Mamoth Health Plan

PO Box 1659, Maseru, 100, Tel: 00 (+266) 223 223 83 Fax: 00 (+266) 223 204 75

Application Form

1. PERSONAL DETAILS OF APPLICANT

TITLE		GENDER	
FULL NAMES		SURNAME	
PASSPORT/ID #		DATE OF BITH	
MARITAL STATUS		EMAIL	
TEL #		MOBILE #	
POSTAL ADDRESS		PHYSICAL ADDRESS	

2. TOTAL MONTHTLY CONTRIBUTION BREAKDOWN

REQUIRED OPTION		CHILD OVER 21yrs (Student) /s	
MEMBER CONTRIBUTION		ADULT DEPENDANT/S CONTRIBUTION	
SPOUSE CONTRIBUTION		SAVINGS	
CHILD DEPENDANT/S CONTRIBUTION		TOTAL CONTRIBUTION	

3. DEPENDANT DETAILS (Persons qualifying whom you wish to nominate)

FULL NAMES	SURNAME	NICKNAME	DATE OF BIRTH	RELATIONSHIP	GENDER

4. ADDITIONAL INFORMATION

4.(a) MEMBER'S NEXT OF KIN

TITLE	
FULL NAMES	
RELATIONSHIP	
TELEPHONE #	
NEXT OF KIN POSTAL ADDRESS	

4.(B) MEMBER'S EMPLOYER

EMPLOYER	
EMPLOYMENT #	
TELEPHONE #	
EMAIL	
EMPLOYER POSTAL ADDRESS	

5. PREVIOUS MEDICAL SCHEME (S) HISTORY (Please attach copies of all previous medical scheme certificates)

Are/were any of your dependants members of a registerd medical scheme/s during the last two years?

If "YES", a certificate(s) of membership (not membership card) must be attached to this application: Please note that health insurance procts and membership of unregistered medical schemes do not qualify.

Name Of Scheme:

Membership Number:

Period: FROM TO

Exclisions

Late Joiner Penalties Emposod

Reason for Termination

6. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS

Have you or any of you dependants experienced any of the following in the past 24 months	YES	NO
Are you or any nominated dependants currently pregnant?		
Any disorder of the heart (e.g. heart attack, rheumatic feaver, heart murmur, coronary artery desease, chest pain, shortness of breath or palpitations)		
High Blood pressure or desease of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder)		
Any respiratory or lung trouble (e.g. asthma, bronchitis, persistant cough or teberculosis)?		
Any respiratory or lung trouble (e.g. asthma bronchitis persistant cough, tuberculosis)?		
Any disorder of the digestive system gall bladder lever or pancreas (e.g. pancreas e.g. gastric or duodenal ulcer pancreatitis, recurrent indigestion, hiatus hernia, hepatitis B or Persistent diarrhea)?		
Any disease or disorder of kidneys bladder or reproduction organs (e.g. albumin in urine stones i.e. problems with female organs or venereal disease)?		
Any nervous or mental disorder (e.g. epilepsy, migraine blackouts, loss of consciousness, paralysis, anxiety state or depression)?		
Any ear, eye, nose or throat disorder (e.g. discharge, defective vision, wear spectacles/contact lenses recurrent tonsillitis, swollen glands, persistant mouth sores, cataracts or any hereditary eye disease, functional nose impairment chronic sinusitis, allergic rhinitis)?		
Any disorder or disease of muscles, bone, joints, limbs, spine (e.g. rheumatism, arthritis, gout, osteoporosis, slipped disc or other back trouble)?		
Diabetes, thyroid or other glandular or blood disorder?		
Any lumps, growths benign or malignant, types of cancers including Hodgkins and Leukaemia skis cancer or skin disorders?		
Any tropical disease (e.g. billharzia malaria, cholera)		
Been tested for or received or expect to receive any medical advice, counseling, treatment or blood test in connection with HIV/AIDS or an AIDS-related connection or any sexually transmitted disease e.g. hepatitis B, gonorrhea or syphilis?		

6.a If "yes" to any of the above questions please complete full details below. should you require more space, please feel free to use a separate page, and attach it to the form

Name Of Person	Illness	Treatment Type	Doctors Contact	Period	End Date

7. BANK DETAILS FOR CLAIMS AND PAYMENTS (We need this information for direct payments of benefits into your bank account should yoyu elect not to complete this section, you carry the resultinng from alternate payment methods)

Account Holder's Name _____ Surname _____

Name Of Bank _____

Branch Name & Town _____

Account Number _____

Type Of Account ☐ Cheque Account ☐ Savings Account ☐ Transmission Account

I hereby authorise you to pay any medical scheme benefits that may be due to me into the abovementioned bank account or ar any other bank account that I might change to in future.

_____ _____

Account Holder's Signature Date

NOTE: Please check that your details are correct and attach supporting documents e.g cancelled cheque or bank statement copy

8. BANK DETAILS FOR DEDUCTION OF MONTHLY CONTRIBUTIONS BY DEBIT ORDER (Compulsory for individual members or groups, only if paymentsare not facilitated by employer)

Account Holder's Name _____ Surname _____

Name Of Bank _____

Branch Name & Town _____

Account Number _____

Type Of Account ☐ Cheque Account ☐ Savings Account ☐ Transmission Account

I hereby authorise Mamoth Employee Benefits to arrange with the above named Bank or any other Bank to which I might change my account, to deduct the contribution on a monthly basis (current and/or arrears) due by me/us in terms of the rules of Mamoth Health Plan (including any ammendments that may be made during the term of my our mambership) from the above-mentioned bank account. I undertake to pay the aplicable premium to the scheme before the 7th of each month.

_____ _____

Account Holder's Signature Date

If joint or company banking account: (etleast two persons who have signing rights must sign this debit order)

_____ _____ _____

First Signature Second Signature Date

NOTE: Please check that your details are correct and attach supporting documents e.g. cancelled cheque or bank statement copy. Should you transfer you bank accountat any time, or if your details change, please advise Mamoth Health Plan immidiately.

8. DECLARATION - Kindly endorse and date the declaration

1) I, the undersigned, hereby make application to the Scheme to be admitted as a member of Mamoth Health Plan. If admitted, I agree to abide by the rules of the Scheme. I declare that all answers given in this application are true, correct and complete in every respect.

2) I further declare that any false statement in this application or the non-disclosure of any material information will render my membership null and void, and that any core contributions paid towards the Scheme shall be forfeited to the Scheme.

3) I am aware of the fact that upon joining the Scheme during the course of a calendar 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 calendar year.

4) On signing, I acknowledge and accept that I will be held personally responsible for all amounts (premiums and claims) due to Mamoth Health Plan. Should Mamoth Health Plan need to take legal action to recover bad debt, I accept responsibility for the legal fees on an attorney and client scale.

5) Furthermore I agree that Mamoth Health Plan has the right to the interest accumalated on outstanding amounts calculated at the maximum interest rate as levied in terms of the Usury Act, Act 73 of 1968.

6) For group membership only: I hereby authorise my employer to deduct from my salary and pay to the Scheme all amounts that may be due by me.

7) I accept that the Scheme cannot be held liable for losses occasioned by non-receipt of posted cheques (where applicable). I undertake to give one calendar month written notice in the case of the termination of my membership of the Scheme and to send such notice to the Scheme by registered mail.

8) Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefits in respect of me as a member, I irrevocably authorise the Scheme to obtain from any person, whom I hereby so authorise and request to give, any information which the Scheme deems necessary, at any time (even after my death) and in such detail, abbreviated or coded form as may from time to time be decided by the Scheme or by the operators of such data base.

9) I undertake to remain a member and to give one calendar month's notice by registered mail, should I wish to terminate my membership.

_____ _____

SIGNATURE (Principal Member) DATE

9. EMPLOYER'S DECLARATION

I/We declare that the above mentioned employee: _____ Occupation: _____

was appointed as full-time (permanent) staff on _____ and is entitle to membership from _____

and the monthly contribution of: M _____ will be paid from salary.

Name of authorised person: _____ Authorised Signature: _____

Designation: _____ Date: _____

STAMP OF EMPLOYER

10. FOR OFFICE USE

Membership

Joining Date: _____ Benefit Date: _____

Membership No: _____ Authorised Date: _____

Broker code _____

Accounts

Premium: _____

Authorised: _____ Date: _____