APPLICATION FOR MEMBERSHIP

Administered by Medscheme Holdings (Pty) Ltd

If printed, please use black ink to complete all unshaded sections of this form and return it as soon as possible to ensure speedy registration.

SECTION 1: GENERAL

Protection of Personal Information

AECI Medical Aid Society, hereafter referred to as "the Society", subscribes to the protection of all beneficiaries' personal and health information provided to the Society for the administration of your medical aid. You are required to understand how and what the Society will use your personal and health information for as a beneficiary of the Society.

In order to provide you and your dependants with optimal healthcare we require your consent and the consent of your dependants, to access, collect, process, store and retain your personal information. Upon signing this Application Form, you are providing the Society with your consent to use your personal and health information in terms of the Protection of Personal Information Act, 4 of 2013.

Upon signing this Application Form, you are providing the Society with your consent to use your personal and health information and you acknowledge that you have read and understood the **Terms and Conditions**.

(a) Purpose

AECI Medical Aid Society, upon your consent, will:

- Share your personal and health information with contracted third parties and healthcare providers, the administrator and managed healthcare organisation as well as partners and service providers of the Society.
- Store your personal and health information in a secure facility, which may include a secure cloud based storage facility.
- Process your personal and health information for the purposes of maintaining your information, providing you with medical scheme services as well as any additional services and sharing your information, where required.
- Use your de-identified personal and health information for medical internal research purposes.
- Use your personal and health information to optimise your medical scheme benefits.
- Use your personal and health information to facilitate the medical scheme benefits in emergency medical situations.
- Retain your personal and health information in terms of the allowable statutory limits.

(b) Collection and Processing of Personal Information

- The Society collects your personal information when you become a member of AECI Medical Aid Society and will process your personal information for the applicable services and benefits.
- Every dependant over 18 years must consent to use the services and benefits. If you are giving consent for a person under 18 (a minor) you confirm that you are the parent or legal guardian of that person and that you have authority to give their consent for them.

(c) Correction of Personal Information

- You have an obligation to notify the Society if any of your personal information has changed or is no longer valid. To ensure your records are up to date, you can email aecisocietymembership@medscheme.co.za or you can phone the member call centre on 0860 002 103.
- You have the right to request any updates, corrections or deletion of your personal information upon termination of your membership. Where your personal information cannot be deleted, the Society will take the necessary steps to make it anonymous.
- Should you wish to determine what personal information is held by the Society, you will need to complete a Promotion of Access to Information form which can be accessed via the AECI member zone on www.medscheme.com. Your identity will be verified before any of your personal information is provided.

(d) Security of your Personal Information

- The Society has taken the appropriate security measures to protect your personal information from loss, misuse or unauthorised alteration. Your personal information is stored in secure databases that have the appropriate safeguards to ensure the privacy and protection of that information.
- The intended recipients of your personal information are yourself, selected healthcare providers, the Society, its administrator and researchers.

(e) Retention of Personal Information

The personal information of each member will be retained by the Society, administrator and managed healthcare organisation for the duration of your membership. Once your membership has been terminated, your personal information will be retained within the allowable statutory limits.

(f) Changes by the Medical Scheme

In the event of there being any changes to these terms and conditions, the Society will endeavor to advise you within 30 days. It is the member's responsibility to familiarise themselves with the registered rules and terms and conditions and to frequently access them to ensure that any changes are noted.

(g) Right to withdraw Consent

The consent provided for the purpose of accessing, using, transferring, sharing, storing and collecting the personal information of you or your beneficiaries can be revoked at any time. You can revoke consent for a specific purpose by contacting the Society. If you revoke your consent in totality the Society will not be able to provide you and your dependants with the necessary medical scheme and related healthcare services.

Acknowledgement and Declaration

1. I hereby apply to be admitted as a member of AECI Medical Aid Society and to register my dependant/s as per section 3 (where applicable).
2. I declare that all the information provided is true and correct and that any false statement on this application can render my membership null and void.
3. I agree to abide by the Society's Rules and the Medical Schemes Act as amended from time to time.
4. As per the Medical Schemes Act, a person cannot belong to more than one medical Scheme at the same time. I therefore declare that I, or any dependant applied for, are not a member or dependant of another medical Scheme.
5. I agree that my and my dependants' healthcare data may be used for the purposes of health risk assessments in order to be registered on managed care programmes for the better management of our health and to activate our personal health records.
6. I confirm that as the main member on the Society I have received permission from my dependants to access and view their healthcare claims made on my membership and to deal with all matters relating to the claims on my membership.
7. I guarantee to the extent that it may be required by law that I have the necessary consent from my dependants to provide the authorisation as set out in this section.
8. I acknowledge that I may access the information the Society holds about myself and my dependants and may request any correction of errors or the deletion of information.
9. I hereby authorise my employer to deduct any amount I may lawfully owe to the Society and to remit such amounts to the Society. I understand that I will be liable for any legal costs incurred in the recovery of any amount owing by me to the Society.
10. I consent to my telephone conversations with the Society's call centre(s) being recorded and forming part of the Society's records. I also agree that such records will remain the sole property of the Society.

I confirm that I am familiar with the terms and conditions and benefits of the Society. ☐

I acknowledge that I have read and understood the **protection of personal and health information** noted on the Society's website. (This block must be ticked to submit your application.)

Signed at _____ on the ___ of _____

Applicants Name: _____

Applicant's signature

Signature: _____ Date: _____

Adult dependants over 18 to give consent that the main member can view their health information.

Adult dependant signature: _____ Date: _____

Adult dependant signature: _____ Date: _____

Select an Option: a) Comprehensive Option ☐ b) Value Option ☐

c) Comprehensive Select Option ☐

SECTION 2: PREVIOUS MEDICAL SCHEMES

Please give full details of your membership of any other medical schemes during the past two years and provide proof by attaching your certificate/s of membership.

Name of Scheme	Membership Number	Memberships					
		From			To		
		Day	Month	Year	Day	Month	Year

SECTION 3: PERSONAL DETAILS

Title (e.g. Prof, Dr, Mr, Ms, Miss, other)																								
Initials																								
Surname																								
Full name/s																								
Date of birth																								
Postal address																								
Physical home address																								
ID/Passport Number																								
Income Tax Number																								
Designation (e.g. manager/secretary)																								
Telephone (W)																								
Telephone (H)																								
Cell																								
Email address																								
Payroll number																								

For statistical purposes (Please mark with x)

Gender	Male		Female								
Marital status	Single		Married		Divorced		Widowed		Partnership		

SECTION 3: PERSONAL DETAILS (CONTINUED)

DEPENDANT'S DETAILS (Number of Membership Cards)

No	Full name/s and surname	ID number	Date of birth	Relationship (spouse, son, daughter)	Gender
1			d d m m y y		m f
	Email address		Cell number		
2			d d m m y y		m f
	Email address		Cell number		
3			d d m m y y		m f
	Email address		Cell number		
4			d d m m y y		m f
	Email address		Cell number		
5			d d m m y y		m f
	Email address		Cell number		
6			d d m m y y		m f
	Email address		Cell number		
7			d d m m y y		m f
	Email address		Cell number		
8			d d m m y y		m f
	Email address		Cell number		

Please remember certified copies of ID documents or unabridged birth certificates for principal member and dependants.

NOTE

1. According to the Rules of the Society, any dependant 21 years of age or older will be considered as an adult dependant.

2. Complete a separate form (Member Record Amendment / Dependant Registration) to apply to register the following dependants of the main member's, grandchild (if biological parent is not registered). Please attach a certified copy of a birth certificate / ID document. Acceptance shall be subject to Board of Trustees approval in accordance with the Rules of the Society.

3. When registering a common-law spouse / partner the following documentation MUST be supplied before registration will be considered.

   Proof that the common-law spouse / partner is nominated as a beneficiary on a provident or pension fund, OR
   Proof of joint bond account, OR
   Proof of joint bank account

4. If the above documentation cannot be supplied, waiting periods and condition specific exclusions may be imposed in terms of the Society Rules

SECTION 4: BANK ACCOUNT DETAILS (ELECTRONIC TRANSFER OF FUNDS)

I, the undersigned, hereby instruct Medscheme (on behalf of the Society) to deposit claim refunds electronically. I understand that transfers cannot be done to and from credit card accounts. I further authorise Medscheme to adjust any incorrect transactions and/or correct any electronic transfer of funds error without prior notice.

USE THIS ACCOUNT FOR CLAIM REFUNDS

Name of Bank	
Name of Branch (Where account is held)	
Branch Code	
Type of Account	
Name on Bank Account	
Bank Account Number	

SECTION 4: BANK ACCOUNT DETAILS (ELECTRONIC TRANSFER OF FUNDS) (CONTINUED)

Required documentation:
Please provide a current bank statement stamped by your bank. Alternatively, you may submit a stamped letter from your bank confirming the bank account details provided above. Please ensure that a copy of the Account Holder's ID document is submitted together with the application.

Signature of bank account holder: _____

Name and surname																									
ID number																									

SECTION 5: MEDICAL DETAILS

Has the member or dependant/s sought any advice, been diagnosed with, or treated for, any of the following conditions in the past 12 months?

1. A chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and/or thyroid disorders). If yes, provide details.	Yes	No

Name of beneficiary	Diagnosis	Date of diagnosis	Name of medication	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating general practitioner, dentist or specialist
		d d m m y y y y				
		d d m m y y y y				
		d d m m y y y y				

2. Gastro intestinal disorders? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, ulcerative colitis, diverticulitis and/or a spastic colon) If yes, provide details.	Yes	No

Name of beneficiary	Diagnosis	Date of diagnosis	Name of medication	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating general practitioner, dentist or specialist
		d d m m y y y y				
		d d m m y y y y				
		d d m m y y y y				

3. Muscle, bone, skin or nerve illnesses or disorders? (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc.) If yes, provide details.	Yes	No

Name of beneficiary	Diagnosis	Date of diagnosis	Name of medication	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating general practitioner, dentist or specialist
		d d m m y y y y				
		d d m m y y y y				
		d d m m y y y y				

SECTION 5: MEDICAL DETAILS (CONTINUED)

4. Urinary or genital disorders? (e.g. kidney stones, prostates, endometriosis, ovarian cysts, menstrual disorders) If yes, provide details.	Yes	No

Name of beneficiary	Diagnosis	Date of diagnosis	Name of medication	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating general practitioner, dentist or specialist
		d d m m y y y y				
		d d m m y y y y				
		d d m m y y y y				

5. Ear, nose or throat disorders? (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics) If yes, provide details.	Yes	No

Name of beneficiary	Diagnosis	Date of diagnosis	Name of medication	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating general practitioner, dentist or specialist
		d d m m y y y y				
		d d m m y y y y				
		d d m m y y y y				

6. Blood disorders, immune deficiency state, HIV/AIDS, cancer etc.? If yes, provide details.	Yes	No

Name of beneficiary	Diagnosis	Date of diagnosis	Name of medication	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating general practitioner, dentist or specialist
		d d m m y y y y				
		d d m m y y y y				
		d d m m y y y y				

7. Are there any other conditions or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months? If yes, provide details.	Yes	No

Name of beneficiary	Diagnosis	Date of diagnosis	Name of medication	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating general practitioner, dentist or specialist
		d d m m y y y y				
		d d m m y y y y				
		d d m m y y y y				

8. Is the beneficiary pregnant? If yes, provide details.	Yes	No

Name of beneficiary	Expected delivery date	Name and contact number of attending doctor
	d d m m y y y y	
	d d m m y y y y	
	d d m m y y y y	

SECTION 6: EMPLOYER

Employer to complete section and sign.

Employer's Name	

Date joined company	d	d	m	m	y	y													
Date joined Society	d	d	m	m	y	y													
Benefit date	d	d	m	m	y	y													
Date of birth	d	d	m	m	y	y													
Payroll number																			
Number of dependants																			
Member's share																			
Employer's share																			
Total monthly contribution																			
Income bracket																			
Percentage of subsidy																			

Contributions are deducted in accordance with the applicant's income and the number of eligible dependants, as per the appropriate contribution table set out in the Society's rules, which are amended from time to time.

Note: Please ensure that all sections have been fully completed.

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions will be deducted according to the Society Rules and the plan chosen.

EMPLOYER'S CONTACT DETAILS

Company code	
Telephone number	
E-mail address	
Full name/s and surname	
Designation	
Date	
Signature	