made for the registration of dependants:
1. Membership certificate from previous medical scheme which the dependant(s) belonged to;
2. Copies of SA ID document / Passport.

B. APPLICATION

I, the undersigned, principal member:

Surname

First Name(s) *(in full)*

Date of Birth D D M M Y Y Y Y | Date of Inception D D M M Y Y Y Y

Employer

Telephone Number(s) Home | Work

Branch / Location | Cell

Language

hereby apply for:

1. The registration of the following person(s) as my dependant(s):
   1.1 The spouse or partner (Rules 7 & 8) (A copy of a marriage certificate and identity document of the dependant must be attached).
   1.2 Proof of income on the Foundation option is determined by the highest income earner in the family. NB. Members with adult dependants registered - Please complete the Household Income Verification form and submit proof of income as per the form's specification.

Dependant Type

1 Spouse / Partner / Dependant 1

Surname

First Name(s) *(in full)*

Initials | Title | Gender M F

ID Number

Passport Number

Date of Birth D D M M Y Y Y Y | Age

Relationship to Applicant

Married? | Disabled? | Full-time student?

Is your dependant financially dependant on you? Y N

Does your dependant earn an income? Y N

If yes, what is the monthly income?

2 Dependant 2

Initials | Title | Gender M F

Date of Birth D D M M Y Y Y Y | Age

Married? | Disabled? | Full-time student?

Is your dependant financially dependant on you? Y N

Does your dependant earn an income? Y N

If yes, what is the monthly income?

Dependant Type

3 Dependant 3

Surname

First Name(s) *(in full)*

Initials | Title | Gender M F

ID Number

Passport Number

Date of Birth D D M M Y Y Y Y | Age

Relationship to Applicant

4 Dependant 4

Initials | Title | Gender M F

Date of Birth D D M M Y Y Y Y | Age

Married?		Disabled?		Full-time student?	

Is your dependant financially dependant on you? Y N

Does your dependant earn an income? Y N

If yes, what is the monthly income?

Married?		Disabled?		Full-time student?	

Is your dependant financially dependant on you? Y N

Does your dependant earn an income? Y N

If yes, what is the monthly income?

Please attach copies for the following: 1) Copy of Birth certificate, 2) Copy of ID.

A dependant who is self-supporting (i.e. earning more than the maximum social pension) will have to enrol as a principal member.

1.3 Details of previous membership (kindly attach a membership certificate of previous medical scheme).

Name of the Scheme

From D D M M Y Y Y Y To D D M M Y Y Y Y

Name of the Scheme

From D D M M Y Y Y Y To D D M M Y Y Y Y

Has your dependant above ever been declined, loaded or exclusions applied by a medical scheme? YES NO

If "YES" please provide details _____

C. DETAILS OF CURRENT MEDICAL PRACTITIONER

1 Name of Principal Member's Doctor

Telephone Date of first Consult D D M M Y Y Y Y

2 Name of Dependant/s' Doctor

Telephone Date of first Consult D D M M Y Y Y Y

NOTE: Please ensure that above details are correct and completed in full as this may delay acceptance of application as well as authorisation request.

DETAILS FOR NOMINATION OF MEDICAL PRACTITIONER – FOUNDATION PLAN ONLY

Dependant Type 1 Principal member

Name of practice or name and surname of doctor:

Tel Number:

Practice Number:

Region:

Suburb:

2 Spouse / Partner / Dependant 1

Dependant Type 3 Dependant 2

Name of practice or name and surname of doctor:

Tel Number:

Practice Number:

Region:

Suburb:

4 Dependant 3

D. SPECIFIC HEALTH QUESTIONS

State whether any of your dependants have ever been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including but not limited to:

1. Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia, clotting disorders.	YES	NO
2. Cancer, growths, abscess or tumours of any kind, whether benign or malignant.	YES	NO
3. Cardiovascular (heart and blood vessels) disorders e.g. congenital heart conditions, chest pain, coronary artery disease / ischaemic heart disease, high blood pressure, valvular disease, arrythmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever, shortness of breath, palpitations, angina, deep vein thrombosis, pulmonary embolism, atheorsclerosis lymphatics.	YES	NO
4. Ear, nose and throat disorders e.g. hearing/speech impairment, ear infections, sinus problems, nasal/throat surgery, ear discharge, hoarseness, mouth disorders, tonsils, adenoids, grommets, previous nasal injuries, upper airway infections, cleft lip/palate, epistaxis, hayfever / rhinitis, blocked nose.	YES	NO

5. Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities, sugar in urine, nutritional disorders, metabolic syndrome, hypo/hyperglycaemic coma.	YES	NO
6. Eye related disorders e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts, lens implants, infections, refractive and laser surgery, short or far sightedness, pterygium.	YES	NO
7. Gastro-intestinal disorders e.g. recurrent indigestion, heartburn, reflux, ulcers, bowel disorders, gallbladder disorders, liver disorders and pancreas disorders, hiatus hernia, piles, anal fissures, rectal bleeding, ulcerative colitis or have you or any of your dependants ever had a gastroscopy or colonoscopy, spleen disorders, Crohn's disease.	YES	NO
8. a. Gynaecological and obstetrical disorders e.g. ectopic pregnancy, caesarian section, fibroids, endometriosis, menstrual irregularities, abnormal papsmear, receiving hormone treatment, vaginal bleeding, laparoscopic surgery, dilatation and curretage, miscarriages, pregnancy related problems, cysts, infertility, breast disorders.	YES	NO
8. b. Pregnancy - expected date of delivery. D D M M Y Y Y Y	YES	NO
9. Male genito-urinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system.	YES	NO
10. Musculo-skeletal disorders e.g. osteo-arthritis, rheumatoid arthritis, back problems, gout, osteoporosis, all joint problems e.g. knee, shoulder, bones, limbs, spine, fractures, carpel tunnel syndrome, bunion, spondylosis, hernia, kyphosis.	YES	NO
11. Neurological disorders e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue, headache, migraine, polio, paralysis, Guillian-Barre, meningitis, Parkinson's Disease, Alzheimer Disease, dementia.	YES	NO
12. Psychological disorders e.g. insomnia, anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit disorder, post traumatic stress, schizophrenia, bi-polar disorders, mood swings, attempted suicide, anorexia/bulimia nervosa.	YES	NO
13. Renal (kidney) disorders e.g. blood in the urine, urinary tract stones, recurrent infections, kidney failure, bladder problems, dialysis, Addisons Disease, nephritis.	YES	NO
14. Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema or cigarette smoking related disorders, tuberculosis, persistant cough, allergies, chronic obstructive pulmonary disease, pneumoconiosis.	YES	NO
15. Skin disorders e.g. eczema, psoriasis, melanoma, skin cancer, burns, acne, scars, keloids, growths, warts, ingrown toe nails.	YES	NO
16. State whether you or any of your dependants have received medical advice or treatment for any infectious and tropical disease e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitus, bilharzia, malaria, cholera.	YES	NO
17. Do you or any of your dependants have any birth defects or hereditary disorders?	YES	NO
18. Have you or any of your dependants ever sought counselling or treatment for HIV or AIDS related infections or ever tested positive for HIV or AIDS?	YES	NO
19. Have you or any of your dependants ever been diagnosed and/or treated for an immune system problem?	YES	NO
20. Previous injuries and trauma including sports injuries?	YES	NO
21. Have you or any of your dependants ever been told to improve your adherence to medical treatment?	YES	NO
22. Have you ever required rehabilitation following an event i.e. stroke or motor vehicle accident?	YES	NO

If "yes" answered to any of the questions above, please supply full details below.

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current Condition

If the space provided is insufficient please complete addendum.

Addendum attached YES NO

SURGERY AND HOSPITAL ADMISSIONS

1. Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that, the new dependant(s) have undergone in the past, and/or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS they expect to undergo in the future.

Applicant	Surgical Procedure/Hospital Admission	Date	Reason	Doctor	Current Condition

CHRONIC MEDICATION

1. Please supply details of any chronic medication (prescribed medicines used continuously for more than 3 (three) months) currently prescribed for any of your new depandants.
2. Do you or the dependants expect chronic medication to be prescribed in the next 12 months? **YES** **NO**

   If so please supply details below.

Applicant	Prescribed Medication	Medical Condition	Date Started/To be Started

E. GENERAL HEALTH QUESTIONS

1. Do you or any of your dependants expect to receive any treatment in the next 12 months and do you or your dependants expect to be, or are currently hospitalised?	**YES**	**NO**
2. Has any close blood relative (excluding dependants named in this application form) ever been diagnosed with heart disease, high blood pressure, high cholesterol, diabetes or any other hereditary disease?	**YES**	**NO**
3. Do you or any of your dependants have incomplete dental treatment plans, dental implants, orthodontic treatment, dentures, wisdom teeth problems or do you or any of your dependants currently receive, or expect to receive dental treatment in the next 12 months?	**YES**	**NO**
4. Are you or any of your dependants currently involved in any third party claim or WCA claim that may include medical treatment? If so please provide below, FULL details of injuries, surgery, investigative procedures for which claims will be or have been lodged.	**YES**	**NO**
5. Do you or any of your dependants smoke, or did you or any of your dependants receive medical advice to reduce the quantity of tobacco used? If so, specify whether cigarettes, cigars or a pipe and how many are or were smoked per day.	**YES**	**NO**
6. Do you or any of your dependants consume alcohol? If so, specify what type of alcohol and quantity consumed per week.	**YES**	**NO**
7. Have you or any of your dependants ever received medical advice, counselling or treatment to reduce alcohol consumption for alcohol abuse or alcoholism?	**YES**	**NO**
8. Do you or any of your dependants use stimulants, any illegal drug substances, or ever been treated for illegal drug substance abuse or addiction?	**YES**	**NO**
9. Investigations and/or specialised treatment. In and out of hospital. a. Are you or any of your dependants currently undergoing, or expect to undergo investigations for any medical condition and/or symptoms not yet diagnosed?	**YES**	**NO**
b. Are you or any of your dependants currently receiving or expect to receive specialised treatment (i.e. chemotherapy, radiotherapy, bone marrow transplant, mechanical ventilation, oxygen therapy, dialysis, psychotherapy or counselling)?	**YES**	**NO**
10. In the past 2 years, have you or any of your dependants had any x-rays, electrocardiogram or other examinations including genetic testing, or tumour markers, operations or been hospitalised?	**YES**	**NO**

If “yes” answered to any of the questions above, please supply full details below.

Question	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and consulting doctor’s details)

If the space provided is insufficient, please provide additional information to this application. - see page 6

HEIGHT AND WEIGHT

Spouse / Partner / Dep.1	Initials ☐☐☐☐	Height ☐☐☐ **cm**	Weight ☐☐☐ **kg**
Dependant 2	Initials ☐☐☐☐	Height ☐☐☐ **cm**	Weight ☐☐☐ **kg**
Dependant 3	Initials ☐☐☐☐	Height ☐☐☐ **cm**	Weight ☐☐☐ **kg**
Dependant 4	Initials ☐☐☐☐	Height ☐☐☐ **cm**	Weight ☐☐☐ **kg**

F. APPLICABLE RULES OF RESOLUTION HEALTH MEDICAL SCHEME WITH REGARDS TO "DEPENDANTS"

4.13 **"Child":** a member's natural child, or a stepchild or legally adopted child or a child in the process of being placed in foster care or being adopted, or a child for whom the member has a duty of support, or a child who has been placed in the custody of the member or his spouse or partner, and who is not a member or a registered dependant of a member of this or any other registered Scheme.

4.26 **"Dependant"**: a member's spouse or partner who is not a member or a registered dependant of a member of a medical Scheme;

4.26.1 A member's child who is not a member or a registered dependant of a member of a medical Scheme;
4.26.2 The immediate family of a member in respect of whom the member is liable for family care and support and is not a member or a registered dependant of a member of another scheme. Provided that the dependant shall be regarded as an adult dependant unless under the age of 25 years;
4.26.3 Such other persons who are recognised by the Board as dependants for purposes of these Rules.

4.27 **"Dependent on":** in relation to a child, a child under the age of **25 (twenty five)** who is studying at a registered institution and is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child who, due to a mental or physical disability, is dependent upon the member, and if he is older than **25 (twenty five)** and still dependent. Proof of registration and/or dependence must be submitted to the Scheme on an annual basis.

4.36 **"Late joiner":** an applicant or the adult dependant of an applicant who, at the date of application for membership, or admission as a dependant, as the case may be is 35 years of age or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from the date proceeding 1 April 2001, without a break in coverage exceeding 3 conservative months since 1 April 2001.

4.57 **"Social pension":** the appropriate maximum basic social pension prescribed by regulations promulgated in terms of the Social Assistance Act, 1992 (Act No. 59 of 1992).

4.58 **"Spouse":** the person to whom the member is married in terms of any law or custom.

7.1 Registration of dependants:

7.1.1 A member may apply for the registration of his dependants at the time that he applies for membership in terms of Rule 8;

7.1.2 If a member applies to register a new born or newly adopted child within 30 days of the date of birth or adoption of the child, such child shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of birth or adoption and benefits will accrue as from the date of birth or adoption. Documentary proof of birth, or of the adoption of the child, must accompany the application for registration. If the application for registration is not received by the Scheme within the 30-day period, the child will be registered from the date that the application is received by the Scheme;

7.1.3 If a member, who marries subsequent to joining the Scheme, applies within 30 days of the date of such marriage to register his spouse as a dependant, his spouse shall thereupon be registered by the Scheme as a dependant. Increased contributions shall then be due as from the first day of the month following the month of marriage and benefits will accrue as from the date of marriage. The spouse shall not qualify for benefits until such time as the member qualifies for benefits. If the application for registration is not received by the Scheme within the 30-day period, the child will be registered from the date that the application is received by the Scheme;

7.1.4 In the event of any person becoming eligible for registration as a dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.3, the member may apply to the Scheme for the registration of such person as a dependant, whereupon the provisions of Rule 8 shall apply **mutatis mutandis**;
Provided that: No person in Rule 4.22(2), (3) and (4) may be registered as a dependant of a member if such person is self supporting.

7.1.5 In relation to a child, a child under the age of 25 (twenty five) who is studying on a full time basis at a registered institution is not in receipt of a regular remuneration of more than the maximum social pension per month, or a child who, due to a mental or physical disability, is dependent upon the member, and If he is older than 25 (twenty five) and still dependent may be registered as a dependant. Proof must be submitted to the Scheme on an annual basis.

8. Terms and Conditions applicable to membership:

8.2 No person may:

8.2.1 Be a member of more than one registered medical scheme;

8.2.2 Be admitted as a dependant of more than one member of a particular registered medical scheme or a member of a different medical scheme;

8.2.3 Claim or accept benefits in respect of himself or any of his registered dependants from any medical scheme other than the Scheme of which he is a member or a registered dependant of a member.

8.4 Waiting periods

8.4.1. The Scheme may impose upon a person in respect of whom an application is made for membership or admission as a dependant, and who was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application:
8.4.1.1. A general waiting period of up to three months; and
8.4.1.2. A condition-specific waiting period of up to 12 months.

8.4.2. The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application.
8.4.2.1. A condition specific waiting period of up to 12 months, except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits;
8.4.2.2. In respect of any person contemplated in this sub rule, where the previous medical scheme had imposed a general or condition-specific waiting period, and such waiting period had not expired at the time of termination, a general or condition-specific waiting period for the unexpired duration of such waiting period imposed by the former medical scheme.

8.4.3. The scheme may impose upon any person in respect of whom an application is made for membership or admission as a dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application, a general waiting period of up to three months. Except in respect of any treatment or diagnostic procedures covered within the prescribed minimum benefits.

8.6 The registered dependants of a member must participate in the same benefit option as the member.

I/we the undersigned, confirm that I/we have read the Applicable Rules of Resolution Health Medical Scheme with regards to "dependants" and understand the implications.

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

SIGNATURE

Signature of Principal Member

WHAT TO EXPECT WITH YOUR APPLICATION:

Upon receipt of the application:
- We capture and check your details.
- If any details are missing, you will be contacted in writing or telephonically.
- We will advise you or your intermediary in writing, SMS or an E-mail to inform you of your acceptance to join Resolution Health Medical Scheme. This correspondence may contain certain conditions:
  - You sign these terms of acceptance to confirm that you accept any waiting period/s or late joiner penalties (if we apply any) and return it to us.
  - When we activate your membership, you will recieve an SMS from us.
  - You will then recieve a membership pack in the post. This will contain details about your plan selection to get you started.

If you do not hear from us 7 (seven) days after submission, please contact your financial advisor or call us on **0861 796 6400**.

OFFICE USE ONLY

CATEGORY	A	B	C
COPY ☐		ORIGINAL	☐
NO WAITING PERIOD	☐	☐	☐
3 MONTHS WAITING PERIOD	☐	☐	☐
TWELVE MONTHS WAITING PERIOD	☐	☐	☐
PMB PAYMENT YES ☐		NO	☐
LATE JOINER PENALTY	☐	☐	☐
MEMBERSHIP PACK TO UNDERWRITING			

Signature

Resolution Health Medical Scheme

Resolution Health Medical Scheme

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Members Number

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D D M M Y Y Y Y

ADDENDUM FOR SECTION D (SPECIFIC HEALTH QUESTIONS) OF APPLICANT FOR REGISTRATION OF ADDITIONAL DEPENDANTS

(Note: Please complete all sections in **BLACK** ink)

Tel: 0861 796 6400

ID Number

Membership Number

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current Condition

SURGERY AND HOSPITAL ADMISSIONS

Applicant	Surgical Procedure/Hospital Admission	Date	Reason	Doctor	Current Condition

CHRONIC MEDICATION

Applicant	Prescribed Medication	Medical Condition	Date Started/To be Started