APPLICATION FOR ADDITION OF DEPENDANTS

PLEASE COMPLETE FORM IN BLOCK LETTERS

- **It is important to complete all sections of this form in full, as incomplete forms will cause a delay in the processing of your application and result in your membership activation being delayed.**
- **Membership will only be finalised upon receipt of a fully completed application form and supporting documents.**
- **Copies of IDs and birth certificates for all dependants must accompany this application.**
- **The Scheme reserves the right and may contact you to request additional information and documentation, if required.**
- **Words used in this application shall bear the same meaning ascribed to them in the Scheme rules.**

1. PRINCIPAL MEMBER'S DETAILS

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

Date of birth (DD/MM/YYYY) | ID/Passport number

Income tax reference number

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Common law ☐ Widow/er

Race* ☐ Black/African ☐ White ☐ Indian ☐ Coloured ☐ Asian

☐ Other If '**other**', please specify: ☐ I don't wish to disclose my race

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

Email address

2. ADDITION OF DEPENDANTS

Please attach a copy of each dependant's ID, passport or birth certificates for children. For a spouse/partner, a marriage certificate, affidavit confirming co-habitation or proof of customary union is required.

Provisions of the Protection of Personal Information Act 4 of 2013 (POPIA), which came into effect from 1 July 2020, requires that all medical schemes communicate directly with dependants who are 18 years and older. Therefore, please provide the contact details for each applicable dependant below. ***If a dependant is not living with you, please provide their postal address.**

Dependant 1

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

Date of birth (DD/MM/YYYY) | ID/Passport number

Race* ☐ Black/African ☐ White ☐ Indian ☐ Coloured ☐ Asian

☐ Other If '**other**', please specify: ☐ I don't wish to disclose my race

Contact number | Relationship to applicant (e.g. wife, son)

Postal address*

Postal code

Email address

Membership join date (DD/MM/YYYY)

****It is not mandatory for you to provide this information. The Scheme is required by the Council for Medical Schemes to collect this data for statistical purposes only.***

2. ADDITION OF DEPENDANTS

***If a dependant is not living with you, please provide their postal address.**

Dependant 2

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

Date of birth (DD/MM/YYYY) | ID/Passport number

Race* ☐ Black/African ☐ White ☐ Indian ☐ Coloured ☐ Asian

☐ Other If '**other**', please specify: | ☐ I don't wish to disclose my race

Contact number | Relationship to applicant (e.g. wife, son)

Postal address*

Postal code

Email address

Membership join date (DD/MM/YYYY)

Dependant 3

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

Date of birth (DD/MM/YYYY) | ID/Passport number

Race* ☐ Black/African ☐ White ☐ Indian ☐ Coloured ☐ Asian

☐ Other If '**other**', please specify: | ☐ I don't wish to disclose my race

Contact number | Relationship to applicant (e.g. wife, son)

Postal address*

Postal code

Email address

Membership join date (DD/MM/YYYY)

Dependant 4

Title | Initials | Gender ☐ Male ☐ Female

Full name and surname

Date of birth (DD/MM/YYYY) | ID/Passport number

Race* ☐ Black/African ☐ White ☐ Indian ☐ Coloured ☐ Asian

☐ Other If '**other**', please specify: | ☐ I don't wish to disclose my race

Contact number | Relationship to applicant (e.g. wife, son)

Postal address*

Postal code

Email address

Membership join date (DD/MM/YYYY)

****It is not mandatory for you to provide this information. The Scheme is required by the Council for Medical Schemes to collect this data for statistical purposes only.***

3. MEDICAL HISTORY OF DEPENDANTS

- Waiting periods and penalties may be applied to this application. For further details, please refer to the latest member guide.
- Please note that this medical questionnaire does not constitute an application to register or authorise chronic medication, prescribed minimum benefit (PMB) services or planned procedures. You need to obtain authorisation for these by contacting **0860 005 037** once your dependant's membership has been finalised.
- Failure to disclose any pre-existing conditions could result in limited benefits, the exclusion of benefits or the termination of your membership.

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 for each applicable answer in the table on page 4.

		SPOUSE/PARTNER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1.	High blood pressure (hypertension), high cholesterol (hyperlipidaemia), ischaemic heart disease, heart failure, angina, stroke (CVA) or peripheral vascular disease					
2.	Cystic fibrosis					
3.	Obstructive lung disease, asthma, emphysema or chronic obstructive pulmonary disease (COPD)					
4.	Diabetes insipidus or diabetes mellitus type 1 and 2 (insulin- or non-insulin dependent)					
5.	Hypo- or hyperthyroidism					
6.	Arthritis, osteoarthritis, rheumatoid arthritis, osteoporosis, gout or all related musculoskeletal					
7.	Gastro-oesophageal reflux disease (GORD/heartburn) or stomach/duodenal ulcers					
8.	Immune deficiency e.g. HIV/AIDS* or immunoglobulin deficiencies, etc.					
9.	Anaemia or abnormalities of clotting mechanism – haemophilia, thrombosis or bleeding disorder					
10.	Hormone replacement therapy, endometriosis or ovarian cysts					
11.	Depression and/or anxiety disorders, anorexia, attention-deficit/hyperactivity disorder (ADHD) or other mental health conditions					
12.	Any neurological complaint, e.g. epilepsy, blackouts, paralysis, headaches or Alzheimer's disease					
13.	Glaucoma, cataracts or any other disorders of the eye					
14.	Parkinson's disease or multiple sclerosis					
15.	Benign prostatic hyperplasia (BPH), prostatism or other conditions relating to the prostate					
16.	Inflammatory bowel disease (Crohn's disease or ulcerative colitis)					
17.	Urinary tract infection (UTI), kidney or bladder calculi (stones)					
18.	Back- or neck-related conditions e.g. lumbago, sciatica, injury, spasm, loss of limb or previous surgery					
19.	Pregnant? Please provide number of weeks and expected delivery date in the table on page 4.					
20.	Taking any medication, including chronic medication, over-the-counter medication or multivitamins?					
21.	Skin conditions e.g. acne, eczema or psoriasis, etc.					
22.	Ear, nose or throat disorders e.g. ear discharge, recurrent tonsillitis or hearing/speech impediments					
23.	Infectious diseases e.g. tuberculosis, shingles or measles, etc.					
24.	Malignant neoplasms e.g. cancer, growths or malignant tumours					
25.	Benign neoplasms or non-malignant tumours/growths					
26.	Specialised dentistry, maxillofacial treatment, dental problems or gum disease					
27.	Previous or planned plastic or reconstructive surgery					
28.	Any hereditary or congenital conditions e.g. Down's syndrome					

3. MEDICAL HISTORY OF DEPENDANTS (CONTINUED)

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 tick the relevant box next to each question. Please provide details for each applicable answer in the table below.

	SPOUSE/PARTNER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
29. Connective tissue disorders e.g. systemic lupus erythematosus (SLE)	☐	☐	☐	☐	☐
30. Participation in any professional or dangerous sports – please specify in the table below	☐	☐	☐	☐	☐
31. Had any surgical procedure during the past 12 months or are you planning a surgical procedure in the next 12 months?	☐	☐	☐	☐	☐
32. Is there any other condition, symptom, injury or illness, 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?	☐	☐	☐	☐	☐
33. Are you aware of any other medical condition, injury or illness that may impact your membership during the next 12 months?	☐	☐	☐	☐	☐

* If any of your dependants are HIV positive and do not wish to disclose their status on this application form, please contact the YourLife Programme to register them. **Your information will be treated as strictly confidential.** They may receive a second membership card from the Scheme, subject to underwriting as per current legislation.

YourLife **Programme contact details:**
Telephone: **0860 005 037** (option 4)
Email: yourlife@pggmeds.co.za

DETAILS OF MEDICAL HISTORY QUESTIONS

Please provide details for each of the medical questions above where you answered 'yes'.

Question number	Name of patient	Illness or condition	Date and duration of illness	Name of treating doctor, hospital or institution	Treatment recommended: likely date and duration of treatment

If more space is required, please include additional pages with this application form.

4. PREVIOUS MEDICAL SCHEME INFORMATION FOR PRINCIPAL MEMBER, SPOUSE AND DEPENDANTS

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

Name of medical scheme	Membership number	Join date	Termination date	Name of employer
		DD/MM/YYYY	DD/MM/YYYY	
		DD/MM/YYYY	DD/MM/YYYY	
		DD/MM/YYYY	DD/MM/YYYY	
		DD/MM/YYYY	DD/MM/YYYY	

5. CONSENT FOR PG GROUP MEDICAL SCHEME TO PROCESS PERSONAL INFORMATION

We request your consent to process and obtain your personal information from any other person for the purposes set out below.

While your consent is voluntary, it is a requirement for your membership of PG Group Medical Scheme and the Administrator, Momentum Health Solutions (Pty) Ltd, a division of Momentum Metropolitan Life Limited, to keep your personal information confidential and to comply with the Protection of Personal Information Act 4 of 2013 (POPIA) when processing your personal information. Your personal information will be processed for the purposes as outlined in the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then the Scheme will not be able to administer or offer you membership. Please read the statements below and sign your acceptance thereof in the **MEMBER DECLARATION** on page 6.

1. I authorise, and give consent to the Scheme and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Scheme membership risk profiling and management, administration of my membership and as set out in this section.
2. If I have consented to the disclosure of my personal information, the Scheme or the Administrator may provide my personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between the Scheme or the Administrator, which requires them to do so.
3. I acknowledge that I must give the Scheme and the Administrator all information and evidence they may require from time to time. I authorise the Scheme and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information the Scheme may require concerning me or any of my dependants in assessing any risk or claim in relation to this application, my membership of the Scheme and risk profiling or management. I consent to that person providing, and instruct that person to provide, the Scheme and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
4. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
5. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
6. I have the right to request my personal information, which is in the possession of the Scheme and the Administrator, provided that I furnish adequate identification.
7. I have the right to request the Scheme and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
8. If I have a complaint relating to the processing of my personal information, I agree to first refer it to the Administrator to resolve it in terms of their internal complaints process. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator on **010 023 5200** or by email at enquiries@inforegulator.org.za.
9. My personal information will be shared between the Scheme, the Administrator and any of their contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to my membership of the Scheme and to provide any credit bureau or registered credit provider with my credit information (e.g. credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgements obtained for outstanding debts) as defined in the National Credit Act 34 of 2005.

6. MOMENTUM MULTIPLY

Sharing of personal information
I, the undersigned, hereby authorise and give consent to PG Group Medical Scheme and its Administrator to share my personal information, including health information, and that of my dependants, with any entity (including an entity forming part of Momentum Metropolitan Holdings and its subsidiaries), with whom I and/or my dependants have a contractual relationship with, or have applied for a product or service from such entity. This personal information will be processed and/or used for further processing in order to administer the products or services.

Direct marketing consent
I, the undersigned, hereby give my consent to PG Group Medical Scheme's Administrator for me to receive direct marketing of complementary products and services by Momentum Metropolitan Holdings Limited and its subsidiaries, to be marketed to me by means of electronic communication. I further acknowledge that I can retract this consent at any time.

☐ Please tick here if you **do not wish** to receive any direct marketing as indicated here.

In the event that a member **does not agree** to receive any direct marketing as indicated above, the Administrator will not share any personal information with Momentum Multiply.

In the event that a member **agrees** to receive direct marketing, the Administrator will share the member's contact information (name, surname and contact details) with Multiply. Multiply will then be in a position to contact the member to offer the Multiply products.

7. MEMBER DECLARATION

1. The answers given herein are full, complete and true and, if I am accepted as a member of the 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 excluded in respect of any particular ailment, disease, disorder, condition or disability which existed on my admission date.
3. I am bound now, and in the future, if my dependants and I are accepted as members, to give the Scheme all such information and evidence as the Scheme may from time to time require and to this end authorise the medical practitioner or other healthcare provider who has attended to me in the past or who will attend to me in the future, to provide the Scheme with such information as it may require, hereby waiving the provisions of any law or regulation restricting the giving of such information. I must also submit, as and when required by the Scheme, to an examination by the Scheme's medical assessor.
4. I acknowledge that I have been given the opportunity to read and understand the rules of the Scheme prior to signing this application and that, even if I have not taken up such an offer, I shall be deemed to have read the rules.
5. I understand and accept that even though I have applied for membership of the Scheme, it does not necessarily mean that I will be accepted as a member of the Scheme.
6. I acknowledge that I am aware of the provisions of the rules dealing with the submission of fraudulent claims to the Scheme, the commission of fraudulent acts and the non-disclosure of material information to the Scheme. In particular, I am aware that I am not permitted to allow any person other than my registered dependants to use my membership card.
7. I am aware that, if I am accepted for membership, the Scheme rules will be binding on me and that, in the case of a dispute, the registered rules will be decisive.
8. I authorise and instruct:
   8.1 my employer to deduct from my remuneration and pay over any amounts that may become due or owing to the Scheme from time to time; and
   8.2 any persons (such as my employer, a pension fund or provident fund) that may hold funds for my benefit after I cease employment, to deduct and pay any amounts that may become due or owing to the Scheme.

   Furthermore, I understand that I will be liable for any legal costs that may be incurred by any party in the recovery of any amount that I owe to the Scheme.
9. I am aware that proof of identification for me and any of my dependants may be requested at any stage.
10. All amounts due by me to the Scheme shall be forthwith due and payable by me to the Scheme on demand.

I, the undersigned, declare that I have carefully read this application form, completed it in full, and confirm that all the information provided herein to be true and correct to the best of my knowledge.

Signature of principal member | **Date** DD/MM/YYYY

8. EMPLOYER DECLARATION

Name of signatory		
Designation of signatory		
Signature on behalf of the Employer		
Date	DD/MM/YYYY	**EMPLOYER/GROUP STAMP**

DISCLAIMER:
PG Group Medical Scheme reserves the right to list members who, in the opinion of the Scheme's Administrator, Momentum Health Solutions (Pty) Ltd Fraud and Ethics Committee, have behaved unethically towards the Scheme, abused their benefits, perpetrated fraud or colluded with others to perpetrate fraud against the Scheme, on the TransUnion Credit Bureau. This information may be viewed by all medical schemes that participate in the Board of Healthcare Funders' (BHF) Forensic Management Unit.

05/2024

PG GROUP MEDICAL SCHEME

Administered by Momentum Health Solutions (Pty) Ltd

PO Box 2070, Bellville 7535
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Membership fax: 0861 222 664
Email: membership@pggmeds.co.za
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