CompCare Wellness medical scheme

The NetworX Option

APPLICATION FORM FOR STUDENTS

Date of commencement _____ End date _____

Confirmation to be sent via Fax ☐ E-mail ☐ SMS ☐

PERSONAL PARTICULARS

Surname

First name/s

Title | Marital status | Nationality | Present age

Date of birth (d d m m y y y y) ID/Passport no

Postal address | Postal code

Physical address

Email address

Telephone details (B) Code ( ) | (H) Code ( )

Facsimile details (B) Code ( ) | Cell:

Study Institution | Student no

Country of Origin | Embassy

DEPENDANT DETAILS

Name	Surname	Relationship	Gender	Date of birth
				yyyy/mm/dd
				yyyy/mm/dd
				yyyy/mm/dd
				yyyy/mm/dd

MEDICAL DETAILS

Please indicate and provide details of whether any medical treatment, including acute conditions, you or any of your dependants have ever experienced or have received during the last twelve months or anticipate receiving within the next twelve months.

have ever experienced or	YES	NO
have received during the last twelve months or	YES	NO
anticipate receiving within the next twelve months	YES	NO

If you answered "Yes" to any of the above questions, please provide details below:

Name	Details of condition	Date of treatment	Degree of recovery

Selection of Doctor

Members are required to nominate a General Practitioner (per beneficiary) from the list of approved network service providers. Kindly note that once you have received your membership certificate please register on http://www.ieasa.studysa.org and select a Universal Healthcare network GP in your area.

PAYMENT DETAILS

I authorise CompCare Wellness to debit the account below for all amounts due in respect of my membership of the Scheme.

Please select method of payment (please tick) Cash ☐ Credit transfer ☐ Credit card ☐

Address of account holder

Name of account holder

Passport no. of account holder

Account/credit card number

Name of bank Branch code

3 Digit credit card validation no Credit card expiry date

Monthly contribution R Months = Total deduction

Banking details:

Account holder: CompCare Wellness Medical Scheme

Bank: ABSA

Branch code: 362005

Account number: 4077182095

Swift no: ABSAZAJJ

Signature of applicant _____ Signature of account holder _____

BANKING DETAILS FOR CLAIMS RE-IMBURSEMENT (ONLY SOUTH AFRICAN BANK DETAILS)

Name of account holder

Name of bank

Branch code - -

Account number

Type of account (please tick) Current ☐ Savings ☐ Transmission ☐

DISCLAIMER

It is the member's responsibility to advise the administrator in writing of any change in banking details. Neither the scheme nor its administrator shall be held liable should an Incorrect account be credited under any circumstances.

Signature of applicant _____ Signature of account holder _____

DECLARATION

1. I, the undersigned hereby apply for membership of CompCare Wellness Medical Scheme and agree that all answers and information contained in this application completed by me or by any other person/s will be the basis of the proposed agreement.
2. I warrant that the contents of this application are true, correct and complete. No cover will be granted unless CompCare Wellness Medical Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
3. I agree to abide by and undertake to familiarise myself with the rules of the scheme as amended from time and grant my employer the right to deduct from my remuneration any amounts (including members portion's) outstanding by myself to CompCare Wellness Medical Scheme, including interest thereon. I further grant my employer the right to pay such monies over the scheme.
4. I understand that the scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998).
5. I agree to notify the scheme within 30 days in the event that any alternation in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk.
6. The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:
   - 6.1. For the purpose of considering application/s for membership, as well as any claims for benefits, CompCare Wellness Medical Scheme and any medical personnel authorised by CompCare Wellness Medical Scheme has the right to obtain or forward any medically relevant information including the HIV/AIDS status, which it may deem necessary from or to any medical practitioner or institution or nominee that possesses or needs such information, and that party may disclose such information to CompCare Wellness Medical Scheme and any party duly authorised by CompCare Wellness Medical Scheme.
   - 6.2. 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 it is supplied.
   - 6.3. By agreeing to sign the application form/s the applicant/member and dependants thereby waives his/her right to privacy in terms of the abovementioned clauses.
7. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the scheme.
8. Neither the applicant nor any of his/her dependant/s will/are be beneficiaries of another registered medical scheme, on the date of registration with CompCare Wellness Medical Scheme.
9. I hereby indemnify and hold harmless the scheme and administrator against any and/or claims that may result due to the use of preferred providers.
10. I hereby acknowledge that I must give 3 (three) months written notice when I voluntarily resign from the Medical Scheme.
11. I hereby give the scheme permission to communicate to me by SMS ☐ Email ☐

I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the scheme from liability and subject my membership cancellation. I warrant that I am authorised to sign on behalf of my dependant/s. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

Members signature		Date	
Employer/University/Embassy Signature or Stamp		Date	
Brokerage name or broker name	ABSA Healthcare Consultants	Broker code	3401
Broker signature		Date	