Administered by MMI Health
PO Box 2070, Bellville 7535
Tel: 0860 00 50 37
General Fax: 0861 64 77 75
Membership Fax: 0861 22 26 64
Email: membership@pggmeds.co.za

APPLICATION FOR ADDITION OF DEPENDANT

ALL QUESTIONS TO BE ANSWERED IN FULL (Please print)

MEMBER DETAILS

Employee Number	
Member Number	
Member Surname	
Member First Name	
Identity Number	

COMPANY STAMP

ALL INFORMATION PROVIDED IS CERTIFIED CORRECT

Name of Signatory

Signed on behalf of the Company

Date D D - M M - 2 0 Y Y

ADDITION OF DEPENDANT

Please supply a certificate of membership if the member was on a previous medical scheme. For all dependants other than a newborn, a medical history questionnaire is required.

DEPENDANT 1

Surname	
First Name	
Gender	Male ☐ Female ☐
Date of Birth	D D M M Y Y Y Y
Identity Number	
Relationship	
Effective Date	D D M M Y Y Y Y

DEPENDANT 2

Surname	
First Name	
Gender	Male ☐ Female ☐
Date of Birth	D D M M Y Y Y Y
Identity Number	
Relationship	
Effective Date	D D M M Y Y Y Y

DEPENDANT 3

Surname	
First Name	
Gender	Male ☐ Female ☐
Date of Birth	D D M M Y Y Y Y
Identity Number	
Relationship	
Effective Date	D D M M Y Y Y Y

DEPENDANT 4

Surname	
First Name	
Gender	Male ☐ Female ☐
Date of Birth	D D M M Y Y Y Y
Identity Number	
Relationship	
Effective Date	D D M M Y Y Y Y

UNDERWRITING QUESTIONS

Have your dependants experienced any of the conditions below for which medical advice, diagnosis, care or treatment was provided during the past 12 months?

PLEASE ANSWER 'YES' OR 'NO' TO EACH QUESTION (Insert 'Y' or 'N' in the relevant box.)

Please provide details on page three if you have answered 'YES' to any of the underwriting questions.

		SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholesterol or lipids, ischaemic heart disease, heart failure, angina, stroke (CVA) or peripheral vascular disease					
2	Cystic fibrosis					
3	Obstructive lung disease (asthma, emphysema or COAD)					
4	Diabetes (insulin or non-insulin dependent diabetes mellitus)					
5	Hypo- or hyperthyroidism					
6	Arthritis (i.e. osteo, rheumatoid arthritis or gout) - all related musculoskeletal conditions					
7	Osteoporosis					
8	Gastro oesophageal reflux disease (GORD/heartburn) or stomach/duodenal ulcers (please circle)					
9	Immune deficiency status (i.e. HIV/AIDS*, immunoglobulin deficiencies)					
10	Anaemia or abnormalities of clotting mechanism - haemophilia, thrombosis, bleeding disorder					
11	Hormone replacement therapy, endometriosis or ovarian cysts					
12	Depression and/or anxiety disorders, anorexia, attention deficit disorder, Alzheimer's disease					
13	Any nervous or mental complaint (e.g. epilepsy, blackouts, paralysis or headaches)					
14	Glaucoma, cataracts or any other disorders of the eye					
15	Parkinson's disease or multiple sclerosis (please circle)					
16	Hyperplasia of prostate (BPH) or prostatism					
17	Inflammatory bowel disease (Crohn's disease or ulcerative colitis)					
18	Urinary tract infection or calculi (stones)					
19	Back or neck related condition (lumbago, sciatica, injury, spasm, loss of limb, previous surgery)					
20	Are you pregnant? If so, how many weeks?					
21	Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure for the following 12 months?					
22	Are you on any medication at present?					
23	Do you take chronic medication?					
24	Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical scheme claim within the next 12 months?					
25	Skin conditions/disorders (e.g acne, eczema, psoriasis, etc.)					
26	Ear, nose or throat disorders (e.g. ear discharge, recurrent tonsillitis, hearing/speech impediments)					
27	Infectious diseases (e.g. tuberculosis, shingles, measles, etc.)					
28	Malignant neoplasms (cancer, growths or malignant tumours)					
29	Benign neoplasms (non-malignant tumours/growths)					
30	Specialised dentistry, maxillofacial treatment, dental problems, gum disease					
31	Have you had or are you expecting to have plastic or reconstructive surgery?					
32	Any hereditary or congenital conditions, e.g. Down's syndrome					
33	Connective tissue disorders, e.g. systemic lupus					
34	Do you or your dependants take part in any professional or dangerous sports?					
35	Are you aware of any medical condition, injury or illness that may impact your membership during the next 12 months?					

* Should you be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership number, **you must fax confirmation of your HIV/AIDS status to LifeSense Disease Management on 0860 80 49 60** to ensure registration on the HIV programme. Please note that this may result in you receiving a second card from the Scheme pending whether your application will require underwriting as per current legislation.

Contact details
Tel : 0860 50 60 80
Fax : 0860 80 49 60
Email : results@lifesense.co.za

UNDERWRITING QUESTIONS (continued)

PLEASE PROVIDE DETAILS BELOW IF YOU HAVE ANSWERED 'YES' TO ANY OF THE UNDERWRITING QUESTIONS

Question Number	Name of Patient	Illness or Condition	Date and Duration of Illness	Name of Doctor, Hospital or Institution	Treatment Recommended: Likely Date and Duration of Treatment

1. Waiting periods and penalties may be applied to this application.
2. Please note that this medical questionnaire does not constitute an application to register, authorise chronic medication, prescribed minimum benefit (PMB) services or planned procedures. You need to obtain authorisation for these by contacting 0860 00 50 37 once your membership has been finalised.
3. For further details please refer to the latest member guide.
4. Failure to disclose any pre-existing conditions could result in limited benefits or the exclusion of benefits or the termination of your membership.

PREVIOUS MEDICAL SCHEME INFORMATION

Please detail previous medical scheme membership.

Name of Scheme	Membership Number	Join Date	Termination Date	Name of Employer

Please attach certificates of membership (not membership cards), which are required in order to avoid late joiner penalties, waiting periods and condition-specific exclusions.

ACKNOWLEDGEMENTS

1. I acknowledge that I am aware of the provisions of your rules dealing with undesirable business practices, the submission of fraudulent claims to PG Group Medical Scheme, the commission of fraudulent acts and the non-disclosure of material information to PG Group Medical Scheme. In particular, I am aware that I am not permitted to allow any person other than my dependants to use my membership card.
2. I am aware that, if I am accepted for membership, the rules will be binding on me and that, in the case of a dispute, the registered rules will be decisive.
3. I hereby authorise and instruct my employer to deduct from my remuneration and any other sums due to me (any amounts which may be due to me to a pension fund or provident fund that holds funds for my benefit after I cease employment) in order to pay, and continue to pay, the amounts referred to in the first sentence hereof to PG Group Medical Scheme as and when they fall due. Furthermore, I understand that I will be liable for any legal costs incurred in the recovery of any amount owing to PG Group Medical Scheme.
4. I am aware that proof of identification may be requested at any stage.

DECLARATION

1. The answers given herein are full, complete and true and, if I am accepted as a member of PG Group Medical Scheme, will constitute the basis of my membership.
2. I realise that I must submit evidence of the good health of myself and my dependants and that benefits may be limited or executed in respect of any particular ailment, disease, disorder, condition or disability which existed on my addition date.
3. I am bound now, and in the future, if my dependants are accepted as a member, to give PG Group Medical Scheme all such information and evidence as PG Group Medical Scheme may from time to time require and to this end authorise the medical practitioner or other provider who has attended to me in the past or who will attend to me in the future, to provide PG Group Medical Scheme with such information as PG Group Medical Scheme may require, hereby waiving the provisions of any law or regulation restricting the provision of such information. I must also submit as and when required by PG Group Medical Scheme, to an examination by PG Group Medical Scheme's medical assessor.
4. I acknowledge that I have been given the opportunity of perusing the rules of PG Group Medical Scheme prior to signing this application and that, even if I have not availed myself of such offer, I shall be deemed to have read the rules.
5. Words used in this application shall bear the meaning ascribed to them in the rules.

DISCLAIMER

PG Group Medical Scheme reserves the right to list members, who in the opinion of MMI Health's Fraud and Ethics Committee have behaved unethically towards PG Group Medical Scheme, abused their benefits, perpetrated fraud or colluded with others to perpetrate fraud against PG Group Medical Scheme, on the Transunion ITC. This information may be viewed by all medical schemes that participate in the Board of Healthcare Funders Forensic Management Unit.

Signature

Date D D - M M - 2 0 Y Y

Signed by me as applicant declaring that I have carefully read this application form and accepting that the fact that I have applied does not necessarily mean that I will be accepted as a member.

Membership will only be finalised upon receipt of a fully completed application form.

Incomplete forms will result in membership being delayed.