Administered by Universal Healthcare (Pty) Ltd
Universal House, 15 Tambach Road, Sunninghill Park, Sandton, 2191
PO Box 1411, Rivonia, 2128, South Africa
Tel +27 (11) 208 1000, Fax +27 (11) 208 1128
www.universal.co.za

Application for Membership

(for employees joining **after 90 days** from employment start date)

Please note that this form may contain sensitive and confidential information

Submit this form directly to Universal Healthcare and not via your Human Resources or Line Manager

This form is issued without admission of liability and must be signed by the main member.
Email your completed form to membership@omsmaf.co.za or call 0860 100 076 for assistance.

Please complete in BLOCK LETTERS

A. APPLICANT'S DETAILS

Identity number: ______ Title: ______

Main member name(s): ______

Surname: ______

Date of birth: (DD/MM/YYYY) ______ Gender: ☐ Male ☐ Female

Marital status: ______

Contact number: H ______ Cell ______

W ______ Fax ______

E-mail address: ______

Postal address: ______ Code ______

Home address: ______ Code ______

Where should your membership card be sent?

☐ Your postal address ☐ Walk-in-centre for you to collect (Mutualpark only)

B. MEDICAL PLAN

☐ **Hospital Plan** ☐ **Traditional Plan**

☐ **Network Plan** ☐ **Traditional SELECT Plan**

☐ **Network SELECT Plan** ☐ **Traditional Plus Plan**

☐ **Savings Plan** ☐ **Traditional Plus SELECT Plan**

C. EMPLOYMENT DETAILS

Staff code: ______ Date of permanent employment: (DD/MM/YYYY) ______

☐ Office Staff ☐ PFA Staff Business Unit: ______

Job title: ______

Income bracket: ☐ R0 – R5 040 ☐ R5 041 – R7 560 ☐ R7 561 – R10 090 ☐ R10 091 – R13 470

☐ R13 471 – R19 970 ☐ R19 971 – R33 300 ☐ R33 301+

Medical aid start date: (DD/MM/YYYY) ______

D. BANKING DETAILS FOR PAYMENT OF REFUNDS

Account holder's name:

Bank's name:

Branch code: Account type: Cheque Savings Transmission

Account number:

I hereby authorise you to pay any medical aid fund benefit that may be due to me to the above-mentioned bank account or any other bank account which I might change to in future.

E. DEPENDANT INFORMATION

1.
Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

2.
Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

3.
Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

4.
Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

5.
Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

Please note that the Fund requires that you submit the following accompanying documentation as proof if:

• Your and your spouse's surnames differ:	Copy of marriage certificate or other appropriate proof if married according to religious or traditional rights.
• If your child dependant(s) surname(s) differs:	Copy of birth certificate/affidavit and proof of adoption (if applicable)
• If a child has been placed in your custody:	Copy of birth certificate and court order
• For a Life Partner	Completed and signed Affidavit: Domestic Partnership Refer below to Affidavit Form: Registered Dependants
• For Indigent parents/siblings/grand children/ great-grand child/great-grand parents	Completed and signed Affidavit Proof of Dependency Refer below to Affidavit Form: Registered Dependants
• Child dependants above 30 years of age	Completed and signed Affidavit Proof of Dependency Refer below to Affidavit Form: Registered Dependants

F. PREVIOUS MEDICAL AID HISTORY

Are or were you or any of your nominated dependants, beneficiaries of a registered medical scheme(s)? ☐ Yes ☐ No

Have condition-specific waiting periods, exclusions or late joiner penalties ever been imposed on you or any of your dependants on application for membership of any other medical Schemes. (see Annex. A for more information) ☐ Yes ☐ No

If any of your answers above was "**yes**", a certificate of membership with an end date (not a membership card) must be attached to this application. It is illegal to belong to two medical aids at the same time. Waiting periods apply – please refer to the "waiting periods" section of this document as well as the Member Guide.

G. MEDICAL DETAILS (Please note that this section is only required if you are joining AFTER 90 days from your employment start date)

PLEASE SAFEGUARD ALL INFORMATION ABOUT ANY MEDICAL CONDITIONS AND ONLY DISCLOSE THIS TO THE MEDICAL AID ADMINISTRATOR AND NOT YOUR HR OR LINE MANAGER.

Failure to disclose information is fraudulent and may result in membership not being granted or termination of membership without refund of contributions paid.

Have you or any of your dependants sought any advice, been diagnosed with or been treated for any conditions in the last 12 months? If yes, please provide details. ☐ Yes ☐ No

If you or any of your dependants are living with HIV/ AIDS and would prefer not to disclose the HIV/ AIDS status on this form in the interest of confidentiality, then please call HIV and AIDS Management Programme on 0860 378 800 to register.

Should this space be insufficient, please attach a separate sheet.

Name of beneficiary ________

Diagnosis ________ Date (DD/MM/YYYY) ________

Name of medication and dosage ________

Are you currently receiving treatment? ☐ Yes ☐ No

Have you been hospitalised? ☐ Yes ☐ No

Name and contact number of treating Family Practitioner, Dentist or Specialist ________

Name of beneficiary ________

Diagnosis ________ Date (DD/MM/YYYY) ________

Name of medication and dosage ________

Are you currently receiving treatment? ☐ Yes ☐ No

Have you been hospitalised? ☐ Yes ☐ No

Name and contact number of treating Family Practitioner, Dentist or Specialist ________

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? Yes No

Have you been hospitalised? Yes No

Name and contact number of treating Family Practitioner, Dentist or Specialist

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? Yes No

Have you been hospitalised? Yes No

Name and contact number of treating Family Practitioner, Dentist or Specialist

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? Yes No

Have you been hospitalised? Yes No

Name and contact number of treating Family Practitioner, Dentist or Specialist

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? Yes No

Have you been hospitalised? Yes No

Name and contact number of treating Family Practitioner, Dentist or Specialist

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? Yes No

Have you been hospitalised? Yes No

Name and contact number of treating Family Practitioner, Dentist or Specialist

H. INFORMATION AVAILABLE TO YOU

Please tick the relevant box(es) if you would you like to receive more information on the following:

☐ Back and Neck Programme

☐ Oncology Benefit Management Programme

☐ HIV and AIDS Management Programme

☐ Mental Health Programme

☐ Active Disease Risk Management Programme

☐ Mother and Baby Programme

☐ Chronic Medicine Management

If you have ticked any of the boxes above, the relevant department(s) will contact you. You can also find more detailed information on all these programmes in your member guide.

PLEASE NOTE: Ticking one or more boxes above does not mean that you are registered on any of these programmes. Set criteria apply to each programme and not all members may qualify.

I. DECLARATION BY THE APPLICANT

I, the undersigned, hereby make application to be admitted as a member of the Fund. If admitted, I agree to abide by the Rules of the Fund. I declare that any false statement in the above application or the non-disclosure of any material information will render my membership null and void, and that any monies paid to the Fund shall be forfeited to the Fund.

I warrant that all the answers given in this application are true, correct and complete in every respect.

I undertake to disclose to the Administrator any material alteration to the facts disclosed in this application and any change in my state of health or that of my dependants which may occur between the date of signature of the application by me and the date of receiving written acceptance of this application, and that such notification shall give the Fund the right to reconsider the application and to process new terms of acceptance. I am also aware that my membership shall not commence unless the Fund notifies me in writing. I accept that the failure to make such disclosure will render my membership null and void, benefits may be reversed and any monies paid to the Fund shall be forfeited to the Fund.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risk and the consideration of any claim for benefits in respect of the membership, I hereby authorise any healthcare provider and any other person who may be in possession of any information concerning my health or that of any of my dependants to disclose the information to the Fund or its authorised Representative and its contracted third parties. A photostat copy or facsimile of this authorisation shall be considered as effective and valid as the original.

I am aware of the fact that on joining the Fund during the course of the benefit year, the maximum benefits to which I may be entitled, shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular benefit year.

Upon termination of membership of the Fund, I agree that the Fund may deduct any amount due to the Fund by me from any monies due to me. If I resign from the Fund during a benefit year and have used the annual PMSA benefit to such an extent that there is an outstanding debt to the Fund, this debt will become fully due on the date of termination of my membership.

I confirm that I am familiar with the conditions and benefits of the Fund.

I declare that neither I nor my nominated dependants are covered by any other medical aid scheme.

I declare that I will inform the Fund of any change of income including additional income. Income changes are effective on date of notification.

I undertake to cancel my membership with the Fund or that of my nominated dependants immediately upon becoming a member or a dependant of another medical aid scheme.

Signed at ____________________ on the ______ day of ______________

Signature of applicant

____

Annexure

INFORMATION

All permanent employees must belong to the Fund, unless they belong to their spouse's or partner's employer-preferred medical scheme (in which case they need to submit proof of such membership by uploading their certificate of membership on Oracle each year). Active members who retire from Old Mutual may continue to belong to the Fund as pensioner continuation members. To qualify, they must have been a member of the Fund at retirement.

You have an opportunity to review and change your choice of Plan at the start of the new benefit year on 1 July each year. Once you have selected a Plan for the benefit year, you will not be allowed to change your Plan during the benefit year. Please refer to your Member Guide for a comparison of the benefits offered by the Fund, as well as detailed information about the benefits and the administration of the Fund.

The Fund offers medical aid benefits to qualifying members and their dependants. There are clear guidelines as to who qualifies to receive benefits, especially relating to dependants and you will need to provide certain documentation to prove their dependency on you. Your monthly contribution will increase as the number of your dependants increase. Please refer to the contribution tables in your Member Guide.

Contributions: All contributions in respect of new members shall be due from the first day of the month during which employment commences or date of admission, except when the date on which employment commences (with simultaneous admission) is the 15th or later of a month, in which case the contributions shall be due from the first day of the following month. Benefits shall commence from the date of registration.

The Fund's benefit year runs from 1 July to 30 June of the following year.

Medical aid contributions are paid in arrears.

- If your membership is terminated up to and including the 14th of the month, no contribution will be due for that particular month and you will be entitled to benefits until your last day of employment.
- If your membership is terminated on the 15th or later of a month, the full contribution will be due and you will be entitled to benefits until the end of the month.

Waiting Periods

- No waiting period will apply for new employees who apply to join the Fund within 90 days of first becoming an employee of Old Mutual or within 90 days of their return to employment after a period of unpaid leave or secondment.
- No waiting period will apply to a dependant whose application is submitted within 30 days after they become eligible to join the Fund as a dependant.
- If you join the Fund by means of the Employer's default process and you wish to add dependants, no waiting period will apply to such a dependant if you add them within 30 days of your join date.
- No waiting period will apply to an employee who undergoes a life-changing event and applies to join the Scheme within 90 days from the life-changing event taking place. A life-changing event is defined as divorce, marriage, retrenchment, a spouse's or partner's change of employment, or death. Proof of such an event needs to be provided.

When will waiting periods apply?

- If you have never been a member or dependant of a medical scheme or were not covered for a period of more than 90 days immediately before applying to the Fund, the Fund may impose the general waiting period and the condition-specific waiting period (if the beneficiary suffers from a pre-existing condition). In this case the waiting periods will also apply to Prescribed Minimum Benefits.

What is a waiting period?

This is the period during which you will not be covered for any medical expenses incurred, even though you may be making contributions to the Fund. There are two types of waiting periods:

Condition-specific waiting period: A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made. This will also apply to PMB.

General waiting period: A period during which a beneficiary is not entitled to claim any benefits. This will also apply to PMB.

- If you have been a member or dependant of a medical scheme for less than 24 months and you apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), a condition-specific waiting period will apply. If the beneficiary suffers from a pre-existing condition, the Fund may also impose any unexpired balances imposed by the previous scheme. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits.
- If you have been a beneficiary of a medical scheme for more than 24 months and apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), the general waiting period will apply. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits.
- If you register your child after 30 days of birth, waiting periods will apply.
- No waiting periods will apply to a newly adopted child as long as such a child is registered within 30 days of adoption.

What is a Late Joiner Penalty (LJP)?

An LJP will be applied to any dependant over the age of 35 except the main member, who has not been on a medical scheme before.

- Dependants' LJPs are, for example, calculated as follows: A dependant is 65 years and has had 5 years' previous medical aid cover. Then we take 65 (age) – 35 = 30 (without medical aid cover) – 5 (previous cover) = 25 years without medical aid cover, therefore the LJP will be 75%.

Years without medical cover	Late joiner penalty (LJP) payable
1 – 4 years	5% of contribution
5 – 14 years	25% of contribution
15 – 24 years	50% of contribution
25 years and more	75% of contribution

In South Africa, medical aid schemes can impose late-joiner penalties on individuals who join a medical aid scheme after the age of 35; those who have never been medical aid members, or those who have not belonged to a medical aid scheme for a specified period of time since April 2001

- On receipt of the member's application form, the administrator will impose LJPs and waiting periods as per the approved Fund Rules.

- It is important to provide all supporting documents, such as membership certificates of previous medical schemes (indicating the membership end date) to the Fund as soon as possible, to ensure that LJPs, if applicable, are not calculated incorrectly. (If you are unable to provide proof of cover, the Fund will accept an affidavit.) Any LJP is only adjusted from the 1st of the next month after proof of previous membership is received and there will be no refunds or backdating.
- Condition of employment: If a member and his dependants join within 90 days, no waiting periods will apply to the member and his/her dependants. but LJP's could apply to dependants over the age of 35.
- Please take note that LJPs are implemented for life and do not expire.
- Also note that the participating companies do NOT subsidise this late joiner penalty.

Recovery of overspent PMSA balances

If you resign from the Fund during a benefit year and you have used the annual Personal Medical Savings Account (PMSA) benefit to such an extent that there is a debt, this debt will become fully due on the date of termination of membership. This practice is supported by the Rules of the Fund.

The Fund will notify you in writing and telephonically of any outstanding debt when you resign from the Fund. This outstanding debt will become fully due on notification of your resignation. Such communication will be delivered to your last known contact details either via electronic media or post.

The Fund will transfer all unsettled accounts to its Debt Recovery Service Provider within 120 days of resignation from the Fund. Unsettled accounts will incur recovery costs once handed over to the Debt Recovery Service Provider.

PROTECTION OF PERSONAL INFORMATION

This Section explains how Old Mutual Staff Medical Aid Fund (the Fund) collects, uses, shares and processes your personal information that you give to the Fund, and this information may include your health and benefit information ("Personal Information"), in terms of the Protection of Personal Information Act, 4 of 2013 ("POPI").

It is important that you read and understand the terms of this Section carefully before accepting these terms and conditions. The acceptance of these terms and conditions is voluntary, but in order to activate your Fund membership, these terms and conditions must be accepted by yourself and your dependants. If you do not accept these terms and conditions, we will not be able to provide you with the full range of our medical scheme services.

It is also important to note that when you accept these terms and conditions, you provide the Fund with your consent and the consent of your dependants, registered on your membership, to activate your personal health record and enrol you on any managed healthcare programmes for your and your dependants' healthcare benefit.

Terms and Conditions:

1. The Fund collects, uses, processes, retains and shares your and your dependants' personal information for the purpose of providing medical scheme benefits and managed healthcare services to you and your dependants. This includes the collecting and sharing of your and your dependants' personal information with our third-party healthcare partners, facilities and associated partners of the Fund, who are essential to the membership process.
2. The personal information of you and your dependants may also be shared with emergency service providers, including hospital facilities, in medical emergency situations that may result in serious bodily impairment, dysfunction or death.
3. The Fund, its administrator and its managed care organisation will keep all personal information of you and your dependants given to us in this application or collected from other sources, confidential and will only provide the personal information to additional third parties not involved in the administration of your membership or healthcare needs, with your consent.
4. You confirm that when you provide us with your personal information and that of your dependants, you have the appropriate permission to disclose their personal information to us for the purposes of receiving medical scheme benefits and related services. In the event of your providing personal information and consent on behalf of a minor dependant person younger than 18 years old, or adult dependant unable to provide their own consent, or any person registered as a dependant on your membership, you confirm that you are authorised to do so on their behalf.
5. You agree to us processing (which shall include collecting, collating, processing, storing, disclosing and retaining) your and your dependants' personal information):
    a. for the administration of your benefit option;
    b. for providing managed healthcare services to you or any dependant/s based on your benefit option;
    c. for providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your benefit option;
    d. for academic research conducted by the Fund, contracted third parties of the Fund, its marketing agents, affiliates and partners;
    e. for any managed healthcare programme or initiative that will benefit you or your dependants in managing any healthcare condition and optimise your medical scheme benefits; and
    f. to activate your personal health record and prepopulate your personal health record with your health and personal information, from the previous 12 months.
6. You acknowledge that your personal information may be stored in a secure web-based facility, where we endeavour to ensure that your personal information is kept confidential at all times.
7. You acknowledge that you have the right to contact the Fund at any time to update, correct or delete your personal information. You and your dependants can update or correct your information at any time by logging on to www.omsmaf.co.za.
8. You have the right to object to the processing of your personal information at any time and revoke any consent you have given for yourself or your dependants. Please contact the Fund to do so.
9. You have the right to request a copy of the personal information we hold about you. Please contact us to find out how to request your personal information.
10. Please note that these terms and conditions may be changed from time to time; please check the OMSMAF website for an updated version.
11. Should you believe that we have used your personal information in a way that is against POPI or without your consent, please contact us immediately to resolve the problem.
12. The terms and conditions applicable to the personal health record can be found on our website at www.omsmaf.co.za, and it is your responsibility to ensure you have read and understood the terms and conditions.

OMSMAF
OLD MUTUAL STAFF MEDICAL AID FUND

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Tel +27 (11) 208 1000, Fax +27 (11) 208 1128
www.universal.co.za

Affidavit Form: Registered Dependants

A Commissioner of Oaths must sign this affidavit.

Main Member Name:	
Main Member Surname:	
Main Member ID / Passport Number:	
Membership Number:	
Dependant Name:	
Dependant Surname:	
Dependant ID / Passport Number:	

Tick and complete ONLY the column relevant to your dependant:

☐ Dependant child over age 30	☐ Parent / grandparent	☐ Dependant	☐ Life Partner (Domestic Partnership)
I confirm that the dependant specified above is **financially dependant*** on me. The dependant is: (Please tick) ☐ Employed OR ☐ Not employed. Earns R________ (gross income) per month from all sources.	I confirm that the dependant specified above is financially **dependant*** on me (Please tick) ☐ Parent ☐ Grandparent The dependant is: (Please tick) ☐ Employed OR ☐ Not employed. Earns R________ (gross income) per month from all sources.	I confirm that the dependant specified above is financially **dependant*** on me and is my or my spouse's/partner's: (Please tick) ☐ Niece ☐ Nephew ☐ Grandchild ☐ Biological child with different surname ☐ Other (please stipulate relationship to you) ________ The dependant is: (Please tick) ☐ Employed and earns R________ (gross income) per month. OR ☐ Not employed.	I confirm that the dependant specified above is my **life partner****. ****A life partner is a person with whom you have a committed and serious relationship, similar to a marriage, based on objective criteria of a shared and common household, irrespective of the gender of either party. Such a dependant will pay adult rates, regardless of age.**

***The term 'financially dependant' shall mean that the dependant is not liable for the payment of normal tax in his/her own right, as determined in terms of the Income Tax Act 58 of 1962.**

I, the undersigned, hereby warrant that all information given in this declaration is true, correct and complete in every respect.

Member's signature:

Date: (DD/MM/YYYY)

A Commissioner of Oaths must complete this section.

Commissioner Name:

Signature: Commissioner of Oaths

STAMP

PROTECTION OF PERSONAL INFORMATION

Old Mutual Staff Medical Aid Fund takes the protection of Personal Information very seriously and for this reason we take all reasonable measures to protect your Personal Information and to keep it confidential. Personal information refers to information that identifies or relates specifically to you, for example, your name, age, gender, health status, identity number and your email address. In short, any information that we know about you will be regarded as your Personal Information.

We use your information or obtain information about you for the following purposes:

- Underwriting
- Assessment and processing of medical services claims
- Fraud prevention and detection
- Statistical analysis
- Audit & record keeping purposes
- Compliance with legal & regulatory requirements
- Verifying your identity
- Sharing information with service providers we engage to process such information on our behalf or who renders services to us.

You may access the personal information that we hold and request us to correct any errors or to delete this information.