MAKOTI
MEDICAL SCHEME

MEMBER AND DEPENDANT APPLICATION FORM

NEW APPLICATION ☐ **NEW DEPENDANT** ☐

NAME OF COMPANY _____ NAME OF INDIVIDUAL _____

DATE OF COMMENCEMENT D D M M Y Y Y Y MEMBERSHIP NO. _____

FOR OFFICE USE ONLY

MEMBER NUMBER _____ COMPANY CODE _____

PERSAL NUMBER _____ CODE _____

RACE (FOR STATISTICAL USE ONLY)	LANGUAGE	SUBS TABLE

Administered by:
Universal Healthcare Administrators (Pty) Ltd

Universal Healthcare

UNIVERSAL HOUSE, 15 TAMBACH ROAD, SUNNINGHILL PARK, SANDTON
Private Bag X47, Rivonia 2128
Tel: 011 208 1000 Fax: 011 208 1028

APPLICATION FOR MEMBERSHIP

COMPANY CODE

MEMBERSHIP NO.

Under no circumstances should contributions be paid directly to intermediaries.

CHOICE OF OPTION (X – Please indicate which Plan you require) PRIMARY COMPREHENSIVE

COMPANY NAME (If applicable) EMPLOYER NO.

SURNAME

FIRST NAMES

ID NUMBER SEX M F

MARITAL STATUS DATE OF BIRTH D D M M Y Y Y Y

OCCUPATION

MONTHLY INCOME R NO. OF DEPENDANTS

RESIDENTIAL ADDRESS

POSTAL CODE

POSTAL ADDRESS

POSTAL CODE

TELEPHONE NUMBERS (HOME) (WORK)

FAX (CELL)

EMAIL

DATE EMPLOYMENT COMMENCED D D M M Y Y Y Y MEMBERSHIP COMMENCEMENT DATE D D M M Y Y Y Y

DEPENDANT INFORMATION

	SURNAME	FIRST NAMES	DATE OF BIRTH	GENDER	RELATIONSHIP	INCOME P.M.
(1)						
	ID NO.					
(2)						
	ID NO.					
(3)						
	ID NO.					
(4)						
	ID NO.					
(5)						
	ID NO.					
(6)						
	ID NO.					

MEDICAL HISTORY

It is most important that the following questions be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit.

Please advise whether you or any of your dependants suffer from, or have suffered from, or received treatment/consultation for any of the following conditions. Please ensure that you tick and complete the appropriate block/s.

			YES	NO	NAME OF MEMBER / DEPENDANT
1.	**Heart & Vascular System**	High blood pressure; high cholesterol; angina; heart attack; angiogram; previous coronary artery bypass; rheumatic fever; heart murmurs; valve problems / replacement; arrhythmias – insertion of pacemakers; heart failure; stroke; varicose veins; DVTs (deep vein thrombosis); pulmonary emboli.	☐	☐	
2.	**Lungs**	Asthma; emphysema; chronic bronchitis; TB; chronic infections - bronchitis & pneumonia.	☐	☐	
3.	**Digestive System, Gallbladder; Liver**	Dyspeptic disease (heartburn; hiatus hernia; peptic ulcers; reflux); irritable bowel syndrome (spastic colon; inflammatory bowel disease e.g. CHRON'S & ulcerative colitis; chronic diarrhoea / constipation); gallstones & jaundice; hepatitis; pancreatitis; haemorrhoids; incontinence; bowel prolapse.	☐	☐	
4.	**Nervous System**	Persistent headaches; epilepsy; paralysis; degenerative diseases – Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).	☐	☐	
5.	**Bone; Muscle & Joints**	Arthritis; rheumatism; gout; back, knee or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease; osteoporosis; previous amputations / artificial limbs; birth defects; joint replacements.	☐	☐	
6.	**Urinary Tract**	Infections; stones; albumin / blood in urine; urinary incontinence; prolapsed bladder.	☐	☐	
7.	**Gynaecological System**	Menopause; female hormone replacement; irregular menses; infertility; breast tumours (benign / malignant); ovarian tumours; cysts; prolapsed uterus / rectum / bladder; miscarriage; caesarean section.	☐	☐	
8.	**Male Genital System**	Prostate problems (hypertrophy / cancer or infections); infertility; hernias – groin; scrotal swellings; testicular tumours; abnormalities of the penis.	☐	☐	
9.	**Gland / Hormonal**	Over / under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.	☐	☐	
10.	**Blood**	Anaemia; bleeding disorders (haemophilia); leukaemia; Hodgkin's disease.	☐	☐	
11.	**Ear, Nose & Throat**	Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness – hearing aids.	☐	☐	
12.	**Eyes**	Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus); allergies – pterygiums; anticipated / previous laser surgery; artificial eyes.	☐	☐	
13.	**Emotional (psychological, psychosomatic problems)**	Depression; bipolar disorder; anxiety; stress; previous treatment for post traumatic stress syndrome; eating disorders – bulimia & anorexia; mental retardation; alcoholism; drug abuse.	☐	☐	
14.	**Infections / Tropical Diseases**	Sexually transmitted diseases; genital warts; HIV / AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzias; cholera; typhoid.	☐	☐	
15.	**Skin Disorders**	Acne; eczema; psoriases; lesions (keloid hypertrophic scars); skin rashes; shingles; Kaposi sarcoma – tumours.	☐	☐	
16.	**Connective Tissue Disorders**	Systemic lupus erythromatosis; scleroderma.	☐	☐	
17.	**Teeth & Gums**	Impacted molars (wisdoms); previous / current orthodontic treatment; braces; crowns; recurrent infections - gums.	☐	☐	
18.	**Cancer**	Cysts; growths; tumours of any kind.	☐	☐	
19.	**Allergies**	Are you or any of your dependants allergic to any specific type of medication (e.g. penicillin, aspirin, sulphas, morphine, NSAIDS); pollen dust; animals; specific food types (e.g. nuts).	☐	☐	
20.	**Immuno-Suppressive Treatment**	Have you or any of your dependants ever had or expecting to undergo an organ treatment transplant? Have you or any of your dependants ever suffered from any condition requiring Immunosuppressive treatment?	☐	☐	
21.	Have you or any of your dependants ever received any form of physiotherapy, occupational therapy or chiropractic treatment?		☐	☐	
22.	Are you or any of your dependants pregnant? If **yes** - how many weeks? Please give expected date of delivery.		☐	☐	
23.	Have you or any of your dependants had any previous or pending claims for which any other party may be liable e.g. MVA (Motor Vehicle Accident) claims? If **yes**, please give details.		☐	☐	
24.	Are you or any of your dependants expecting to undergo any medical treatment, e.g. hospitalisation, operation, specialised dentistry etc, within the next twelve months?		☐	☐	
25.	Do you or any of your dependants have a chronic condition requiring ongoing medication? If **yes**, please give the name and dosage of all the medication you or any of your dependants are currently taking.		☐	☐	
26.	Have you or any of your dependants ever received any medical attention of any nature, e.g., hospitalisation, operation, specialised dentistry etc, not mentioned above?		☐	☐	
27.	Have you or any of your dependants ever appeared before a medical board in view of early retirement and declared medically unfit?		☐	☐	

If any of the above questions were answered YES, please supply the full details below. If more space is required, please attach an extra page.

Name	Details	Date of last treatment

PREVIOUS MEMBERSHIP

To ensure continuous benefits, attach membership certificate from previous medical schemes.

Name of previous Medical Scheme	Membership No.	Date Joined	Date Terminated

DECLARATION

APPLICANT

The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:

1. For the purpose of considering applications for membership, as well as any claim for benefits, the Makoti Medical Scheme and any medical personnel authorised by Makoti Medical Scheme has the right to obtain any medically relevant information which it may deem necessary from any medical practitioner or institution or nominee that possesses such information, and that party may disclose such information to the Makoti Medical Scheme and any party duly authorised by the Makoti Medical Scheme.

2. The Makoti Medical Scheme and any medical personnel duly authorised by Makoti Medical Scheme may request and acquire from service providers any relevant information that may be required for the fulfilment of any of its obligations. The Makoti Medical Scheme and any party duly authorised by the Makoti Medical Scheme may keep such information in their databases and use it for statistical purposes.

3. The information may be requested and supplied at any time, including after the death of the member or dependants, and will include accounts from service providers, indicating diagnoses, and medical or clinical reports when indicated. Such information will, however, be treated as confidential at all times by the party to whom its supplied.

4. By agreeing to sign the application form(s) the applicant/member and dependants thereby waives his/her right to privacy to the extent implied by the above clauses 1, 2 and 3.

5. Contribution amount R

I DECLARE THAT I HAVE DISCLOSED ALL PARTICULARS RELEVANT TO THIS APPLICATION, AND THAT I AM AWARE THAT ANY FALSE STATEMENT WILL RENDER MY MEMBERSHIP NULL AND VOID.

SIGNATURE OF APPLICANT

D D M M Y Y Y Y

DATE

EMPLOYER

This application has been scrutinised, and we are not aware of any facts other than those stated which should be made known to the Scheme.

DATE D D M M Y Y Y Y

EMPLOYER'S NAME

CAPACITY

EMPLOYER'S SIGNATURE

BANKING DETAILS

BANK NAME

BRANCH

NAME OF ACCOUNT HOLDER

BRANCH CODE

ACCOUNT TYPE Cheque Savings

ACCOUNT NO.

SIGNATURE OF BANK ACCOUNT HOLDER

D D M M Y Y Y Y

DATE

BROKER DETAILS

BROKERAGE NAME

BROKER CODE

BROKER'S NAME

BROKER'S TELEPHONE NUMBERS (CELL) (HOME)

BROKER CONSULTANT

BROKER CONSULTANT NAME

BC CODE

SIGNATURE OF BROKER CONSULTANT

D D M M Y Y Y Y

DATE