

SECTION 3 CHANGE IN BANKING ACCOUNT DETAILS OF PRINCIPAL MEMBER

Account Holder

Account Number

Account Type Current/Cheque Transmission Savings

Name of Bank

Branch Branch Code

SECTION 4 PROCEEDING ON RETIREMENT

Completion of this section is for notification purposes only.
Please provide your date of retirement.

Date

SECTION 5 DEATH OF A MEMBER

Completion of this section is for notification purposes only.
Please provide the date on which the member passed away.
Please provide Afrox Medical Aid Society with the death certificate.

Date of Death

Please note: In cases where registered dependants want to continue with their membership, they need to inform the Society of any personal information changes, i.e. banking account, address, telephone, etc.

SECTION 6 ADMISSION OF NEW BENEFICIARIES AS DEPENDANTS

Penalties and waiting periods may apply to late joiners. (Please see your handbook/rules.)

DEPENDANTS No person may be enrolled with different medical schemes simultaneously.

Please note: Legal documentation is required in the case of marriage.

1.	Initials <input type="text"/>	Surname <input type="text"/>	Full First Name <input type="text"/>	Date of Birth <input type="text"/>
	Over 21 <input type="checkbox"/> <input type="checkbox"/>	Relationship (son, wife, etc.) <input type="text"/>	ID no. (compulsory) <input type="text"/>	Monthly Income <input type="text"/>
				Late Joiner Penalty Applies <input type="checkbox"/> <input type="checkbox"/>
2.	Initials <input type="text"/>	Surname <input type="text"/>	Full First Name <input type="text"/>	Date of Birth <input type="text"/>
	Over 21 <input type="checkbox"/> <input type="checkbox"/>	Relationship (son, wife, etc.) <input type="text"/>	ID no. (compulsory) <input type="text"/>	Monthly Income <input type="text"/>
				Late Joiner Penalty Applies <input type="checkbox"/> <input type="checkbox"/>
3.	Initials <input type="text"/>	Surname <input type="text"/>	Full First Name <input type="text"/>	Date of Birth <input type="text"/>
	Over 21 <input type="checkbox"/> <input type="checkbox"/>	Relationship (son, wife, etc.) <input type="text"/>	ID no. (compulsory) <input type="text"/>	Monthly Income <input type="text"/>
				Late Joiner Penalty Applies <input type="checkbox"/> <input type="checkbox"/>

Should you require additional space, please attach information on a separate sheet in the above format.

Where a dependant is over the age of 21 years and has a mental or physical impairment, please attach a medical report.

Where the dependant is a common-law wife/husband, please attach an affidavit to that effect.

Where the dependant is a full-time student and not over the age of 25, please attach a copy of certificate of the learning institution.

Proof of previous medical cover is required.

Where the dependant's surname is different from the member, provide valid documentation.

If you do not wish to enrol your dependants with the Society, please indicate on a separate sheet the reason therefor.

ADDITIONAL FINANCIAL DEPENDANTS (Member pays in full.) No person may be enrolled with different medical schemes simultaneously.

1.	Initials <input style="width: 100%;" type="text"/>	Surname <input style="width: 100%;" type="text"/>	Full First Name <input style="width: 100%;" type="text"/>	Date of Birth <table border="1" style="width: 100%; text-align: center; font-size: small;"> <tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr> </table>	D	D	M	M	Y	Y	Y	Y																	
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Should you require additional space, please attach information on a separate sheet in the above format.

Any other financial dependant, i.e. the dependant is living in the household with the principal member. Where a dependant is a second common-law wife/husband, an affidavit to this effect must be attached. Proof of previous medical cover is required.

If you do not wish to enrol your dependants with the Society, please indicate on a separate sheet the reason therefor.

SECTION 7 DETAILS REQUIRED IF APPLICANT WAS A MEMBER OR DEPENDANT OF ANOTHER MEDICAL SCHEME

Name of scheme

Period of membership from

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 to

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Name of scheme

Period of membership from

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 to

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Have you ever been a member of the Afrox Medical Aid Society? If so, please state your membership number.

Certificate of membership of previous schemes is required. Note: Not membership cards.

If you have been a member of more than two medical schemes, please attach extra details on a separate sheet of paper.

SECTION 8 QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please complete all the required information by inserting a tick in the relevant box. If the answer to any question is "YES" provide details overleaf.

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

1. Have you or any of your dependants ever experienced any of the following?

1.1 Any disorder/dysfunction of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.2 High blood pressure or disorder/dysfunction of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder/dysfunction)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.3 Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis, persistent cough or tuberculosis)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.4 Any disorder/dysfunction of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, hepatitis B or persistent diarrhoea)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.5 Any disorder/dysfunction of the kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.6 Any nervous or mental disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.7 Any eye, ear, nose or throat disorder/dysfunction (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment or chronic sinusitis)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.8 Any disorder/dysfunction of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.9 Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder/dysfunction?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		
1.10 Any lumps, growths (benign or malignant), types of cancers (including Hodgkins and leukaemia), skin cancers or skin disorders/dysfunctions?	<table border="1" style="width: 40px; text-align: center; font-size: x-small;"> <tr><td>YES</td><td>NO</td></tr> </table>	YES	NO
YES	NO		

SECTION 8 QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH (continued)

- | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----|----|
| 1.11 Any tropical disease (e.g. bilharzia, malaria or cholera)? | | YES | NO |
| 1.12 Any other condition, illness, disease, disorder/dysfunction, disability or accident which required medical, radiological, surgical, pathological or dental investigations during the past 12 months? | | YES | NO |
| 1.13 Been tested for or received or expect to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or an AIDS-related condition or any sexually transmitted disease (e.g. hepatitis B, gonorrhoea or syphilis)? | | YES | NO |
| 2. Have or are you or any of your dependants receiving any surgical, medical, major dental (including implants), chiropractic, optical or gynaecological treatment, procedures, advice or tests? | | YES | NO |
| 3. Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? | | YES | NO |
| 4. Do you or any of your dependants currently use medication on a daily basis? | | YES | NO |
| 5. Has your weight or the weight of any of your dependants changed by more than 5kg over the last 12 months? | | YES | NO |
| 6. Are you or any of your dependants experiencing any other ailment or disease at present? | | YES | NO |
| 7. Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire relating to past or present diseases, accidents, operations or other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months? | | YES | NO |
| 8. Are you or any of your dependants expecting to undergo any medical procedure, operation, confinement or receive any major dental treatment during the next 12 months? | | YES | NO |

If you answered "YES" to any of the questions above, please complete details in Section 9 in full.

SECTION 9 ADDITIONAL MEDICAL INFORMATION

	1.	2.	3.
Question number			
Name of person suffering from the illness			
Type of illness/condition (diagnosed)			
Date on which illness began			
Frequency of attacks (hourly/daily/weekly/monthly)			
Date of last occurrence			
If hospitalised, when and for how many days			
Duration of illness or condition			
Treatment and/or type of medication received in the past	Treatment		
	Medication		
Current treatment and/or type of medication received	Treatment		
	Medication		
Approximate monthly cost of treatment/type of medication	Treatment		
	Medication		
Details of operations previously performed, treatment and/or type of medication			
Name of attending medical practitioner, treatment and/or type of medication			

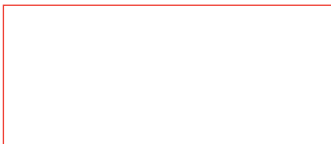
SECTION 9 ADDITIONAL MEDICAL INFORMATION (continued)

	4.	5.	6.
Question number			
Name of person suffering from the illness			
Type of illness/condition (diagnosed)			
Date on which illness began			
Frequency of attacks (hourly/daily/weekly/monthly)			
Date of last occurrence			
If hospitalised, when and for how many days			
Duration of illness or condition			
Treatment and/or type of medication received in the past	Treatment		
	Medication		
Current treatment and/or type of medication received	Treatment		
	Medication		
Approximate monthly cost of treatment/type of medication	Treatment		
	Medication		
Details of operations previously performed, treatment and/or type of medication			
Name of attending medical practitioner, treatment and/or type of medication			

DATE

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

SIGNATURE OF MEMBER _____



OFFICIAL EMPLOYER'S STAMP

THIS SECTION MUST BE COMPLETED BY AN AUTHORISED OFFICIAL AFTER THOROUGH SCRUTINY.

I certify that the foregoing details, where relevant, agree with those held in our personnel files.

DATE

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

SIGNATURE OF EMPLOYER _____

IMPORTANT: Amendments will be delayed should this application be incomplete or if the required documents are not attached, as it will be returned to your employer for correction.