Nampak SA Medical Scheme

Nampak
SA Medical Scheme

Administered by Momentum Medical Scheme Administrators
P O Box 2338, DURBAN 4000
Tel: 0860 101047, Fax: 031-580 0480

APPLICATION FOR MEMBERSHIP (COLLECT A CAN EMPLOYEES)

ALL QUESTIONS TO BE ANSWERED IN FULL (Please print)

Have you ever been a member of the Nampak SA Medical Scheme? No ☐ Yes ☐

If "yes", previous Nampak number

If "no" refer to page 4 for previous medical scheme information.

GROUP SALARIES STAMP

FOR THE ADMINISTRATOR'S USE ONLY

Actioned by:

PERSONAL PARTICULARS

APPLICANT

Surname

First name

Gender M ☐ F ☐

Date of Birth D D M M Y Y Y Y

I.D.No.

MARK APPLICABLE BOX WITH AN "X"

Single ☐ Married ☐ Divorced ☐ Widow(er) ☐

CONTACT DETAILS

Postal Address

Code

Physical Address

Code

Telephone (H)

Telephone (W)

Fax

Cell

E-mail

SPOUSE / PARTNER

Surname

First Name

Gender M ☐ F ☐ Date of Birth D D M M Y Y

Identity No.

Relationship

DEPENDANT 1

Surname

First name

Gender M ☐ F ☐ Date of Birth D D M M Y Y

Identity No.

Relationship

DEPENDANT 2

Surname

First name

Gender M ☐ F ☐ Date of Birth D D M M Y Y

Identity No.

Relationship

DEPENDANT 3

Surname

First name

Gender M ☐ F ☐ Date of Birth D D M M Y Y

Identity No.

Relationship

DEPENDANT 4

Surname

First name

Gender M ☐ F ☐ Date of Birth D D M M Y Y

Identity No.

Relationship

UNDERWRITING QUESTIONS

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

	Question	APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholestrol or lipids, Ischaemic heart disease, Heart failure, Angina, Stroke (CVA) or Peripheral vascular disease.						
2	Obstructive lung disease (asthma, emphysema or c.o.a.d)						
3	Diabetes (insulin or non-insulin dependant diabetes mellitus)						
4	Hypo or hyperthyroidism						
5	Arthritis, i.e. osteo, rheumatoid arthritis or gout all related musculoskeletal conditions						
6	Osteoporosis.						
7	Gastro-Oesophageal reflux disease (gord/heartburn) or stomach or duodenal ulcers (please circle)						
8	Immune deficiency states i.e. hiv/aids, immunoglobulin deficiencies						
9	Anaemia or abnormalities of clotting mechanism						
10	Hormone replacement therapy, endometriosis or ovarian cysts						
11	Depression and/or anxiety disorders						
12	Any nervous or mental complaint e.g epilepsy, blackouts, paralysis or headaches.						
13	Glaucoma , cataracts or any other disorders of the eye.						
14	Parkinson's disease or Multiple Sclerosis (please circle where applicable)						
15	Hyperplasia of prostate (BPH) or prostatism						
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)						
17	Urinary tract infection or calculi (stones)						
18	Back or neck related condition (lumbago, sciatica, injury, spasm etc)						
19	Are you pregnant, if so how many weeks?						
20	Have you had any surgical procedure during the past 12 months or planning a surgical procedure for the following 12 months						
21	Are you on any medication at present?						
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.						
23	Skin conditions/disorders e.g Acne, Eczema, Psoriasis etc.						
24	Ear, nose or throat disorders, e.g. ear discharge, recurrent tonsillitis?						
25	Infectious diseases e.g Tuberculosis. Shingles, measles etc,						
26	Malignant neoplasms (Cancer, growths or malignant tumours)						
27	Benign Neoplasms (non malignant tumours/growths)						
28	Specialized dentistry /maxillo facial treatment.						
29	Have you had or are you expecting to have Plastic or reconstructive surgery.						

DO YOU TAKE CHRONIC MEDICATION ? Y/N ☐

If you have answered YES to any of the above the following details are to be provided. HIV / AIDS information can be faxed confidentially to The Administrator on (031) 580 0484.

Question No.	Nature and duration of complaint and full details of treatment being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment ?

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

OPTION SELECTION

Please confirm your selection - tick the relevant box:
NB: The correct choice of Plan is important, as changes may only be made annually for 1 January each year.

OPTIONS	SAVINGS	
STANDARD OPTION	NO	
EXTENDED OPTION	15%	

BANKING DETAILS OF APPLICANT

(For direct payment of monies due to members.)

Name of Account Holder

Bank Name

Branch Number

Account Number

Account Type (C=Current, T=Transmission, S=Savings)

Would you like access to your information on the Nampak website? Yes ☐ No ☐

E-mail Address

Preferred User Name

EMPLOYER INFORMATION

Name of Employer

Group Number 5 6 7 0 7 0 1 5

Business Telephone

Applicant's Employee Number

Applicant Commenced Employment on

D D M M Y Y

Applicant's Monthly Gross Income
(Including all fixed income)

Applicant's Occupation

Date this contract is to start

D D M M Y Y

ALL INFORMATION HERETOFORE GIVEN IS CERTIFIED CORRECT

SIGNED ON BEHALF OF THE COMPANY/EMPLOYER

SIGNATURE

NAME OF SIGNATORY

DATE

D D M M Y Y

DIVISION STAMP

WAITING PERIODS

Nampak SA Medical Scheme reserves the right to underwrite all applications according to the rules and regulations set out in the Medical Schemes Act (Act 131 of 1988) that prevail at the time of the application. These include the imposition of a 3 month general waiting period (all benefits), a 12 month waiting period on pre-existing sickness conditions and late joiner premium penalties.

PREVIOUS MEDICAL SCHEME INFORMATION

Please detail previous medical scheme membership

Name of Scheme	Membership No.	On date	Off 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 the Nampak 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**
2. **I am aware that, if I am accepted for membership, the Nampak 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.**
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 by me to Nampak from time to time and to pay the same to Nampak. Likewise, I hereby authorise and instruct any person (such as my Employer or a pension fund or provident fund) who holds funds for my benefit after I cease employment to pay,**
4. **and continue to pay, the amounts referred to in the first sentence hereof to Nampak as and when they fall due. I am aware that proof of identification may be requested at any stage.**
5. **All sums due by me to Nampak shall be forthwith due and payable by me to Nampak immediately upon my ceasing to be a Member.**

ONLINE ACCESS

1. **I accept that Nampak will not in any way be responsible or liable for any claims of any nature whatsoever made by anyone (myself excluded) which arise as a result of my failing to keep my password and user name secure and confidential to myself.**
2. **I indemnify Nampak and hold it harmless against any such claims.**
3. **I understand that this service may not be available 24 hours a day.**

DECLARATION

1. **The answers given herein are full, complete and true and, if I am accepted as a Member of Nampak SA 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 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 I am accepted as a Member, to give Nampak all such information and evidence as Nampak 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 with such information as Nampak 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 to examination by Nampak's Medical Assessor.**
4. **I acknowledge that I have been given the opportunity of perusing the Rules of Nampak 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

Nampak SA Medical Scheme reserves the right to list members who in the opinion of The Administrator's Fraud and Ethics Committee have behaved unethically towards Nampak SA Medical Scheme, abused their benefits, or perpetrated fraud or colluded with other to perpetrated fraud against Nampak SA 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

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 awarded upon receipt of a fully completed application form.