

## ADDITION OF DEPENDANTS FORM

### MEMBER DETAILS (This is very important)

Member Number

Employee Number

Member Surname

Member First Name

**COMPANY STAMP**

### ADDITION OF DEPENDANT:

(Please supply certificate of membership if member on a previous medical scheme. For all dependants other than a new-born, a medical questionnaire is required. Please also ensure that you have included all necessary affidavits.)

Dependants First Name	Dependants Surname	Sex	Date of Birth	I.D. Number	Relationship	Join Date

### ACKNOWLEDGEMENTS:

- I acknowledge that I am aware of the provisions of your Rules dealing with undesirable business practices, 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 dependants to use my membership card.
- I am aware that, if I am accepted for membership, your Rules will be binding on me and that, on admission to membership, a copy of these Rules will be delivered to me and that I will be notified by you as to the place where such delivery will take place.
- 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 by me to Nampak Medical Scheme from time to time and to pay the same to Nampak Medical Scheme. Likewise, I hereby authorise and instruct any person (such as my Employer or a person fund or provident fund) who holds funds for my benefit after I cease employment to pay, and to continue to pay, the amounts referred to in the first sentence hereof to Nampak Medical Scheme as and when they fall due.
- I am aware that proof of identification may be requested at any stage.

### DECLARATION:

- The answers given herein are full, complete and true and, if I am accepted as a Member of Nampak Medical Scheme, will constitute the basis of my membership.
- 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.
- I am bound now, and in the future, if I am accepted as a Member, to give Nampak Medical Scheme all such information and evidence as Nampak Medical Scheme may from time to time require and to this end authorise the medical practitioner or other Provider who has attended me in the past or who will attend me in the future to provide Nampak Medical Scheme with such information as Nampak Medical Scheme 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 Nampak Medical Scheme's Medical Assessor.
- I agree to abide by the rules of the fund which will be made available on request.
- Words used in this Application shall bear the meaning ascribed to them in the Rules.

### DECLARATION OF HEALTH:

- I warrant that I, my spouse/partner and dependants are in good health and save in the respect or respects referred to overleaf.
- I consent to undergo a medical examination and realise that you will be entitled to decline to accept me, my spouse/partner or my Dependants as Members where evidence of good health is not furnished.
- To the extent that I, my spouse/partner and Dependants suffer from any particular ailment, disease, disorder, condition or disability, I shall provide details overleaf.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# UNDERWRITING QUESTIONS

PLEASE ANSWER "YES" OR "NO" FOR EVERY QUESTION

Item No:	Do you, or all your dependants, have or have you had, or plan to have any treatment, advice, investigations or management for any of the following conditions or diseases in the past or in the future:-	APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholesterol or lipids, ischaemic heart disease, heart failure, angina, stroke(C.V.A.), or peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Obstructive Lung Disease (Asthma, Emphysema or C.O.A.D)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Diabetes (Insulin or non-insulin dependant diabetes mellitus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Hypo or Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Arthritis, I.e. Osteo, Rheumatoid Arthritis or Gout related musculoskeletal conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Gastro-oesophageal reflux disease (GORD/Heartburn) or Stomach or Duodenal Ulcers (please circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Immune Deficiency States I.e. HIV/AIDS, Immunoglobulin deficiencies * Should you be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership (contract) number we require you to please fax confirmation of your HIV/Aids status to our HIV/Aids Department on (031) 580 0484. For more information on the Aid for Aids Programme members may also call Aid for Aids on 0860 100 646. Note that all information supplied will be treated as confidential. 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Anaemia or abnormalities of clotting mechanism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Hormone Replacement Therapy, Endometriosis or Ovarian Cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Depression and/or anxiety disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Glaucoma or cataracts (please circle where applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Parkinson's disease or Multiple sclerosis (please circle where applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Hyperplasia of prostate ( BPH) or prostatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Urinary Tract infection or calculi (stones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Back or neck related condition (Lumbago, sciatica, injury, spasm etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Are you, or any of your dependants pregnant, if so how many weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Have you, or any of your dependants had any surgical procedure during the past 12 months or are you or any of your dependants planning a surgical procedure within the following 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Are you, or any of your dependants on any medication at present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	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 aid claim within the next 12 months.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Item No. \_\_\_\_\_ Name: \_\_\_\_\_  
 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_ Tel. no. \_\_\_\_\_

Item No. \_\_\_\_\_ Name: \_\_\_\_\_  
 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_ Tel. no. \_\_\_\_\_

Item No. \_\_\_\_\_ Name: \_\_\_\_\_  
 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_ Tel. no. \_\_\_\_\_

Item No. \_\_\_\_\_ Name: \_\_\_\_\_  
 Condition: \_\_\_\_\_  
 Treatment (including future treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor Name: \_\_\_\_\_ Tel. no. \_\_\_\_\_

**NB Failure to disclose any pre-existing conditions could result in benefits being limited, excluded and /or membership terminated.**