

- **C** 0860 100 871
- 086 608 0771
- membership@sizwehosmed.co.za
- 7 West Street,
 - Houghton Estate, Johannesburg,
 - 2198

ADDITIONAL DEPENDANTS APPLICATION FORM

PLEASE PRINT IN CAPITAL LETTER. USE A BLACK PEN ONLY. PLEASE MARK APPROPRIATE CHOICE USING A CROSS (x) THIS FORM SHOULD BE COMPLETED IN RESPECT OF SUBSEQUENT ADDITIONS TO THE FAMILY UNIT

Membership Number																															
Broker Code																															
DOCUMENTS REQUIRE	D																				Yes	Ν	ło	_							
• Dependant's copy of I)																								Broke	er Sta	mp				
• Main member's copy o	١D																														
Birth certificate of child	l (wł	nere	ID is	not	availa	able)																									
Clinic card for new bor	n ba	by (w	/ithin	30	days	of bi	irth	to av	oid w	aitir	ng pe	riod)																		
• Documentary proof if o	epe	ndan	it is a	dop	ted/f	oste	r ch	ild/st	uden	t/di	sabili	ty si	tatus	/adu	ılt de	epen	dant														
• Marriage certificate whether the second se	en r	egist	ering	g a sp	oous	e (wi	thin	30 d	ays o	f ma	rriag	ge to	avo	id w	aitin	g pei	riod)														
• Affidavit when register	ng a	com	nmon	law	spou	use c	or pa	rtnei	conf	irmi	ng co	o-ha	bitat	ion (whe	re ap	plica	able))					L				 	 	 	
Membership certificate	fro	n pre	eviou	ıs me	edica	l aid	(wh	ere a	pplic	able)																				
Proof of latest income	alar	y adv	vance	e / 3	mor	ths l	bank	stat	emer	nts																					

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss					Initi	ials						Firs	t na	me																					
Surname																					Ide	ntity	/ no.												
Name of employer																				Em	nploy	/er co	ode												
Email																																			
Tel. no. (h)										(w	v)												(0	Cell)											
Residential address																																			
																													Ро	stal	code				
Postal address																																			
																													Ро	stal	code				
Race (please tick)	1	Afric	an	Colo	oure	ed	Inc	lian/	Asian		W	/hite			 Pre	ferre	d me	thoo	lofo	com	nuni	catio	on (p	lease	tick)	Emai	ιĒ		SMS		٦	Po	st	

SECTION B: PARTICULARS OF DEPENDANTS

			Dep	penda	nt 2	2		Dependant 3							Dependant 4							Dependant 5									
Name and Surname of dependant																															
ID number (compulsory)																															
Relationship to member (spouse, partner, daughter etc.)																															
Sex (M/F)																															
Race (African, Coloured, Indian/ Asian, White)																															
Address, if different from member																															
Cell no.																															
Date of admission to Hosmed																															
Date of marriage where dependant is spo	use						_				_											_									
Is or was the dependant previously regist	ered with	a med	lical sch	neme?				Yes		No	(lf yes	, plea	ase c	ompl	ete t	he fo	llow	ing):												
Name of previous medical aid(s) for past 2 years																															
Membership no.																															
Period of membership From				-	То															KINI				CERT						RSH	IP
Give details of illnesses, treatments or co (If space is insufficient attach separate scl		or whi	ch the	depen	dant	was e	xcluc	led fro	om	benefit	ts by	the a	bove	e nan	ned n	nedic	al ai	d sch	eme												

Kindly complete health questionnaire on reverse side hereof in full detail. PLEASE NOTE: Failure to complete or submit all information required will delay processing of membership of dependant. Failure to disclose medical information or the provision of incorrect information can result in the immediate cancellation of your membership.

	SECTION C: EMPLOYER DETAILS													
Com	pany													
Regi	n					Date of emp	oloyment							
Date	of addition effected by Employer													
NB: P	ease complete debit order form for unsubsidised dependants													
Emplo	yer Signature Name Designation			-	Company Stamp		Date							
	SECTION D: DEPENDAN	NT M	EDIC	AL HIST	TORY									
Doy	our dependants have, or ever had the following? If "yes" state full details below (complete all q	uestion	s). If in	sufficient s	pace please attach	schedule.								
1.	Any disorder of the heart e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	No	Yes					Name						
2.	High blood pressure, chronic headache or disease of the blood vessels including cholesterol or circulatory disorder?	No	Yes											
3.	Any respiratory or lung trouble, e.g. asthma, bronchitis, persistent cough, tuberculosis?	No	Yes											
4.	Any disorder of the digestive system, gall bladder or liver, e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?	No	Yes											
5.	Disease or disorder of the kidneys, bladder or reproductive organs, e.g. albumin in urine, stones, prostatitis or infertility?	No	Yes											
6.	Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety state or depression, alcoholism or narcotism?	No	Yes											
7.	Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, tonsilitis and sinus problems?	No	Yes											
8.	Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?	No	Yes											
9.	Diabetes, acne or skin problems, sugar in urine, thyroid or other glandular or blood disorders?	No	Yes											
10.	Cancer, growth or tumour of any kind?	No	Yes											
11.	Any tropical disease, e.g. Bilharzia?	No	Yes											
12.	Any other illness, disorder, operation, disability or injuries from any accident?	No	Yes											
13a	Any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement, e.g. Caesarian section or miscarriage? If "Yes", state full details including dates.	No	Yes											
13b	Are you now pregnant? If "Yes", how many months? If "Yes" is this a multiple birth?	No	Yes											
14.	Any special dental treatment, e.g. crowns, bridges, orthodontic, etc?	No	Yes											
15.	Any illness or physical defect likely to necessitate medical or dental treatment, e.g. headaches, lumps, orthodontic work etc.?	No	Yes											
16.	Do you expect any medical or dental treatment within the next three months?	No	Yes											
17.	Do you or your dependants have a medical condition not disclosed?	No	Yes											
18.	Detail all medication used by applicant and dependants during the last 2 years, as well as all Pathology and Radiology tests.													
19.	Please state full name and contact details of usual medical practitioner													

SECTION E: UNDERTAKING BY MAIN MEMBER

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- Please ensure relevant documentation is attached to the Update Form to avoid any delay in processing. I declare that the information given is true and correct and I am aware that any false statement will render my membership of the Scheme null and void. •
- I accept that my dependants may be subjected to a general waiting period as per Scheme rules.
- I accept that I will be liable for the additional contribution for the dependants added on this form.
- Where applicable: Member Savings Account allocations will be pro-rated depending on when joining the option. •
- The Scheme has the sole right to collect negative balances owed to the Scheme by the member, even when member has terminated from the Scheme.

Member Signature