APPLICATION FOR MEMBERSHIP

086 010 4012 | membership@sisonkehealth.co.za | **www.sisonkehealth.co.za**
Administered by Medscheme Holdings (Pty) Ltd. | PO Box 1101, Florida Glen, 1708

SISONKE HEALTH MEDICAL SCHEME
As amalgamated with **Lonmin Medical Scheme**

Please complete this application form electronically.

INDUSTRY NUMBER: | PAY POINT:
EMPLOYER: | CONSULTANT:

CHECKLIST

- ☐ 1. Copy of member ID or Industry card
- ☐ 2. Copy of birth certificates/ ID of all dependants
- ☐ 3. Employer and Pay Point completed on front page
- ☐ 4. Cell number completed
- ☐ 5. Form signed by Member
- ☐ 6. Medical questionnaire completed

SECTION 1: PERSONAL DETAILS

Title | Initials | First names
Surname
ID/Passport number | Date of birth (dd / mm / yyyy) | SARS tax number
Nature of person: ◯ Individual ◯ Foreign Individual ◯ Individual Estate (Including late estate)
Marital status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced
Contact details: Home | Work | Cell
Email
Preferred method of communication: ◯ SMS ◯ Email Card collection: ◯ Post ◯ Centre
Physical address | Postal code
Postal address | Postal code

Member or dependants on chronic medication? ◯ YES ◯ NO *If "yes" please complete the below details:*
Pharmacy | Contact number

Member or dependants on dialysis? ◯ YES ◯ NO *If "yes" please complete the below details:*
Medical practitioner | Contact number

Member or dependants on oncology? ◯ YES ◯ NO *If "yes" please complete the below details:*
Medical practitioner | Contact number

If the applicant has a DISABILITY – please complete:

Type of disability: ☐ Hearing disability ☐ Vision disability ☐ Speech disability ☐ Mental disability ☐ Physical disability ☐ Intellectual disability
Nature of disability: ◯ Temporary ◯ Permanent
Disability limitation: ◯ Mild ◯ Moderate ◯ Severe
Disability start date (dd / mm / yyyy) | Disability end date (dd / mm / yyyy)
Medical practitioner | Practitioner email
Practice number | Tel | Cell

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MEMBER SURNAME | INDUSTRY NUMBER

SECTION 2: SPOUSE AND DEPENDANT DETAILS

A: SPOUSE DETAILS

Title | Initials | First names

Surname | Disability ☐ *(If selected, complete section 2C)*

ID/Passport number | Date of birth (dd / mm / yyyy) | Gender ◯ M ◯ F

Contact details | Home | Work | Cell

Email

B: DEPENDANT DETAILS *NOTE: Acceptance of dependants will be decided in accordance with the Scheme Rules.*

B1 First names | Surname

ID/Passport number | Relationship to Member

Date of birth (dd / mm / yyyy) | Gender ◯ M ◯ F | Disability ☐ (*If selected, complete section 2C)*

Complete if over 18: Cell | Email

Address

B2 First names | Surname

ID/Passport number | Relationship to Member

Date of birth (dd / mm / yyyy) | Gender ◯ M ◯ F | Disability ☐ (*If selected, complete section 2C)*

Complete if over 18: Cell | Email

Address

B3 First names | Surname

ID/Passport number | Relationship to Member

Date of birth (dd / mm / yyyy) | Gender ◯ M ◯ F | Disability ☐ (*If selected, complete section 2C)*

Complete if over 18: Cell | Email

Address

2C: DEPENDANT DISABILITY DETAILS

Dependant name

Type of disability ☐ Hearing disability ☐ Vision disability ☐ Speech disability ☐ Mental disability ☐ Physical disability ☐ Intellectual disability

Nature of disability ◯ Temporary ◯ Permanent

Disability limitation ◯ Mild ◯ Moderate ◯ Severe

Disability start date (dd / mm / yyyy) | Disability end date (dd / mm / yyyy)

Medical practitioner | Practitioner email

Practice number | Tel | Cell

MEMBER SURNAME | INDUSTRY NUMBER

2C: DEPENDANT DISABILITY DETAILS

Dependant name

Type of disability ☐ Hearing disability ☐ Vision disability ☐ Speech disability
☐ Mental disability ☐ Physical disability ☐ Intellectual disability

Nature of disability ◯ Temporary ◯ Permanent

Disability limitation ◯ Mild ◯ Moderate ◯ Severe

Disability start date (dd / mm / yyyy) Disability end date (dd / mm / yyyy)

Medical practitioner Practitioner email

Practice number Tel Cell

SECTION 3: EMPLOYER TO COMPLETE AND SIGN

Employer ◯ SIBANYE-STILLWATER GOLD ◯ GOLD FIELDS LTD ◯ SIBANYE-STILLWATER PLATINUM ◯ DRD GOLD

Date of employment (dd / mm / yyyy) Scheme join date (dd / mm / yyyy)

Basic salary **R** Mine name Pay point

Number of subsidised dependants: ☐ Spouse ☐ Children ☐ Adult dependants

Plan Selected ☐ Heritage Plan ☐ Diversity Plan ☐ Pride Legacy Plan

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the selected SISONKE HEALTH MEDICAL SCHEME'S Rules. All sections of the application form have been completed and signed.

Employer's telephone number Employer's email address

Name of Medical Scheme/Salary Administrator

Designation

Date (dd / mm / yyyy) Signature

COMPANY STAMP

SECTION 4: MEMBER'S BANKING DETAILS

USE THIS ACCOUNT FOR CLAIM REFUNDS

Bank name Branch name

Account holder name

Account number Branch number

Account type ◯ Current ◯ Cheque ◯ Savings ◯ Transmission

APPLICATION FOR ELECTRONIC TRANSFER OF FUNDS

I hereby instruct SISONKE HEALTH MEDICAL SCHEME to electronically deposit refunds into my bank account. I understand that credit card accounts may not be used for these transactions. I also irrevocably authorise SISONKE HEALTH MEDICAL SCHEME to reverse any erroneous transaction and/or to rectify any incorrect electronic transfer of funds without prior notice.

Account holder's signature Date (dd / mm / yyyy)

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MEMBER SURNAME		INDUSTRY NUMBER	

PRIMARY MEMBER'S CONSENT SECTION

You give permission to make information available to the third party/family member specified below.

Title | Initials | First names

Surname | Contact number

Relationship | ID / Passport number

Please select one option: ◯ All consent ◯ Updating details ◯ Financial info ◯ Clinical info ◯ None

Member's name

Date (dd / mm / yyyy) | Signature

SPOUSE'S CONSENT SECTION

You give permission to make information available to the third party/family member specified below.

Title | Initials | First names

Surname | Contact number

Relationship | ID / Passport number

Please select one option: ◯ All consent ◯ Updating details ◯ Financial info ◯ Clinical info ◯ None

Member's name

Date (dd / mm / yyyy) | Signature

SECTION 5: FAIR COLLECTION NOTICE

This Fair Collection Notice ("Notice"): explains how we obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPIA").

Acceptance of these terms and conditions is voluntary, but is a requirement for activating and servicing of your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your membership.

1. **Please note:**
   - We may amend this Notice from time to time. Please check our website (www.sisonkehealth.co.za) occasionally to keep up to date with any changes;
   - You have the right to object to the processing of your Personal Information;
   - Should you believe that we have utilised your Personal Information contrary to the applicable law, you must first resolve any concerns with us. If you are not satisfied with the process, you have the right to lodge a complaint with the Information Regulator, under POPIA.
2. Sisonke Health Medical Scheme and Medscheme (we/us) will keep any information, including Personal Information relating to yourself and your dependant/s, and/or beneficiaries, supplied to us in this application or collected from other sources confidential.
3. You confirm that when you provide us with your Personal Information, your dependant/s and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes.
4. In the event that you are providing information and signing consent on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised do so on their behalf.
5. **You agree to us processing and disclosing your Personal Information in the following manner:**
   We may collect, collate process, store and disclose your Personal Information:
   - To administer your membership;
   - To provide managed care services to you or any dependant/s;
   - To provide relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s;
   - For profile and risk analysis;
   - For academic research conducted by any company within the Medscheme Group and/or contracted research and survey providers in South Africa as well as outside the borders of the Republic.

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MEMBER SURNAME		INDUSTRY NUMBER	

CONSENT FOR SISONKE HEALTH TO PROCESS PERSONAL INFORMATION

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of Sisonke Health Medical Scheme.

Sisonke Health Medical Scheme and the Administrator, Medscheme, will keep your Personal Information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then Sisonke Health will not be able to administer or offer you membership of Sisonke Health Medical Scheme.

Please read the statements below and sign your acceptance thereof.

1. I authorise, and give consent to Sisonke Health Medical Scheme and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my Sisonke Health Medical Scheme membership risk profiling and management, administration of my membership and as set out in this section.
2. If I have consented to the disclosure of my personal information, Sisonke Health Medical Scheme or the Administrator may provide my personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between Sisonke Health Medical Scheme or the Administrator which requires my personal information. I have the right to request Sisonke Health Medical Scheme and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
3. I acknowledge that I must give Sisonke Health Medical Scheme and the Administrator all information and evidence they may require from time to time. I authorise Sisonke Health Medical Scheme and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information Sisonke Health Medical Scheme may require concerning me or any of my dependants in assessing any risk or claim in relation to this application, my membership of Sisonke Health Medical Scheme and risk profiling or management. I consent to that person providing, and instruct that person to provide, Sisonke Health Medical Scheme and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.
4. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
5. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.
6. I have the right to request my personal information which is in the possession of Sisonke Health Medical Scheme and the Administrator, provided that I furnish adequate identification.
7. I have the right to request Sisonke Health Medical Scheme and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.
8. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.
9. It remains the responsibility of the applicant to make full disclosure of the required information pertaining to the applicant and/or all their dependants. Should you wish to add a medical report from your family practitioner you are welcome to do so. The Medical Schemes Act makes provisions for a membership to be terminated where non-disclosure of material information is proven and the law does not recognise ignorance as an excuse. Your signature to the application form indicates, amongst others, that you understand the terms and conditions of membership, and that the information furnished in the application form is true and correct. If you are unsure about any of the questions, please do not hesitate to contact the Medical Scheme call centre.
10. Disclosure of information: Any breach of any warranty or non-disclosure of any information by myself or my dependants relevant to the assessment of this application will render my membership null and void, and all contributions paid by me will be forfeited to the Scheme.

Member's name			
ID / Passport number			
Date	*dd / mm / yyyy*	Signature	

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MEMBER SURNAME		INDUSTRY NUMBER	

SECTION 5: DECLARATION BY MEMBER

I hereby apply to Sisonke Health Medical Scheme for membership for me and my listed dependants, and agree to abide by the Rules of the Scheme.

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform the Scheme of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable.

Acting for others: You may apply to Sisonke Health Medical Scheme on your own or together with other people - your spouse, your partner and people who are financially dependent on you as defined in the Sisonke Health Medical Scheme rules. For anyone to be treated as financially dependent for this application, you must be responsible for providing financially for that dependant. We might ask you to provide us with proof of financial responsibility. You will be referred to as the principal member or main member in future communication with you.

I understand that false information could result in my application for membership being rejected or my membership being cancelled. Should this occur, I agree to refund to Sisonke Health Medical Scheme all relevant payments which Sisonke Health Medical Scheme has made on my behalf.

Inform us immediately if your information changes: You or your employer must inform us in writing should any of the information you have provided, in your application for membership, changes between the day you sign this document and the day your membership commences. This includes information regarding your health and the health of those for whom you apply. If at any stage you become a direct paying member, we require advance notice of any administrative changes such as cancellation of membership, as we cannot accept backdated changes.

I acknowledge that failure to do so may lead to the termination of my membership and that Sisonke Health Medical Scheme shall be entitled to reclaim any amount it may have paid to any service provider on my or my dependant's behalf.

I understand that I have been informed that the Scheme Rules will be made available on request and I understand that I am responsible to read the Rules and will be bound by them.

I understand that should any contribution due to Sisonke Health Medical Scheme be unpaid, it may result in me or my dependants being suspended from Sisonke Health Medical Scheme until all arrear contributions have been settled. Should two months contributions be outstanding, Sisonke Health Medical Scheme shall have the right to immediately cancel my membership. I also understand that should my membership be suspended or terminated, I shall not be entitled to any benefits arising from my membership whatsoever.

I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any monies owing to Sisonke Health Medical Scheme.

I acknowledge that I am required at all times, if accepted as a member, to give Sisonke Health Medical Scheme all such information and evidence as Sisonke Health Medical Scheme may require. To this end I hereby authorise any healthcare provider who has attended to me and/or my dependants in the past or the future to provide Sisonke Health Medical Scheme with such information as long as such information is treated as confidential at all times.

I agree to provide Sisonke Health Medical Scheme with any medical or historical information or grant Sisonke Health Medical Scheme access to medical information reasonably requested pertaining to a particular ailment, disease, disorder, condition or disability.

I declare that my dependants are not beneficiaries of another registered medical scheme.

I consent to my telephone conversations with Sisonke Health Medical Scheme being recorded and forming part of Sisonke Health Medical Scheme's records. I also agree that such records shall remain the sole property of Sisonke Health Medical Scheme.

I agree that Medscheme, as the appointed administrator of Sisonke Health Medical Scheme, is permitted access to all my information in order to render services to Sisonke Health Medical Scheme.

I confirm that the following documentation is attached to the application form: (a) Copy of my ID / passport document and my dependants' ID documents/birth certificates

I confirm that I understand that my child dependant is not eligible for membership on Sisonke Health Medical Scheme if he/she is employed and earns more than the applicable social pension amount each month.

By signing below I hereby give permission for, warrant, acknowledge and/or agree to the following:

- That the information in this application, whether in my own handwriting or not, is complete and accurate.
- To undergo a medical examination, at my own expense, should this be required.
- To submit proof of good health for me and my dependants and that the Scheme benefits may be limited or excluded in respect of any particular admission to Sisonke Health Medical Scheme, or Sisonke Health Medical Scheme may decline to accept me or any of my dependants in, accordance with the Scheme Rules.
- That I am required at all times, if accepted as a member, to give Sisonke Health Medical Scheme all such information and evidence as Sisonke Health Medical Scheme may require. I hereby authorise the medical practitioner, or any provider who has attended to me and/or my dependants to provide Sisonke Health Medical Scheme with such information. I hereby waive the provision of any law or regulation restricting access to such information.
- My doctor, or the doctor of a patient who is a dependant of mine, may provide personal and/or clinical information on this application form.
- Contributions due to Sisonke Health Medical Scheme by me or my dependants will be paid MONTHLY (due in advance for private and continuation members). Failure to do so will result in my membership being suspended or terminated as per the Sisonke Health Medical Scheme Scheme Rules.
- Savings due to Sisonke Health Medical Scheme on termination of membership, shall be paid to the Scheme. If I terminate my membership before the year ends and I have spent more than I have paid, I will owe savings to the Scheme. Failure to pay over utilised savings will result in the account being handed over for debt collection.
- I accept any penalties that may be applied in accordance with the Medical Schemes Act of 1998. I understand that these penalties include a 3-month general waiting period, a 12-month waiting period for pre-existing conditions and, if applicable, a late-joiner penalty fee.

Member's name	
Date	*dd / mm / yyyy*
Signature	

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MEDICAL INFORMATION

SISONKE HEALTH MEDICAL SCHEME

As amalgamated with **Lonmin Medical Scheme**

Have you or any of your dependants ever experienced, been treated for, or currently suffer from any of the following conditions?

CONDITION CATEGORY	YES / NO	BENEFICIARY/IES (*M = Member / S = Spouse / 1-5= Oldest to youngest child*)							MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED *(dd/mm/yyyy)*	DATE OF LAST RELATED SYMPTOMS/ CONSULTATION/ HOSPITALISATION *(dd/mm/yyyy)*	CURRENTLY ON TREATMENT FOR THIS CONDITION?	MEDICATION USED FOR THIS CONDITION AND DATE LAST TAKEN *(dd/mm/yyyy)*
1. **Cardiovascular (Heart)** E.g. high blood pressure, raised cholesterol, heart failure, angina (chest pain), heart attack, heart murmurs, palpitations, rheumatic fever, previous heart surgery	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
2. **Blood** E.g. haemophilia, bleeding disorders, thrombosis (blood clots), leukemia, lymphoma	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
3. **Mental/Emotion** E.g. depression, anxiety, anorexia or other eating disorder, Attention Deficit Hyperactivity Disorder, schizophrenia, Alzheimer's	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
4. **Nervous System** E.g. epilepsy, multiple sclerosis, paralysis, Parkinson's, stroke, migraine	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
5. **Eyes** E.g. glaucoma, cataract, macular degeneration, visual impairment, conjunctivitis, disorders of the cornea	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
6. **Mouth** E.g. dental problems, gum disease, over/underbite, missing/skew teeth, planned dental treatment	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
7. **Ear, Nose and Throat** E.g. allergic rhinitis, ear infections, hearing/speech impairment, tinnitus (ringing ears)	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
8. **Respiratory** E.g. asthma, chronic obstructive pulmonary disease, cystic fibrosis, emphysema, chronic bronchitis, shortness of breath, persistent cough, coughing up blood, any lung surgery	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	

CONDITION CATEGORY	YES / NO	BENEFICIARY/IES *(M = Member / S = Spouse / 1-5= Oldest to youngest child)*							MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED *(dd/mm/yyyy)*	DATE OF LAST RELATED SYMPTOMS/ CONSULTATION/ HOSPITALISATION *(dd/mm/yyyy)*	CURRENTLY ON TREATMENT FOR THIS CONDITION?	MEDICATION USED FOR THIS CONDITION AND DATE LAST TAKEN *(dd/mm/yyyy)*
9. Gastrointestinal E.g. peptic ulcer, heartburn, irritable bowel, ulcerative colitis, hiatus hernia	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
10. Liver/Pancreatic Disorders E.g. hepatitis, cirrhosis, liver failure, gallstones, pancreatitis	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
11. Kidney/Urinary/Reproductive system E.g. renal failure, prostate problem, kidney stone, recurrent infection, nephritis, blood/protein in urine, polycystic kidneys	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
12. Gynaecological E.g. ovarian cysts, endometriosis, fibroid, disorder of the cervix, menstrual disorder	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
13. Skin problems E.g. eczema, acne, rosacea, psoriasis	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
14. Muscle/Bones E.g. osteoporosis, gout, arthritis (osteo or rheumatoid), pain, previous fractures, myasthenia gravis, loss of limb, back problems/operations, slipped disk, backache	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
15. Connective tissue disorders E.g. systemic lupus erythematosis, scleroderma, dermatomyositis/polymyositis, mixed connective tissue disorder	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
16. Metabolic/Endocrine E.g. diabetes, thyroid problem, Addison's disease, growth problems, pituitary problems, Cushing's syndrome	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
17. Infections/tumors E.g. HIV, cancer, hepatitis, tuberculosis, benign tumors	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	
18. Other Please specify	◯ Yes ◯ No	M	S	1	2	3	4	5				◯ Yes ◯ No	

PLEASE COMPLETE THE FOLLOWING GENERAL MEDICAL QUESTIONS *(M = Member / S = Spouse / 1-5= oldest to youngest child)*

19. **Height** (metres)	Member (M)		Spouse (S)		1		2		3		4		5	
20. **Weight** (kilograms)	Member (M)		Spouse (S)		1		2		3		4		5	

QUESTIONS (If YES, indicate applicable beneficiary/ies & provide details)	YES / NO	M	S	1	2	3	4	5	DETAILS
21. Do you/your dependants smoke?	◯ Yes ◯ No								
22. Are you/your dependants pregnant or suspect pregnancy?	◯ Yes ◯ No								How many weeks?
23. Have you/any of your dependants undergone an operation recently?	◯ Yes ◯ No								
24. Do you/any of your dependants consume alcohol? Specify details	◯ Yes ◯ No								◯ Rarely ◯ Moderately ◯ Frequently
25. Do you/your dependants take part in professional/dangerous sport?	◯ Yes ◯ No								
26. Do you/your dependants use chronic medication?	◯ Yes ◯ No								
27. Do you/your dependants have a congenital/hereditary or physical disability?	◯ Yes ◯ No								
28. Are you/your dependants expecting any surgery/hospitalisation/treatment in the next year?	◯ Yes ◯ No								
29. Have you/your dependants had surgery or been admitted to hospital in the past year?	◯ Yes ◯ No								
30. Have you/your dependants in the last 24 months been involved in a motor vehicle accident, been injured on duty or contracted a work-related illness?	◯ Yes ◯ No								
31. Have you/your dependants ever had or are currently suffering from alcohol/ drug problems?	◯ Yes ◯ No								

If there is any further relevant medical information, which has not been disclosed above, please provide details: