HERITAGE HEALTH®
LIVE BOLDLY

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MEMBERSHIP APPLICATION FORM

Section A: Applicant Details

Title		Initials		Full Names											
Surname															
Postal Address															
Telephone Number	H	Code						W	Code						
Cellphone Number								Fax Number							
Email Address															
Date of Birth	D	D	M	M	Y	Y	Y	Y	Age		ID / Passport Number				
Gender	M		F												
Marital Status		Single		Married		Divorced		Widowed							

Section B: Benefit Option

Please note: Your benefit plan already includes emergency evacuation/ambulatory services and travel insurance. Please mark your option(s) with ✓ in the appropriate box.

All Hospital Plans include Chronic Medication, Oncology, Specialised Radiology and Doctors on Call															
In Hospital Options		Baobab		Acacia		Kiaat									
Optional Day-to-Day Options		Super		Standard											
Comprehensive Options		Camelthorn Comprehensive Plan		Maroela Comprehensive Plan		Hoodia Comprehensive Plan		Moringa Comprehensive Plan							
Aloe Day-To-Day Plan															
Date Cover Commences	D	D	M	M	Y	Y	Y	Y							

Section C: Employment Details *(Information must always be completed by the Main Member)*

Employer Name									Will Employer Pay Monthly Contributions?			Y	N				
Employment Date	D	D	M	M	Y	Y	Y	Y	Eligible Start Date of Cover	D	D	M	M	Y	Y	Y	Y
Employer Address																	
Employer Telephone Number	H	Code															
Cellphone Number									Fax Number								
Signature of Company Official																	

Section D: Family Members to be Covered

Please note: Only legal beneficiaries may be registered. Documentary proof is required, for example birth certificate, marriage certificate, death certificate. For children above 18, proof of full-time study must be included.

	Full Names and Surname	Gender (M/F)	Date of Birth
Spouse/Partner			D D M M Y Y Y Y
Child 1			D D M M Y Y Y Y
Child 2			D D M M Y Y Y Y
Child 3			D D M M Y Y Y Y
Child 4			D D M M Y Y Y Y
Child 5			D D M M Y Y Y Y

Section E: Previous Medical Aid History

Please note: Kindly attach a copy of the certificate of termination from your previous medical aid, if applicable. Provide 3 years' claim history of your past medical aid scheme.

Have you, as the main member, or any of your dependants, had medical aid cover?	Y	N														
If "YES" please confirm from when	D	D	M	M	Y	Y	Y	Y		D	D	M	M	Y	Y	Y	Y
Have any waiting periods, exclusions or any other penalties been imposed on any previous cover for you, or any of your dependants?	Y	N														

If "YES" please provide the details below

Name of beneficiary	Name of medical aid fund	Reason or Condition for waiting period/exclusion/penalty

Section F: Health History

To be completed by all applicants. Please place a tick in the relevant box. Detail on next page.

	Have you or any named dependant ever suffered from or been treated for any of the following or related conditions?		
1.	High cholesterol, stroke, high blood pressure, heart murmur, angina/chest pain, heart attack, coronary artery disease, shortness of breath, congenital heart disorder or any blood disorder?	Y	N
2.	Nephritis, kidney stone, congenital kidney disorders, blood in urine, kidney or bladder infections, removal of kidney stones or any other urinary or related kidney disorder or treatment?	Y	N
3.	Difficulty in breathing, persistent cough, tuberculosis (TB), asthma, bronchitis, croup, emphysema, pneumonia, cystic fibrosis, or any other respiratory related disorder?	Y	N
4.	Conditions of the joints or spine, including rheumatism, arthritis, neck or back disorders, or any other bone or skeletal disorders or any physical disability?	Y	N
5.	Diabetes, thyroid problems, Cushing's syndrome, Addison's disease, pituitary gland disorder, high sugar in the blood or urine or any other glandular disorders?	Y	N
6.	Any lumps or growths, benign or malignant, types of cancers, including Hodgkin's disease or leukaemia, skin cancer, etc.?	Y	N
7.	Epilepsy, migraine, stroke or any other neurological disorder for which treatment was/is received?	Y	N
8.	Ulcers, hiatus hernia, gall bladder or liver disorders or any other digestive system disorder?	Y	N
9.	Any gynaecological conditions/symptoms including infertility/miscarriages, ovarian cysts, breast biopsies, prostate infections, prostate enlargement or any other reproductive problems?	Y	N
10.	Advice, counselling, treatment/therapy for alcoholism, drug dependency, mental or emotional disorders, stress/depression, attention deficit disorder or any other psychological conditions?	Y	N
11.	Medical advice, counselling or treatment for HIV/AIDS or any other sexually transmitted disease?	Y	N
12.	Orthodontic treatment, dental surgery, wisdom teeth removal/surgery, cysts or any other dental conditions?	Y	N
13.	Do you have a family history (first and second order relatives) of any genetic illnesses such as cancer, blood disorders, water immune disorders or any other?	Y	N
14.	Are you or any of your dependants pregnant? If so, what is the expected date of delivery?	Y	N
15.	Impairment of the eyes, cataracts, glaucoma, retinitis pigmentosa or any other eyesight problems?	Y	N
16.	Haemorrhoids or varicose veins?	Y	N
Biometric Information and Habits			
17.	Do you smoke?	Y	N
18.	Do you or any of your dependants do any dangerous sports?	Y	N
19.	**Principal member:** *Height*	*Weight*	**Spouse:** *Height*	*Weight*

Section G: If you answered “YES” to any of the questions under “F” please provide the full details below

Please note: Failure to disclose medical conditions may limit and/or exclude certain benefits or result in the termination of your medical benefits. Persons over 55 years must submit full medical reports and eye reading tests.

No.	Name of Person	Condition/Illness	Name of Doctor	Duration of Treatment

Section H: Health Information

Please note: If you or any of your dependants take any form of medication on a regular basis you need to disclose it in the below table. You must submit a copy of the latest prescription to enable dispensing. To register new chronic conditions after becoming a member you need to complete the prescribed form and register the applicable medication and provide a copy of a valid prescription. Valid and registered chronic medication will be covered immediately.

Name of Person	Name of Condition	Name of Medication	Duration of Medication
			D D M M Y Y Y Y to D D M M Y Y Y Y
			D D M M Y Y Y Y to D D M M Y Y Y Y
			D D M M Y Y Y Y to D D M M Y Y Y Y
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Section I: Bank Details

Please note: Your banking details are required for reimbursements on claims and/or order deductions. You must attach a copy of the identification document of the account holder.

Use this account for Monthly Contribution deduction and any Claim Refunds				**Use this account for Monthly Contributions only**	
Bank Name					
Branch Name					
Name of Account Holder					
Bank Account Number					
Branch Code					
Type of Account	*Transmission*		*Savings*		
Total Monthly Contribution					

Use this account for Claim Refunds only				
Bank Name				
Branch Name				
Name of Account Holder				
Bank Account Number				
Branch Code				
Type of Account	*Transmission*		*Savings*	

I hereby instruct the administrator to electronically collect monthly contributions and to deposit claim refunds via electronic banking facilities to the above stated banking account(s). I understand and accept that no transfers can be undertaken from credit card accounts and that no post office savings accounts are allowed. I further authorise Heritage Health to increase the monthly contribution due in terms of the conditions of the Fund. I also authorise the administrator to correct any incorrect transactions and/or adjust any electronic transfers.

I agree that I am not entitled to recover any amount drawn from my account by means of this debit order. This authorisation is to remain in force until cancelled by me by giving 30 days' written notice to Heritage Health. If my debit order is declined as a result of insufficient funds and I fail to pay the outstanding amount by the seventh day of the month, I accept that my benefits will be suspended. Three consecutive non-payments will result in automatic termination of my membership of the Fund.

CHECK LIST

	Certified copy/verified copy of the Main Member's ID	Certified copy/verified copy of his/her spouse's ID and marriage certificate	
	Certified copy/verified copy of ID/passport of spouse	Certified copy/verified copy of full birth certificates of dependants who are children	
	Proof of cover by previous medical aid	Provision of medical report and eye tests where applicable	
	Proof of full-time study for children who are students	Certified copy/verified copy of proof of banking details (or original obtained from the bank)	
	Residential address (eg Municipal Bill)	Proof of income (eg copy of pay slip, employment letter, Social security proof of income letter or Pension Fund proof of income letter)	

1.	The application must be completed in full and all information required must be provided.
2.	The date that cover commences is always on the first day of a month.
3.	Do not use nicknames or abbreviated names to register dependants.

Section J: Declaration and Acknowledgment

1.	I acknowledge having read and I understand the **significance of the importance of the correct completion of the information requested** in this application form pertaining to me and my dependants. **I declare all entries made on this form to be true and correct and that I am not aware of any circumstances which might affect the risk on my health or any of my dependants.** Should there be any non-disclosure or misrepresentation, I understand and accept that my membership may be terminated and that I may forfeit my contributions. Heritage Health has the right to claim any costs incurred in respect of my non-disclosure or misrepresentation.
2.	Should any of my or my dependant(s)' circumstances be altered subsequent to the date of completing this application, prior to or after the acceptance of my membership by Heritage Health Medical Aid Fund, I undertake to notify the Fund immediately. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership.
	I understand that any changes to this document as well as membership status of any of myself or any of my beneficiaries will require the completion of the necessary forms.
3.	I understand and agree that it is my responsibility to ensure that the monthly contribution to be paid for my membership is paid by no later than the seventh day of each month upfront (in advance) whether such payment is undertaken by debit order or by my employer or any other person who pays on my behalf. I accept that failing to pay the applicable monthly contribution will result in the suspension of all benefits. Failing to pay for contributions for three consecutive months will automatically terminate my cover.
4.	I authorise the obtaining of any personal medical information relating to me or any of my dependants from a treating physician who has attended to or examined me or my dependants and which may be required in respect of this application or any future claims submitted by me.
5.	It is further agreed and understood that, notwithstanding any statements made to the contrary by any person, membership will not commence and no liability whatsoever will attach to Heritage Health Medical Aid Fund, unless express written notice of acceptance of risk is given by the Fund.
6.	I authorise and permit Heritage Health Medical Aid Fund to take all reasonable steps to verify the information provided by me in this application form.
7.	I further accept that the provisions of any declaration made have been read and understood by me and will also apply mutatis mutandis to and form part of this application.
8.	I understand and accept that this declaration and my application form constitute the basis of my contract with Heritage Health Medical Aid Fund. No oral representations, inducement, statements or promises by or on behalf of any party, and not contained in the application form, shall be relied upon.
9.	I agree to be bound by the terms and conditions of cover under Heritage Health Medical Aid Fund.
10.	I hereby consent that all my contact details may be used by Heritage Health for the distribution of information.
11.	I agree that any payment accompanying the application shall be a deposit only and I understand that any cover will only commence once I receive the membership card and any conditions pertaining to the cover.
12.	I declare that no material fact(s) have been withheld, misstated or concealed by myself or in respect of my beneficiaries and that I herewith unequivocally undertake to disclose all material facts prior to acceptance of the risk and I agree that any misrepresentation, misstatements and / or omission(s) of any material information, particularly in so far as it relates to disclosure of medical information pertinent to risk, will render my membership null and void.
13.	I hereby acknowledge that Heritage Health Medical Aid Fund does not extend credit for myself or my dependants whilst being a members of Heritage Health Medical Aid Fund, therefore upon termination of membership of Heritage Health Medical Aid Fund, all outstanding payable credit and interests may be charged on all amounts owing to Heritage Health Medical Aid Fund.
14.	I acknowledge that in the event of any modification or variation of this standard form, Heritage Health Medical Aid Fund will regard this form as being invalid and of no force and effect.
15.	I understand that any changes to this document as well as membership status of any of myself or any of my beneficiaries will require the completion of the necessary forms.
16.	I hereby acknowledge that I understand that the product selected has an overall annual limit with applicable sub limits.
17.	I understand and agree to all the above.

Signed at _____ on this _____ day of _____20____

_____
Signature of main member

Company Stamp

FOR OFFICE USE ONLY

Broker Number	Accept	Decline	Group Code	Individual

Member Number	Monthly Contribution	Benefit Option
	N$_____	

Entry Date	D	D	M	M	Y	Y	Y	Y	

Confinement Period Excluded

Yes ..... No…….

Waiting Period

Three Month Waiting Period	Y	N	

Twelve Months **NAME OF BENEFICIARY**	**CONDITION**

Total Exclusions **NAME OF BENEFICIARY**	
Control Officer	

Date	D	D	M	M	Y	Y	Y	Y	