transmed
MEDICAL FUND

Contact details:
Customer service department 0800 450 010

Email:
membership@transmed.co.za

MEMBERSHIP NUMBER

(FOR OFFICE USE ONLY)

APPLICATION FOR FOR MEMBERSHIP

PLEASE COMPLETE THE FORM IN BLOCK LETTERS.
It is important that all sections of this form be completed in full. Failing to do so will cause a delay in the processing of the application. Once the form has been completed, it should be returned to your Human Resources Department. Your Human Resources Department should forward your completed form to membership@transmed.co.za. If you require assistance in completing this form, please call 0800 450 010.

1. APPLICANT'S INFORMATION

Identity/Passport number (copy of identity document required)

Title Initials Date of birth D D M M Y Y Y Y

Surname

First names

Gender Male Female Language English Afrikaans

Marital status Single Married Co-habitate (domestic partnership)

Divorced Widowed Civil union partnership

Date of marriage or civil union (attach a copy of the certificate): D D M M Y Y Y Y

Race* African Coloured Indian/Asian White Other Don't wish to disclose

***Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.**

Telephone (W) (H)

Cell number

Email address

Residential address

Code

Postal address

Code

2. EMPLOYMENT DETAILS

Employer group name

Employment start date D D M M Y Y Y Y Employee number

3. BANK DETAILS FOR DIRECT DEPOSITS OR REFUNDS

Please complete this section in full. Banking details are required for the purpose of making out refunds due to members and for the collection of membership contributions.

Account holder

Account number

Name of bank

Branch name

Branch code

Account type Current/Cheque Savings Transmission

MEMBERSHIP NUMBER

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4. OPTION, SALARY AND INCOME TAX DETAILS

Membership commencement date D D M M Y Y Y Y

Plan selection (please select your plan by ticking the relevant block) **Link plan** **Select plan** **Prime plan**

Gross monthly income (proof of income required for pensioner members) **R**

Income tax reference number

5. DEPENDANT INFORMATION

Please complete the cell number, email address and residential address fields of your spouse/partner/dependant that is 18 or older. See **Annexure 5.1** for dependant classification and proof that is required in each instance.

Spouse/Partner

Surname

First names

Identity/Passport number Gender Male Female

Date of birth D D M M Y Y Y Y Relationship to applicant (e.g. wife)

Race* African Coloured Indian/Asian White Other Do not wish to disclose

Contact number

Email address

Residential address

Code

Dependant 1

Surname

First names

Identity/Passport number Gender Male Female

Date of birth D D M M Y Y Y Y Relationship to applicant (e.g. son)

Race* African Coloured Indian/Asian White Other Do not wish to disclose

Contact number

Email address

Residential address

Code

Dependant 2

Surname

First names

Identity/Passport number Gender Male Female

Date of birth D D M M Y Y Y Y Relationship to applicant (e.g. son)

Race* African Coloured Indian/Asian White Other Do not wish to disclose

Contact number

Email address

Residential address

Code

***Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.**

MEMBERSHIP NUMBER

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5. DEPENDANT INFORMATION (CONTINUED)

Dependant 3

Surname

First names

Identity/Passport number | Gender | Male | Female

Date of birth (D D M M Y Y Y Y) | Relationship to applicant (e.g. son)

Race* | African | Coloured | Indian/Asian | White | Other | Do not wish to disclose

Contact number

Email address

Residential address

Code

Dependant 4

Surname

First names

Identity/Passport number | Gender | Male | Female

Date of birth (D D M M Y Y Y Y) | Relationship to applicant (e.g. son)

Race* | African | Coloured | Indian/Asian | White | Other | Do not wish to disclose

Contact number

Email address

Residential address

Code

***Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.**

ANNEXURE 5.1: DEPENDANT CLASSIFICATION (please remember to indicate if documents are attached)

Dependants	Documents required to register dependants
Adopted child	Copy of ID or birth certificate Legal proof of adoption (adoption/court order) **Note** Age 21 up to 24 who is a full- or part-time student: proof of registration at an accredited learning institution required Age 21 up to 24 and not studying: affidavit stating financial dependency on the member or the member's spouse or partner required Age 25 and older than age 25: affidavit stating financial dependency on the member or the member's spouse or partner required
Disabled child	Copy of ID or birth certificate Confirmation of disability supplied by a medical practitioner
Foster child	Copy of ID or birth certificate Court order **Note** Age 21 up to 24 who is a full- or part-time student: proof of registration at an accredited learning institution required Age 21 up to 24 and not studying: affidavit stating financial dependency on the member or the member's spouse or partner required Age 25 and older than age 25: affidavit stating financial dependency on the member or the member's spouse or partner required

MEMBERSHIP NUMBER

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ANNEXURE 5.1: DEPENDANT CLASSIFICATION (please remember to indicate if documents are attached) (CONTINUED)

Dependants	Documents required to register dependants
Grandchild	Copy of ID or birth certificate Affidavit from the main member stating financial dependency on the member, member's spouse or partner **Note** Age 21 up to 24 who is a full- or part-time student: proof of registration at an accredited learning institution required Age 21 up to 24 and not studying: affidavit stating financial dependency on the member or the member's spouse or partner required Age 25 and older than age 25: affidavit stating financial dependency on the member or the member's spouse or partner required
Natural child, including posthumous child	Copy of ID or birth certificate **Note** Age 21 up to 24 who is a full- or part-time student: proof of registration at an accredited learning institution required Age 21 up to 24 and not studying: affidavit stating financial dependency on the member or the member's spouse or partner required Age 25 and older than age 25: affidavit stating financial dependency on the member or the member's spouse or partner required
Natural child with different surname to principal member	Copy of ID, birth certificate or abridged birth certificate Affidavit from the main member stating the child is the biological child of the member **Note** Age 21 up to 24 who is a full- or part-time student: proof of registration at an accredited learning institution required Age 21 up to 24 and not studying: affidavit stating financial dependency on the member or the member's spouse or partner required Age 25 and older than age 25: affidavit stating financial dependency on the member or the member's spouse or partner required
Parent	Copy of ID Affidavit from the main member stating financial dependency on the member, member's spouse or partner
Partner	Copy of ID Affidavit from the main member stating the relationship, co-habitation and financial dependency on the member
Sibling	Copy of ID or birth certificate Affidavit from the main member stating financial dependency on the member, member's spouse or partner **Note** Age 21 up to 24 who is a full- or part-time student: proof of registration at an accredited learning institution required Age 21 up to 24 and not studying: affidavit stating financial dependency on the member or the member's spouse or partner required Age 25 and older than age 25: affidavit stating financial dependency on the member or the member's spouse or partner required
Spouse (husband/wife)	Copy of ID Copy of marriage certificate
Stepchild	Copy of ID or birth certificate Marriage certificate and affidavit from the main member stating the child is the biological child of the spouse **Note** Age 21 up to 24 who is a full- or part-time student: proof of registration at an accredited learning institution required Age 21 up to 24 and not studying: affidavit stating financial dependency on the member or the member's spouse or partner required Age 25 and older than age 25: affidavit stating financial dependency on the member or the member's spouse or partner required

PLEASE NOTE: From time to time the Fund may review whether dependants still qualify for benefits in terms of the Fund's rules.

MEMBERSHIP NUMBER

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6. PREVIOUS MEDICAL SCHEME MEMBERSHIP HISTORY (please attach membership certificates of previous medical schemes)

Are or were you or any of your nominated dependants previously beneficiaries of a registered medical scheme? ☐ Yes ☐ No

If 'yes', a **certificate of membership** indicating your date of resignation from that scheme must be attached before registration on the Transmed Medical Fund will be finalised. Please note that in terms of the Medical Schemes Act, it is unlawful to be registered on two schemes simultaneously. List each medical scheme that you have been a member of (note that only medical schemes registered in South Africa apply). This information needs to be supplied for the principal member and all dependants applying for membership. If more space is required, please include additional pages.

Name of member	Medical scheme name	Membership number	Joining date	Termination date
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y

7. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS (this section is only applicable to members joining after three months of employment)

Please provide the required information by ticking the relevant **Yes** or **No** blocks below. If the answer to any question is 'yes', please provide details in section 8. Please note that if you do not provide full details of all the medical conditions known to you at the time of this application or before acceptance of this application, your membership will be declared null and void.

Are you or any of your dependants currently pregnant? ☐ Yes ☐ No

If so, for how many weeks/months? ☐☐ weeks ☐☐ months

Name and surname of mother-to-be

Have you or any of your dependants received treatment or advice or consulted a medical practitioner for any of the following conditions in the past 12 months?

1. Disorders or problems with the heart or cardiovascular system, e.g. heart murmur, high blood pressure, high cholesterol, shortness of breath, palpitations, chest pain, angina, heart attack and/or any other cardiac or blood disorder. ☐ Yes ☐ No
2. Respiratory or lung disorders, e.g. tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis. ☐ Yes ☐ No
3. Disorders of the digestive system, stomach, gall bladder, pancreas or liver, e.g. gastric or duodenal ulcer, heartburn, hiatus hernia, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis, cirrhosis, liver failure or have you ever had a gastroscopy or colonoscopy? ☐ Yes ☐ No
4. Disease or disorders of the kidneys, bladder or reproductive organs, e.g. abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections or sexually transmitted diseases. ☐ Yes ☐ No
5. Disorders of the nervous system or brain, e.g. epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease or been advised to have an MRI or CT scan? ☐ Yes ☐ No
6. Mental disorders, e.g. depression, anxiety, panic attacks, schizophrenia, eating disorders, attention deficit hyperkinetic disorder (ADHD) or post-traumatic stress disorder. ☐ Yes ☐ No
7. Ear, nose, throat or eye disorders, e.g. defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies. ☐ Yes ☐ No
8. Disorders or diseases of the skin, muscles, bones, joints, limbs or spine, e.g. any skin rash, arthritis, gout, fibromyalgia, any back/neck/hip/knee or other joint trouble, multiple sclerosis, any joint problems or replacements, acne, eczema or psoriasis? ☐ Yes ☐ No
9. Diabetes, sugar in urine, thyroid or other glandular or blood disorders, e.g. anaemia, bleeding disorders, growth disorder, Cushing's disease or Addison's disease. ☐ Yes ☐ No

MEMBERSHIP NUMBER

(FOR OFFICE USE ONLY)

7. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS (this section is only applicable to members joining after three months of employment)

10. Cancer, a growth or tumour of any kind, including moles removed (malignant/benign). ☐ Yes ☐ No

11. Gynaecological disorders, e.g. abnormal pap smear or mammogram, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, menstrual disorders or any abnormality of pregnancy or confinement. ☐ Yes ☐ No

12. Are any of your dependants pregnant? ☐ Yes ☐ No
If so, what is the expected date of delivery? D D M M Y Y Y Y

13. Are any of your dependants currently undergoing or anticipating any specialised dental/maxillofacial treatment? ☐ Yes ☐ No

14. Have any of your dependants had any accidents (including motor vehicle accidents) in the past 24 months? ☐ Yes ☐ No
If yes, please provide details of injuries sustained.

15. Are any of your dependants taking ongoing medication for any condition not listed in any other question? ☐ Yes ☐ No

16. Have any of your dependants undergone any surgical procedure in the past 24 months? ☐ Yes ☐ No

17. Are any of your dependants waiting for or planning any operation or admission to any hospital in the next 12 months? ☐ Yes ☐ No

18. Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical claim within the next 12 months? ☐ Yes ☐ No

If you require additional space, please complete a separate sheet of paper and attach it to the application. Please attach the relevant medical reports. Should you be HIV positive and do not wish to disclose this on your application form, please note that once you have received your membership number, you must fax confirmation of your HIV/AIDS status to the HIV YourLife programme on 0860 109 793 or email it to mail@hivyourlife.co.za to ensure registration on the programme.

8. ADDITIONAL MEDICAL INFORMATION (Please provide details below if you answered 'yes' to any of the underwriting questions)

If more space is required, please include additional pages

Question number	Name of patient	Illness or condition/ reason	Date and duration of illness	Name of doctor, hospital or institution	Treatment recommended: Likely date and duration of treatment

Failure to disclose any pre-existing conditions could result in limited benefits, the exclusion of benefits or the termination of your membership.

MEMBERSHIP NUMBER

(FOR OFFICE USE ONLY)

9. YOUR PREFERRED METHOD OF RECEIVING WRITTEN COMMUNICATION

Kindly indicate your preferred method of receiving communication. **Please choose only one method of delivery for each item.**

Personalised letters	☐	Email	☐	Post		
Claims statements*	☐	Email	☐	Post	☐	Cell phone
Claims processed	☐	Email	☐	Post	☐	Cell phone

*You need a cell phone that can access the internet to receive your statements via SMS.

10. CONSENT FOR TRANSMED MEDICAL FUND TO PROCESS PERSONAL INFORMATION

Transmed Medical Fund and the Administrator, Momentum Health Solutions, a division of Momentum Metropolitan Holdings, are committed to maintaining the confidentiality of your personal information and complying with the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act, 131 of 1998.

We request your consent to process your personal information and obtain your personal information from any other person for the purposes set out in this section. While your consent is voluntary, it is a requirement for your membership of Transmed Medical Fund. If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, Transmed Medical Fund will not be able to administer or offer you membership of the Fund. Please read the statements below and sign your acceptance thereof.

1. That you authorise, and give consent to, Transmed Medical Fund and the Administrator to collect, store, collate, process, share and further process your personal information, including health information, and that of your dependants, for purposes of your membership of Transmed Medical Fund, risk profiling, management, administration of your membership and as set out in this section.

2. If you have consented to the disclosure of your personal information, Transmed Medical Fund or the Administrator may provide your personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between Transmed Medical Fund or the Administrator that requires them to do so.

3. You acknowledge the need to give Transmed Medical Fund and the Administrator all information and evidence they may require from time to time. You authorise Transmed Medical Fund and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to you or your dependants in the past, or who will attend to you or your dependants in the future, any information Transmed Medical Fund may require concerning you or any of your dependants in assessing any risk or claim in relation to this application, your membership of Transmed Medical Fund and risk profiling or management. You consent to that person providing, and instruct that person to provide, Transmed Medical Fund and the Administrator with this information on request. You waive the provisions of any law or regulation that restricts the disclosure of this information.

4. You have the right to withdraw your consent to have your personal information processed, provided that the lawfulness of the processing of your personal information before your withdrawal will not be affected.

5. You have the right to object, on reasonable grounds relating to your particular situation, to the processing of your personal information, unless processing is required by law.

6. You have the right to request your personal information that is in the possession of Transmed Medical Fund and the Administrator, provided that you furnish adequate identification.

7. You have the right to request Transmed Medical Fund and the Administrator, where necessary, to correct or delete your personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or that has been obtained unlawfully.

8. If you have a complaint relating to the processing of your personal information, you agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If you are not satisfied with the outcome of the complaint, you understand you may refer the complaint to the Information Regulator, who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.

9. Your personal information will be shared between Transmed Medical Fund, the Administrator and contracted third parties, both locally and outside the Republic of South Africa, who require this information for purposes related to your membership of Transmed Medical Fund, and:
   - to grant you access to interact with Transmed Medical Fund on its website; and
   - to provide any credit bureau or registered credit provider with your credit information, as defined in the National Credit Act, 2005 (credit information includes, for example, your credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgements obtained for outstanding debts).

11. TERMS AND CONDITIONS

Please read the clauses below carefully. They contain an acknowledgement of fact/a potential liability to pay costs/an indemnity provision and they may potentially compromise your rights. Please ensure that you fully understand the consequences of the clauses.

1. The answers that I have given here are full, complete and true. I understand that if I am accepted as a member of the Fund, my answers on this form will form the basis of my membership.

MEMBERSHIP NUMBER

(FOR OFFICE USE ONLY)

11. TERMS AND CONDITIONS (CONTINUED)

2. I apply for my dependants and I to join Transmed Medical Fund.

3. I have been provided with a summary of the rules of the Fund (i.e . benefits guide) and I have been given an opportunity to consider, familiarise myself with and agree to be bound by the rules if my application for membership is accepted. I understand that I may obtain a full copy of the rules in accordance with the Medical Schemes Act. The rules of the Fund are also available on the Fund's website at www.transmed.co.za.
   3.1 I understand that the summary of the rules of the Fund will be amended by the Fund annually.
   3.2 I also understand that, in the event of a dispute, the rules will prevail.
   3.3 The words used in this application have the meaning that the rules give them.
4. I acknowledge that if my dependants and I do not disclose all the information that is relevant to the assessment of this application, it will make any contract that may result from this application null and void.
   4.1 If I or my dependants have failed to disclose relevant information and the contract becomes void, the Fund will have the right to claim back any amounts that it may have paid to me or any person on behalf of me or my dependants under such contract.
   4.2 I will be reimbursed any membership payments made by me, but may be charged a reasonable penalty by the Fund.

5. I will notify the Fund if any alteration takes place in any circumstances on which the Fund based its assessment of its risk after the date of this application and before the date of the Fund's acceptance of the risk. I acknowledge that failure to do so will make any contract that may result from this application null and void.
   5.1 If I or my dependants have failed to disclose relevant changes in circumstances and the contract becomes void, the Fund will have the right to claim back any amounts that it may have paid to me or any person on behalf of me or my dependants under such contract.
   5.2 I will be reimbursed any membership payments made by me, but may be charged a reasonable penalty by the Fund.

6. I have been provided with a schedule reflecting the benefits I may become entitled to if this application is accepted. The benefits have also been explained to me and I have had an opportunity to question and consider them.
   6.1 The monthly contributions I will be expected to pay if this application is accepted have been explained to me. I have had an opportunity to question and consider the monthly contributions and I understand the consequences if I fail to pay the monthly contributions.
   6.2 It is my responsibility alone (as a member) to make sure that the Fund receives the monthly contribution.
   6.3 I will pay all sums that I owe to the Fund on demand. Failure to pay any debt due to the Fund may result in the suspension of my membership and/or having the matter handed over to a third party for debt collection.
   6.4 Should we not receive a single month's contribution, it will result in the suspension of the Fund's benefits.
   6.5 Should we not receive two months' contributions, it will result in the cancellation of my membership of the Fund.

7. 7.1 If the employer is responsible for paying my contributions, I authorise and instruct my employer to:
      7.1.1 deduct from my remuneration (and any other sums due to me) any amounts that I may owe to the Fund from time to time
      7.1.2 pay such amounts to the Fund.
   7.2 I also authorise and instruct any person (such as my employer or a pension or provident fund) who holds funds on my behalf after I cease employment, to pay and continue to pay the amounts referred to in clause 7.1 to the Fund as and when it is due.

8. If I am accepted as a member, I must, both now and in future, give the Fund all such information and evidence as it may require from time to time.
   8.1 For this purpose, I authorise the Fund and/or its agents to obtain from any person any necessary information that they may require concerning any of my dependants or me in assessing any risk or claim in relation to this application or my membership of the Fund. I direct that person to provide the Fund and/or its agents with such information on request.
   8.2 I authorise any medical doctor or other provider who has attended to me in the past or who will attend to me in the future, to provide the Fund and/or its agents with such information as it may require.
   8.3 I therefore give up the protection afforded to me under the provisions of any law or regulation that restricts the giving of such information and expressly authorise the Fund to access my information, as and when it is necessary.

9. I understand that this is an indemnity. This means that in certain circumstances I will be responsible for paying for claims or damage incurred by the Fund and/or its agents.
   9.1 I will obtain the necessary consent from any of my dependants (who may become members in terms of this application) that may be required.
   9.2 If I do not obtain their consent, I will have no claim against the Fund and/or its agents.
   9.3 If I do not obtain their consent and if any third party has a claim against the Fund and/or its agents because my dependants did not consent, as required, I will be responsible for any costs, fees or other amounts the Fund and/or its agents may be liable for.

10. I consent to the recording of all conversations between me and the Fund and/or its agents and all information obtained through these conversations will form part of the records of the Fund and/or its agents. I also consent to all these records remaining the sole property of the Fund and/or its agents.

11. I will notify the Fund should I or any of my dependants require hospitalisation for a planned event at least 48 hours before the event. I acknowledge that failure to do so will result in a reduction of benefits the Fund will pay to me or any supplier on my or my dependants' behalf for any procedure undertaken.

12. I understand that this application form is valid for 30 days only.

13. I am aware that the Fund may ask for proof of identification during any stage of communication with the Fund.

MEMBERSHIP NUMBER

(FOR OFFICE USE ONLY)

11. TERMS AND CONDITIONS (CONTINUED)

14. In the case of new members of the Fund, the following may apply:
    14.1 a three-month general waiting period
    14.2 a twelve-month exclusion on a pre-existing condition
    14.3 a late joiner contribution penalty.

15. I undertake to give a calendar month's notice should I wish to terminate my membership.

16. **Please note:** Registration will be delayed should this application be incomplete or if the required documents are not attached. Should your application reach our offices after the fifth day of the month, you will be registered from the first day of the following month.

12. HUMAN RESOURCES SECTION

CHECKLIST

PLEASE INDICATE BELOW THAT THE APPLICATION FORM HAS BEEN COMPLETED IN FULL AND THAT THE REQUIRED DOCUMENTS ARE ATTACHED.

Section	Description	Tick box
All sections	All sections of the application form have been completed in full	
Section 1: Copy of ID	Copy of member ID/passport attached	
Section 3: Bank details for direct deposits or refunds	The member's full bank details have been completed	
Section 4: Options	Did the member choose one option only?	
Annexure 5.1: Dependant classification	All required documents/proof attached	
Section 7: Medical fund history	Membership certificate of previous medical fund cover attached	
Declarations/Signatures	Are declarations signed?	

I HAVE READ AND UNDERSTAND THE AFOREMENTIONED CLAUSES, HAD AN OPPORTUNITY TO QUESTION AND CONSIDER THEM, AND I AGREE TO THEIR CONSEQUENCES.

NAME OF MEMBER

SIGNATURE OF MEMBER

D	D	M	M	Y	Y	Y	Y

DATE

OFFICIAL EMPLOYER STAMP

SIGNATURE OF
HUMAN RESOURCES OFFICER

D	D	M	M	Y	Y	Y	Y

DATE

09/2022