Resolution Health Medical Scheme

EMPLOYER GROUP APPLICATION FORM

Name of Group

Region

Please ensure that the Member Application form is completed in respect of each applying member

FOR OFFICE USE ONLY

Group Reference Number

Region

Date of Inception

D D M M Y Y Y Y

Applicable option

- ☐ **Hospital**
- ☐ **Progressive Flex**
- ☐ **Progressive Flex Plus**
- ☐ **Millennium**
- ☐ **Millennium Select**
- ☐ **Supreme**
- ☐ **Foundation**

Income category

- ☐ R0 - R4 840
- ☐ R4 841 - R7 470
- ☐ R7 471 – R10 210
- ☐ R10 211+

I need to submit proof of income. I have attached the following (please tick the appropriate box):

- ☐ Latest salary advice
- ☐ Auditor / Accountants letter
- ☐ Commission / fee statement (submit 3 months statements)
- ☐ Latest income tax return
- ☐ Electronic take on
- ☐ An official signed affidavit

Contribution via:

Schedule Date Monthly

10 15 20 25

Underwriting Decision:

_____

_____

_____

_____

_____

_____

Authorisation:

Name

Signature _____

Date:

D D M M Y Y Y Y

A. EMPLOYER DETAILS (Note: Please complete all sections in **BLACK** ink)

Employer Name

Registration No. | Employer Contact Person

Telephone No. | Title | Fax No.

Email Address

Alternative Email Address

Postal Address

Code

Physical Address

Code

Nature of Business

B. GROUP ELIGIBILITY DETAILS

Note: With the exception of pensioner members, members must be actively at work at the commencement date of this contract. Where this is not the case, confirmation of cover will be deferred until such time as the applicant is actively at work.

1. DETAILS OF THE GROUP (To be completed in all instances)

Will membership of the scheme be available to all employees employed by your company? YES NO

State the total number of employees actively employed by your company

State the total number of pensioners

State the total number of active employees eligible to be covered under the Scheme

State the total number of active employees that will participate under the Scheme

State the total number of pensioners eligible to be covered under the Scheme

State the total number of pensioners that will participate under the Scheme

State the number of branches

Member correspondence to group HR? YES NO

C. EXISTING MEDICAL SCHEME DETAILS

Please provide details of your group's medical scheme membership over the past 2 years.

1 Name of scheme

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

2 Name of scheme

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

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

(If "Yes" please provide details)

D. BILLING METHOD (Please indicate with an "X" where applicable)

☐ Advance ☐ Arrear

Schedule ☐ 10th ☐ 15th ☐ 20th ☐ 25th

Contact person for schedule

Name

Designation

Telephone No. | Email

Prefered option for all group members YES NO of which option:

ACTIVE MEMBERS ☐ One bill for the entire group **OR** ☐ One bill per branch

PENSIONER MEMBERS ☐ Employer **OR** ☐ Member

OR ☐ Specify

E. MEMBERSHIP CARDS

☐ Posted to each member's postal address ☐ Delivered to Company

F. COMMUNICATION

May we communicate directly with the RHMS members? YES NO

If "Yes" please indicate communication type ☐ Email ☐ Internet ☐ Printed Media ☐ SMS

☐ Other _____

Name of Contact Person

Contact No. Email

G. PAYMENT DETAILS

Payment Method ☐ Debit Order ☐ Electronic Transfer

Name of Bank Branch

Account Type Branch Code

Name of Account Holder

Account No.

Resolution Health Medical Scheme ("the Scheme") is hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted, and similarly I/we authorise my/our bank debit my/our account with amounts drawn against it by the Scheme, or to credit my/our account with amounts due to me by the Scheme.

I understand that the withdrawals hereby authorised will be processed by computer through a system known as Nedbank/Debit Order/Multidata and I also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher.

I/we agree to pay any bank charges relating to this debit order instruction.

This authority may be cancelled by me/us by giving the Scheme thirty (30) days' notice in writing, sent by prepaid registered post, but I/we understand that I/we shall not be entitled to any refund of amounts which the Scheme has withdrawn while this authority was in force if such amounts were legally owing to the Scheme. Receipt of this instruction by the Scheme shall be regarded as receipt thereof by my/our bank.

I/we further agree to advice the Scheme in writing of any changes which may occur.

Authorised Signatory(ies)	SIGNATURE	SIGNATURE
Full Name		
Surname		
Designation		

H. INTERMEDIARY DECLARATION

1. *I, the unsersigned hereby confirm:*

1.1 That the appointed intermediary is accredited at date of signing the application form;

1.2 That the appointed intermediary is licensed by the FSB in terms of the FAIS Act;

1.3 That the appointed intermediary has made his/her name, physical, postal address and contact number available;

1.4 That I am aware of commission payable by the Scheme on this transaction to the appointed intermediary;

1.5 That the appointed intermediary is contractually bound to the Scheme;

1.6 That there has been no material misrepresentation of facts by the appointed intermediary and that in such an event the appointed intermediary undertakes to refund all monies paid to the Scheme;

1.7 That I have been given all the relevant information with regards to the application information to the appointed intermediary;

1.8 That the advice given to me by the appointed intermediary was in my best interest and unprejudiced.

I. INTERMEDIARY DETAILS

Full name of Broker Individual Broker Reference No.

Name of Brokerage Resolution Health Brokerage Code

Telephone No. Email Address

Fax No.

SIGNATURE

Signature of Intermediary

SIGNATURE

Signature of Consultant

J. DECLARATION

General

1. As a participating employer we hereby apply for membership for our employees of the Resolution Health Medical Scheme ("the Scheme").
2. On our employees' behalf, we accept:

2.1 The benefits provided for in terms of the Rules of the Scheme;

3. We warrant the correctness of the statements and information contained in this application and acknowledge that the correctness thereof and of all other documents submitted now or in the future by any officer, member or intermediary of or on behalf of the employer shall constitute a condition precedent to the payment of the benefits provided for in terms of the Scheme.
4. We consent to our employees and their listed dependants participating in the contracts to which this proposal relates being called upon to submit to such medical examinations and tests as the Scheme deems necessary, during the currency of the said contracts and of the Scheme addressing such requests directly to our employees or their dependants, with the same legal consequences as if such requests had been addressed to us.
5. We acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any contribution is not paid on due date.
6. We understand that the Scheme assumes no liability for any employee until such time as a notice of acceptance of the risk is given by the Scheme and payment of the first contribution has been received.
7. We undertake to give the Scheme immediate notice should any changes relating to the assessment of this application occur prior to the date upon which the Scheme grants written acceptance. Thus enabling the Scheme to reconsider the terms of acceptance.

Signed at _____ on this _____ day of _____ / _____

Authorised Signatory(ies)	SIGNATURE	SIGNATURE
Designation		

NB. Any misrepresentation or non-disclosure of material, medical or factual information will render all benefits granted by the Scheme null and void. In addition, any payment made due to such actions will be recovered from the member by the Scheme

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			