Application for membership and record amendment form

medical aid society
there when you need us.

bp

FOR OFFICE USE ONLY

Account | Date D D M M Y Y Y Y | Type

Membership number | *Membership number to be completed by members only when registering dependants.*

IMPORTANT **Return to Human Resources Department**

Title (Mr, Mrs or Miss) | Initials | ID Number

Surname

First name

Postal address

Code

Telephone (H) (W)

(Cell)

Email address

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow/er | Date of marriage D D M M Y Y Y Y

Employee number | Salary per month

Date of employment D D M M Y Y Y Y | Medical aid commencement date D D M M Y Y Y Y

Location | Installation/Depot

Workplace address

A. DEPENDANTS

Please tick appropriate block ☐ **Registration** ☐ **Deletion**

Full first name	Surname	Identity number	Relationship	Income (if any)	Gender	
1.					M	F
2.					M	F
3.					M	F
4.					M	F
5.					M	F
6.					M	F
7.					M	F
8.					M	F

THE FOLLOWING DOCUMENTATION MUST BE SUBMITTED TOGETHER WITH THIS APPLICATION

- Certificate for membership of previous schemes.
- Certified copies of your and your dependants' identity documents.
- If married, a certified copy of marriage certificate.
- If in common-law relationship, affidavit confirming that you have a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household.
- Proof of income of your spouse(s) and/or partner.
- If traditionally married, affidavit confirming the date of the traditional marriage.
- If registering your immediate family, i.e. a parent, brother, sister or grandchild, an affidavit confirming that you are responsible for the dependant's family care and support. This affidavit will be required on an annual basis.

In respect of child dependants

- If your dependant is mentally or physically disabled, a medical certificate stating the nature and extent of disability.
- If your dependant is a student, annual proof of registration as a student.
- If your dependant is aged 18 and over and is not a student, an affidavit confirming that you are responsible for the dependant's family care and support. This affidavit will be required on an annual basis.

B. BANKING ACCOUNT DETAILS

Bank | Branch name

Branch number | Banking account number

Type of account ☐ Savings ☐ Current ☐ Transmission

C. STATE OF HEALTH AND GENERAL INFORMATION

Have you or your dependant(s) ever been subject to any of the following? Answer questions by writing **YES** or **NO**, depending on your circumstances, in the spaces provided. (**Do not** draw crosses, or lines, or use the word "ditto".)

NB: HIV/AIDS status should not be disclosed on this form. To enrol confidentially on the HIV/AIDS management programme, call the toll-free line on 0861 888 300.

1.	Any disorder of the heart, e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	1
2.	High blood pressure, disease of the blood vessels or circulatory disorder, e.g. cramps during exercise, stroke, high cholesterol or hardening of arteries?	2
3.	Any respiratory or lung disease, e.g. asthma, bronchitis, persistent cough or tuberculosis?	3
4.	Any disorder of the digestive system, gall bladder, pancreas or liver, e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia or anal bleeding?	4
5.	Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis, venereal disease or impotence?	5
6.	Any nervous or mental complaint, e.g. epilepsy, blackouts, anxiety state or depression?	6
7.	Any type of nerve ailment, e.g. loss of sensation, numbness or paralysis, etc.?	7
8.	Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, deafness or hoarseness?	8
9.	Disorder or disease of skin, muscles, bones, joints, limbs or spine, e.g. psoriasis, arthritis, gout, slipped disc or other back trouble?	9
10.	Diabetes, hormonal imbalance, glandular or metabolic disease, thyroid or blood disorders?	10
11.	Cancer, growth or tumour of any kind?	11
12.	Pregnancy, any other illness, disorder, operation, disability, accident, e.g. fractured nose, breathing disorder, mammary hypertrophy (enlarged breasts with associated side-effects) or congenital abnormalities?	12
13.	Are you or your dependants currently undergoing or expecting to undergo any medical, dental or surgical treatment?	13
14.	Have any exclusions been imposed by any medical scheme on which you or your dependants have been registered? If YES please state details: _____	14

C. STATE OF HEALTH AND GENERAL INFORMATION (CONTINUED)

If your answer was YES to any of the questions on the previous page, please provide full details in the space below. If the space is insufficient, please provide particulars in the form of attachments.

Question no.	Name of patient	Illness or condition	Date and duration of illness or condition	Name of doctor, hospital or institution	Treatment recommended: Likely date and duration of treatment

D. PLEASE TICK THE APPROPRIATE BLOCKS BELOW:

☐ I hereby apply for membership of the BP Medical Aid Society for myself and/or my dependant(s) and agree to abide by the rules and regulations of the Scheme.

Commencement date | D | D | M | M | Y | Y | Y | Y |

☐ I hereby notify the BP Medical Aid Society of the above member record amendment.

ACTIVE MEMBERS ONLY

☐ I authorise BP to deduct the monthly subscriptions by or in respect of my membership and any amounts due by me to the Scheme from my salary and to pay it to such scheme on my behalf. On termination of membership, any amount due by me to the Scheme may be deducted from monies due to me by BP.

PENSIONER MEMBERS ONLY

☐ I authorise the BP Southern Africa Pension Fund to deduct the monthly subscriptions by or in respect of my membership or any arrear subscriptions due by me to the Scheme from my pension and to pay it to such scheme on my behalf.

PROVIDENT FUND MEMBERS ONLY

☐ I authorise the BP Medical Aid Society to deduct the monthly subscriptions by or in respect of my membership and any amounts due by me to the Scheme from my bank account and to pay it to such scheme on my behalf.

I hereby declare that the information completed on this form is true and correct and agree that any false declaration will render my application null and void.

I understand and accept that during my membership of the Society both personal and clinical information relating to me and my dependants, as beneficiaries, will be disclosed to the Society, as well as the Administrator and/or managed care provider and form part of the records of the Society.

I hereby authorise the Society and its Administrator and/or managed care provider to provide both personal and special personal information, including clinical information, relating to me and/or my dependants under the age of 18, including any authorisations, to the Society's contracted designated service providers and/or other third parties, provided that such information will only be used for the purposes of:

- considering this application;
- the payment of any claims relating to benefits payable under the Society rules;
- the granting of any approvals and/or authorisations, including those relating to hospital admission and/or the participation in any managed care programmes which the Society has contracted to be provided to beneficiaries.

I also undertake to take all such steps as to ensure that any dependant over the age of 18, or younger, as may be required by law, also provide their written consent to the disclosure of any such information.

This consent is provided on the clear understanding that:

1. the designated service providers and/or any third parties will be bound by the same confidentiality agreement as exists between the Society and its Administrator and/or its managed care provider, as well as their employees relating to the confidentiality of such information;
2. this information will be provided solely for the purposes of providing relevant healthcare and/or managed healthcare services and/or benefits to myself and/or my dependants;
3. wherever reasonably possible, such information is to be anonymised or encrypted.

Date | D | D | M | M | Y | Y | Y | Y |

ID Number | | | | | | | | | | | | | |

Signature of applicant _____

IMPORTANT

To avoid unnecessary delay in processing your application, please ensure that this form is completed in full including any documentation that should accompany it. Should there be any outstanding information, your application will not be processed.

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

I certify the foregoing details to be a true statement and that the applicant is a permanent employee of BP.

OFFICIAL EMPLOYER'S STAMP

Date | D | D | M | M | Y | Y | Y | Y |

Signature of BP representative _____

07/14 L4016