PROFMED APPLICATION FORM

ATTENTION: PROFMED NEW BUSINESS
Email: applications@profmed.co.za

1 ELIGIBILITY*

**Eligibility criteria apply.*

A) PROFESSION CATEGORY

Medical ☐ Humanities ☐ Student ☐ Legal ☐ Sciences ☐
Financial ☐ Built Environment ☐ Other ☐

B) PROFESSION DETAIL, E.G. ADVOCATE, ENGINEER

Profession

C) CURRENT OCCUPATION/ EMPLOYMENT

D) QUALIFICATIONS

DEGREE/QUALIFICATION	ACADEMIC INSTITUTION	MINIMUM DURATION OF DEGREE/QUALIFICATION

(Please attach copy of degree(s)/qualification(s). Attach additional information if space is insufficient.)

E) ARE YOU A MEMBER OF PPS? Yes ☐ No ☐ PPS member no. ☐☐☐☐☐☐☐☐☐☐☐

2 BENEFIT OPTION

A) PLEASE SELECT ONE OF THE FOLLOWING BENEFIT OPTIONS BY TICKING THE APPROPRIATE BOX:

PROPINNACLE ☐	PROSECURE PLUS ☐	PROSECURE ☐	PROACTIVE PLUS ☐	PROACTIVE ☐
PROPINNACLE SAVVY ☐	PROSECURE PLUS SAVVY ☐	PROSECURE SAVVY ☐	PROACTIVE PLUS SAVVY ☐	PROACTIVE SAVVY ☐

B) DATE MEMBERSHIP TO COMMENCE D D M M Y Y Y Y

Note: *It is illegal to belong to more than one medical scheme at the same time.*

C) FINANCIAL ADVICE

Note: *In terms of the FAIS Act, this section must be completed.*
My decision to join Profmed, and my choice of benefit option, is based on (please tick the appropriate box):

☐ The advice received from ..... [name], a Profmed consultant.

☐ The advice received from ..... [name], my independent broker.

☐ I have not received advice from or been influenced in any way by a Profmed consultant or an independent broker. I have considered my personal requirements and those of my dependants and I acknowledge the risk that my decision could be inappropriate to my circumstances, needs or objectives without having obtained a full healthcare needs analysis.

3 PERSONAL DETAILS

A) PRINCIPAL MEMBER (please attach a copy of ID document)

Title | First names

Surname | Maiden name | Gender: Male | Female

ID/Passport no. | Date of birth D D M M Y Y Y Y

Street address | Postal address

SUBURB | SUBURB

CITY/TOWN | Post code | CITY/TOWN | Post code

Telephone: Work | Home

Cell | Fax

Email address

Gross monthly income from all sources R p.m.

B) SPOUSE/PARTNER IF JOINING AS A DEPENDANT (please attach a copy of ID document)

Title | First names

Surname | Gender: Male | Female

Relationship to principal member (e.g. wife, partner, etc.)

ID/Passport no. | Date of birth D D M M Y Y Y Y

Telephone: Work | Home

Cell | Fax

Email address

Gross monthly income from all sources R p.m.

C) DEPENDANTS (OTHER THAN SPOUSE/PARTNER)

Child dependants:

A child dependant is a member's child who is younger than 21 years. If your dependant(s) are 21 years and older but younger than 28, please provide proof of study or proof of financial dependance, whichever is applicable, in order for your dependant(s) to qualify as child dependants.

Adult dependants:

Dependants who are 28 years and older are required to submit proof of dependence on the principal member to qualify for membership. Three months' recent bank statements of all the dependants' bank accounts and a tax directive from SARS is required. In the case of dependants who are mentally or physically disabled, a medical report in this regard is required from an independent doctor.

DEPENDANT 1

Title | First names

Surname

ID/Passport no. | Date of birth D D M M Y Y Y Y

Gender: Male | Female | Relationship to principal member

DEPENDANT 2

Title | First names

Surname

ID/Passport no. | Date of birth (D D M M Y Y Y Y)

Gender: Male ☐ Female ☐ | Relationship to principal member

DEPENDANT 3

Title | First names

Surname

ID/Passport no. | Date of birth (D D M M Y Y Y Y)

Gender: Male ☐ Female ☐ | Relationship to principal member

DEPENDANT 4

Title | First names

Surname

ID/Passport no. | Date of birth (D D M M Y Y Y Y)

Gender: Male ☐ Female ☐ | Relationship to principal member

DEPENDANT 5

Title | First names

Surname

ID/Passport no. | Date of birth (D D M M Y Y Y Y)

Gender: Male ☐ Female ☐ | Relationship to principal member

(Attach additional information if space is insufficient.)

4 BANK DETAILS

A) CONTRIBUTIONS

Debit Order ☐ EFT ☐ Persal (for Government employees) ☐

If Debit Order, please complete Annexure A, Authority and Mandate for Debit Order Instruction, attached.

B) REFUNDS

If refunds are to be paid into the same account as your contributions, as detailed in Annexure A, Authority and Mandate for Debit Order Instruction, attached, please tick here ☐

If different bank account than for contributions, please complete this section

I authorise Profmed to deposit any credits due to me into my bank account:

Name of account holder

Name of bank | Branch name | Branch code

Account number | Type of account: Cheque | Transmission | Savings

Signature of account holder _____ Date D D M M Y Y Y Y

Please note: If your membership date is confirmed after the monthly contribution debit orders have been generated, a double contribution will be deducted the following month.

Are your contributions paid by Government? Yes ☐ No ☐ If yes, please attach a copy of your latest salary advice.

5 DETAILS OF PREVIOUS MEDICAL SCHEME(S)

Please provide below the details of all previous medical scheme membership and attach the relevant membership certificates. To avoid a late joiner penalty or a waiting period being imposed, please provide proof of your membership of all previous medical schemes. General and/or condition-specific waiting periods and/or late joiner penalties will be imposed if you do not have proof of sufficient medical cover.

NAME OF APPLICANT/ DEPENDANT	DATE OF BIRTH	MEDICAL SCHEME	MEMBERSHIP NUMBER	JOIN DATE	RESIGN DATE

(Attach additional information if space is insufficient.)

I have no previous medical scheme cover ☐

Late joiner penalties will be applied in respect of persons over the age of 35 years who were without medical scheme cover for the periods indicated hereunder:

1 - 4 years	@ 5%	x the relevant contribution	15 - 24 years	@ 50%	x the relevant contribution
5 - 14 years	@ 25%	x the relevant contribution	25+ years	@ 75%	x the relevant contribution.

Note: *It is illegal to belong to more than one medical scheme at the same time.*

I confirm that I will resign from my current medical scheme before becoming a member of Profmed. Yes ☐

6 DETAILS OF YOUR GENERAL PRACTITIONER

Do you consult a general practitioner? Yes ☐ No ☐ If yes, please provide the details of your general practitioner:

Name _____ Telephone _____

7 MEDICAL HISTORY

THIS SECTION IS EXTREMELY IMPORTANT

- Any misstatement in, or omission from this form may lead to refusal to admit any claims for treatment given, suspension or termination of membership.
- A 12-month condition-specific waiting period may be applied to any condition declared, subject to the requirements of the Medical Schemes Act No. 131 of 1998.
- It is essential to declare all conditions/illnesses/symptoms, no matter how insignificant they may seem, and irrespective of whether there is no gap in cover between your previous medical scheme membership and your membership of Profmed.
- If the space provided below is insufficient, please attach additional information to this application form.
- Disclosure is not limited to the example conditions cited below.
- Related, consequent and suspected conditions and symptoms must also be disclosed.
- Should a new medical condition arise or be diagnosed between the time of completing this form and the commencement date of membership, please inform the Scheme immediately.
- Medical reports may be required in respect of the conditions declared.

If you or any of your dependants experience any new symptoms or obtain medical advice or treatment or counselling for a new condition, between the time of submitting this application form and your date of membership of the Scheme, please inform the Scheme thereof immediately.

Have you or any of your dependants experienced any of the following conditions or sought or obtained any medical advice, treatment or counselling in respect thereof? *(The conditions listed below are examples and are prompts, not a restrictive list.)*

	Y	N
1. Any blood disease or condition (e.g. anaemia, haemophilia)?		
2. Any psychological or psychiatric disease or condition (e.g. depression, anxiety, neurosis, tension, and or any drug, substance and/or alcohol abuse/dependency or rehabilitation)?		
3. Any neurological disease or condition (e.g. epilepsy, fainting, paralysis, stroke, Alzheimer's, Parkinson's, multiple sclerosis)?		
4. Any headaches or migraines?		
5. Any transmissible disease (e.g. Hepatitis B, Hepatitis C)?		
6. Any disease/affection of the skin (e.g. acne, eczema, psoriasis)?		
7. Any affection of the bone system and/or joints (e.g. osteoporosis, rheumatism, gout, arthritis, back problems, hip problems, knee problems)?		
8. Any affection of the muscular system (e.g. muscular dystrophy)?		
9. Any affection of the heart or blood circulation system (e.g. hypertension, coronary heart disease, chest pains, irregular heartbeat, rheumatic fever, heart failure, valve lesions)?		
10. Any affection of the chest or respiratory system (e.g. asthma, bronchitis, chronic cough, TB or other lung diseases)?		
11. Any affection of the digestive system, liver and gallbladder (e.g. gastric ulcers, hernia, poor digestion, gallstones, spastic colon)?		
12. Any affection of the urinary system and/or sex organs (e.g. bladder infection, nephritis, kidney stones,prostatitis)?		
13. Any affection/disorder of the eyes (e.g. cataracts, glaucoma)?		
14. Any affection of the ears, nose or throat, irrespective of whether it is congenital or developed later (e.g. deafness)?		
15. Any affection/disorder of the teeth or gums?		
16. Any metabolic condition (e.g. Gaucher's disease, porphyria)?		

	Y	N
17. Diabetes mellitus?		
18. High cholesterol?		
19. Any condition of the thyroid gland?		
20. Any cancer, malignant or pre-malignant tumours?		
21. Any other physical disease/condition, irrespective of whether it is congenital or developed later (e.g. spasticity, cleft palate)?		
22. Do you suffer from chronic sinusitis?		
23. Any affection of the female organs (e.g. womb, ovaries, abnormal Pap smears, breasts, endometriosis)?		
24. Varicose veins?		
25. A disease or condition for which you or any of your dependants have received a gratuity, pension, pay-out and/or guaranteed medical treatment from the Compensation Commissioner, Department of War Pensions or arising from the Motor Vehicle Insurance Act during the past 24 months?		
26. Is any female member/dependant currently pregnant? If so, provide expected date of confinement below.		
27. Do you or any of your dependants suffer from any chronic disease for which you and/or your dependants have to use chronic medication?		
28. Are you aware of any existing condition(s) that may require medical or surgical treatment within the next 12 months?		
29. Are you or any of your dependants currently undergoing any other medical and/or surgical treatment?		
30. Have you or any of your dependants undergone any medical and/or surgical treatment?		
31. Were you or your dependants subjected to any waiting periods, exclusions or penalties by your previous medical scheme?		
32. Are there any other conditions or symptoms not detailed in any other question, that you or any of your dependants have experienced and for which you have not yet sought medical advice?		

If you indicated yes to any of the questions in the medical questionnaire on the previous page, please provide full details of the condition below. Attach additional information if this space is insufficient.

Question number	Name of patient	Type of illness/condition	Date diagnosed	Date of first treatment	Date of last treatment	Last symptoms/consult/ hospitalisation	Treatment received and/or medication used

If you indicated yes to any of the questions in the medical questionnaire on the previous page, please provide the details below:

Question number	Treating practioner	Treating practioner telephone number

8 CONSENT TO RECEIVE MARKETING MATERIAL

Profmed's Administrator (PPS Healthcare Administrators) may use my information for the purpose of marketing (including direct marketing) of life and non-life insurance products (including sickness benefits), investments, retirement benefits, and any other financial or non-financial services offered by PPS Insurance Company Limited and its subsidiaries.

Yes ☐ No ☐

9 DETAILS OF BROKER

Surname _____ Initials ☐☐☐☐

Profmed broker no. ☐☐☐☐☐☐☐☐☐

FSP no. ☐☐☐☐☐ Business/company name _____

Signature of Profmed broker _____ Date D D M M Y Y Y Y

10 ADDITIONAL INFORMATION

DOCUMENTS

To facilitate the quick and efficient processing of your membership, use the tick boxes below to ensure all the applicable documents accompany this application form:

Copy of principal member's ID ☐

Copy of spouse/partner's ID ☐

Copy of certificate(s) of degree(s)/qualification(s) ☐

Membership certificate(s) of all previous medical scheme cover ☐

Proof of study or dependence in respect of child dependants older than 21 years but younger than 28 years ☐

Proof of study or dependence in respect of dependants 28 years or older ☐

Proof of combined monthly household income from all sources, i.e. a sworn affidavit confirming your income and/or a tax directive from SARS, or your latest tax return, and 3 months' recent bank statements of all your household bank accounts (only if your combined household income is less than R11 000 per month) ☐

Additional information in respect of sections 1, 5 and 7 of this application form ☐

Copy of latest salary advice in respect of Government employees ☐

11 PROFMED'S RESPONSIBILITIES IN RESPECT OF YOUR PERSONAL INFORMATION

1. Profmed will collect personal information about you and your dependants ("your personal information") at the time of application, for the duration of and after termination of your membership of Profmed, as permitted in terms of the Medical Schemes Act or any other relevant legislation. Such personal information includes the information provided by you on this application as well as information collected from service providers who have treated or attended to you and your dependants, your broker, your employer and any other source from which Profmed may lawfully collect such personal information. The information to be collected includes, but will not be limited to, your personal, demographic and employment details as well as health information.
2. Your privacy and the security of your personal information are important to Profmed. Your personal information will be kept confidential at all times.
3. Adequate data security measures are in place to protect your personal information from destruction and unauthorised access.
4. Access to your personal information will be granted to employees of Profmed and its contracted service providers as may be necessary to perform their functions and duties. Profmed will take reasonable steps to ensure that its employees and contracted service providers keep your personal information confidential and comply with relevant legislation. All employees and contracted service providers of Profmed are bound by confidentiality agreements. In the event of a breach of confidentiality, Profmed will manage such breach according to its internal disciplinary procedures or contractual arrangements, as may be applicable, or as may be required in terms of the law.
5. Profmed will share relevant personal information, including health information, of your dependants with you as the principal member to ensure the efficient administration of your membership and benefits.
6. Profmed will only disclose your personal information to other third parties or grant them access to such information in accordance with the law or otherwise with your or your dependants' consent as may be appropriate.
7. If you are a member of an employer group Profmed may share information relating to your membership with your employer. This will be limited to information that is relevant to your application or information that is required for the ongoing servicing of your membership, but will not include any health information unless you have given Profmed permission to do so. Profmed may also share your relevant personal information with credit rating agencies, including personal information about any judgment or default history, should you default on any payment to Profmed.

8. Should your broker request personal information about you and your dependants, Profmed will only provide information that enables your broker to provide you with sound advice, such as your option type and your contact details. Profmed will not share any information about your or your dependants' medical conditions with your broker unless you have given Profmed permission to do so.
9. Profmed will only share your personal information with third parties outside of the borders of the Republic of South Africa if it is necessary for the provision of healthcare and other services to you and your dependants in terms of the Rules, subject to the provisions of relevant legislation.
10. Profmed and its contracted service providers will process, which includes the collection and storage of your personal information as provided for in the Rules of the Scheme, this application and the law, only for the following purposes:
    - 10.1 Processing and assessment of your application and eligibility for membership;
    - 10.2 Collection of contributions and other money owed to Profmed;
    - 10.3 Assessment of your entitlement to benefits;
    - 10.4 Assessment and payment of claims;
    - 10.5 Underwriting;
    - 10.6 Risk assessment and management;
    - 10.7 Managed healthcare;
    - 10.8 Administration of your membership;
    - 10.9 Investigating and reporting of suspicious behaviour or fraudulent conduct to appropriate persons and bodies;
    - 10.10 Communication of information relevant to your membership, including Profmed's products and services;
    - 10.11 Communication of relevant personal information to healthcare service providers to enable you or your dependants to access benefits in terms of the Rules;
    - 10.12 Protection of your legitimate interests or pursuit of the legitimate interests of Profmed and persons to whom the personal information is supplied by Profmed;
    - 10.13 Systems testing, maintenance and development;
    - 10.14 Member surveys;
    - 10.15 Reporting to authorised persons and authorities, e.g. the Board of Trustees and the Council for Medical Schemes;
    - 10.16 Profiling your compliance with treatment plans and prescribed medication as well as utilisation of Profmed's services and benefits;
    - 10.17 Historical, statistical and research purposes;
    - 10.18 Compliance with any relevant legislation; and
    - 10.19 Any other lawful purpose which directly relates to your membership of Profmed or which is authorised in terms of the law or the Rules.
11. You may object to the processing of your personal information contemplated in 10.12 above in the manner prescribed in terms of the Protection of Personal Information Act, 2013 (Act 4 of 2013) unless Profmed is authorised to such information in terms of legislation.
12. Profmed will not use your personal information for commercial purposes.

⓬ DECLARATION BY THE APPLICANT

1. I am applying for membership of Profmed and warrant and declare that the information given and statements made herein, whether completed by me or on my behalf, are correct and complete in every respect. I confirm that I have read and understand the requirements and implications of Section 7 and that I have declared all medical conditions. I understand that acceptance of my membership of Profmed is subject to the eligibility criteria and the Rules of Profmed.
2. I expressly authorise any healthcare service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to Profmed, or its contracted service providers, on request, also after the death or termination of membership of any of us. I expressly grant Profmed the right to access our personal information as and when necessary.
3. I expressly authorise Profmed, to the extent that it may be required by law, to process, which includes the collection, usage and storage of, our personal information, comprising amongst others our demographic, health and biometric information, contact details as well as information related to any suspected fraudulent behaviour by me or any of my dependants, and which information has been supplied by us to Profmed or which Profmed may lawfully collect from any third party, for the purposes specified above.
4. I consent to the recording of all conversations between myself or any of my dependants and Profmed or any of its contracted service providers and agree that all information so obtained as well as all other information about us may form part of the records of Profmed, which records may be retained for as long as it is required in terms of the Rules or applicable legislation, for historical, statistical or research purposes, subject to the requirements of the law, or for any other lawful purpose.
5. I understand that my dependants and I must ensure that Profmed is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of our application for membership, underwriting, the administration of our membership, the calculation of contributions, the processing of claims, payment of benefits, communication by Profmed with us, and other purposes relevant to our membership as stipulated above.
6. I understand that my dependants and I may have access to our personal information held by Profmed and may request Profmed to correct any inaccurate information subject to the provisions of applicable legislation.
7. I understand that should any of my dependants or I have any concern about the processing of our personal information, we may raise the matter with the Principal Officer. I also understand that once the Information Regulator has been established we may also lodge a complaint with this Regulator.
8. I agree that the information supplied on this application form, together with the supporting information, forms the basis of my membership of Profmed and that my membership of Profmed is subject to the conditions, exclusions and limitations of benefits in accordance with the Medical Schemes Act and the Rules of the Scheme. I also understand that should any information be incorrect or incomplete, my application for membership might not be approved, my membership might be terminated subject to payment of a reasonable cancellation fee or it might prevent Profmed from providing me and my dependants with benefits and services, including payment of claims.
9. I agree that my dependants and I shall abide by the Rules of the Scheme, as amended from time to time.
10. I authorise Profmed to deal with my dependants and I electronically and treat electronic communication (such as email, fax, telephone, or communication through Profmed's digital App) as being the same as written authority and confirmation. I agree further that, where I choose to use electronic methods to transact with Profmed, we will carry the risk of such use.
11. I declare that in the event of any amount being paid by Profmed in respect of me or any of my dependants arising from injuries which may involve a claim against any other party, I undertake to refund Profmed the whole amount relevant to medical expenses incurred by Profmed that I recover from any other source.
12. I guarantee that, to the extent that it may be required by law, I have the necessary authority from my dependants to provide the consent and permissions contained in this application and to receive communication from Profmed on their behalf regarding any matter related to their membership and medical scheme cover, including relevant health information.
13. I acknowledge that acceptance of this application by Profmed shall be conditional upon there having been no deterioration in the state of my health or that of my dependants between the date of completion of this application and the date of membership. I undertake to advise Profmed immediately of any such deterioration.
14. I understand that Profmed will inform me whether my application for membership has been successful and whether any underwriting condition will be imposed.

Signature of applicant _____ Date | D | D | M | M | Y | Y | Y | Y |

ANNEXURE A

AUTHORITY AND MANDATE FOR DEBIT PAYMENT INSTRUCTIONS

Written authority and mandate is not necessary if the employer pays your TOTAL membership contribution, or if you pay your contributions by EFT.

A DEBIT ORDER DETAILS

Name of bank account holder

Physical address *(Please provide again even if provided elsewhere on this form)*

Name of bank | Branch name | Branch code

Account number | Type of account: Cheque / Transmission / Savings

Amount: **AS PER THE MEMBERSHIP CERTIFICATE TO BE ISSUED**

Commencement date of debit order mandate: **1ST DAY OF THE MONTH OF THE DATE OF COMMENCEMENT OF MEMBERSHIP**

Debit order deduction date: **1ST DAY OF EACH MONTH**

Name of recipient: **PROFMED** | Abbreviated name of recipient as registered with the bank: **PROFMED0001**

Profmed's registered address: **PROFMED PLACE, 15 ETON ROAD, PARKTOWN, 2193, JOHANNESBURG**

This signed Authority and Mandate refers to the application form dated: D D M M Y Y Y Y

I/We hereby authorise Profmed to issue and deliver payment instructions to First National Bank for collection against the above-mentioned account at the above-mentioned bank (or any other bank or branch to which I/we may transfer my/our account, of which I/we will inform Profmed accordingly) and continuing until this Authority and Mandate is terminated by me/us by giving you notice in writing of not less than 20 ordinary working days, and submitted to Profmed at contributions@profmed.co.za.

The individual payment instructions so authorised to be issued must be issued and delivered monthly.

The payment date is the 1st day of the month. If the 1st falls on a weekend or recognised South African public holiday, the payment will take place on the first working day thereafter. Furthermore, if there are insufficient funds in my account to meet the obligation, I understand that it is my responsibility to ensure that the outstanding amount is paid to Profmed within seven days of default.

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African banks. I also understand that details of each withdrawal will be printed on my bank statement. Such must contain a number, which must be included in the said payment instruction and if provided to me should enable me to identify the withdrawal. This number is displayed on this form in Section D.

B MANDATE

I/We acknowledge that all payment instructions issued by Profmed shall be treated by my/our above-mentioned bank as if the instructions have been issued by me/us personally.

C CANCELLATION

I/We agree that, although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel my membership of Profmed. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force if such amounts were legally owing to Profmed.

D WITHDRAWAL TRANSACTION REFERENCE NUMBER

This reference number is: **PROFMED0001**

Signature of account holder _____ Date D D M M Y Y Y Y