PROFMED

APPLICATION FORM

ATTENTION: PROFMED NEW BUSINESS

Email: applications@profmed.co.za

1 ELIGIBILITY*

**Eligibility criteria apply.*

A) PROFESSION CATEGORY

Medical ◯ Humanities ◯ Student ◯ Legal ◯ Sciences ◯

Financial ◯ Built Environment ◯ Other ◯

B) PROFESSION DETAIL, E.G. ADVOCATE, ENGINEER

Profession

C) CURRENT OCCUPATION/ EMPLOYMENT

D) QUALIFICATIONS

DEGREE/QUALIFICATION	ACADEMIC INSTITUTION	MINIMUM DURATION OF DEGREE/QUALIFICATION

(Please attach copy of degree(s)/qualification(s). Attach additional information if space is insufficient.)

E) ARE YOU A MEMBER OF PPS? Yes ◯ No ◯ PPS member no.

2 BENEFIT OPTION

A) PLEASE SELECT ONE OF THE FOLLOWING BENEFIT OPTIONS BY TICKING THE APPROPRIATE BOX:

PROSELECT ◯ (Network Option)

PROACTIVE PLUS ◯

PROSECURE ◯

PROSECURE PLUS ◯

PROPINNACLE ◯

PROSELECT SAVVY ◯ (Network Option)

PROACTIVE PLUS SAVVY ◯ (Network Option)

PROSECURE SAVVY ◯ (Network Option)

PROSECURE PLUS SAVVY ◯ (Network Option)

PROPINNACLE SAVVY ◯ (Network Option)

B) DATE MEMBERSHIP TO COMMENCE

D D M M Y Y Y Y

Note: *It is illegal to belong to more than one medical scheme at the same time.*

C) FINANCIAL ADVICE

Note: *In terms of the FAIS Act, this section must be completed.*

My decision to join Profmed, and my choice of benefit option, is based on (please tick the appropriate box):

◯ The advice received from ..... [name], a Profmed consultant.

◯ The advice received from ..... [name], my independent broker.

◯ I confirm that I have not received any advice from, or been influenced by, a Profmed consultant or independent broker. I have considered my own and my dependants requirements and understand that, without a full healthcare needs analysis, my decision may not fully align with our circumstances, needs, or preferred benefit option choice.

3 PERSONAL DETAILS

A) PRINCIPAL MEMBER (please attach a copy of ID document)

Title | First names

Surname | Maiden name | Gender: Male | Female

Race: Black | Coloured | Indian | White | I do not wish to disclose this information

This information is used to establish the race demographics of Profmed in terms of the Broad-Based Black Economic Empowerment Act (BBBEE)

ID/Passport no. | Date of birth D D M M Y Y Y Y

Street address | Postal address

SUBURB | SUBURB

Please note that the the physical address will be used as the domicilium address.

CITY/TOWN | Post code | CITY/TOWN | Post code

Telephone: Work | Home

Cell | Fax

Email address

Gross monthly income from all sources **R** p.m.

B) SPOUSE/PARTNER IF JOINING AS A DEPENDANT (please attach a copy of ID document)

Title | First names

Surname | Gender: Male | Female

Relationship to principal member (e.g. wife, partner, etc.)

ID/Passport no. | D D M M Y Y Y Y

Telephone: Work | Home

Cell | Fax

Email address

Gross monthly income from all sources **R** p.m

C) DEPENDANTS (OTHER THAN SPOUSE/PARTNER)

Child dependants:

A child dependant is a member's child who is younger than 21 years. If your dependant(s) are 21 years and older but younger than 28, please provide proof of study or proof of financial dependence, whichever is applicable, in order for your dependant(s) to qualify as child dependants.

Adult dependants:

Dependants who are 28 years and older are required to submit proof of dependence on the principal member to qualify for membership. Three months' recent bank statements of all the dependants' bank accounts and a tax directive from SARS is required. In the case of dependants who are mentally or physically disabled, a medical report in this regard is required from an independent doctor.

DEPENDANT 1

Title | First names

Surname

ID/Passport no. | | | | | | | | | | | | | D D M M Y Y Y Y

Gender: Male ◯ Female ◯ Relationship to principal member

DEPENDANT 2

Title First names

Surname

ID/Passport no. | | | | | | | | | | | | | D D M M Y Y Y Y

Gender: Male ◯ Female ◯ Relationship to principal member

DEPENDANT 3

Title First names

Surname

ID/Passport no. | | | | | | | | | | | | | D D M M Y Y Y Y

Gender: Male ◯ Female ◯ Relationship to principal member

DEPENDANT 4

Title First names

Surname

ID/Passport no. | | | | | | | | | | | | | D D M M Y Y Y Y

Gender: Male ◯ Female ◯ Relationship to principal member

DEPENDANT 5

Title First names

Surname

ID/Passport no. | | | | | | | | | | | | | D D M M Y Y Y Y

Gender: Male ◯ Female ◯ Relationship to principal member

(Attach additional information if space is insufficient.)

4 BANK DETAILS

A) CONTRIBUTIONS

Debit Order ◯ EFT ◯ Persal (for Government employees) ◯

If Debit Order, please complete Annexure A, Authority and Mandate for Debit Order Instruction, attached.

B) REFUNDS

◯ If refunds are to be paid into the same account as your contributions, as detailed in Annexure A, Authority and Mandate for Debit Order Instruction, attached, please tick here

If different bank account than for contributions, please complete this section

I authorise Profmed to deposit any credits due to me into my bank account:

Name of account holder

Name of bank | Branch name | Branch code

Account number | Type of account: CHEQUE | TRANSMISSION | SAVINGS

Signature of account holder _____ D D M M Y Y Y Y

Please note: If your membership date is confirmed after the monthly contribution debit orders have been generated, a double contribution will be deducted the following month.

Are your contributions paid by Government? ◯ Yes ◯ No If yes, please attach a copy of your latest salary advice.

5 DETAILS OF PREVIOUS MEDICAL SCHEME(S)

Please provide details of all previous medical scheme memberships below and attach the corresponding membership certificates. To avoid the application of late joiner penalties or general and/or condition-specific waiting periods, you must submit proof of cover for all prior medical scheme memberships. Failure to provide adequate proof may result in waiting periods and/or penalties being imposed.

NAME OF APPLICANT/ DEPENDANT	DATE OF BIRTH	MEDICAL SCHEME	MEMBERSHIP NUMBER	JOIN DATE	RESIGN DATE

(Attach additional information if space is insufficient.)

I have no previous medical scheme cover ◯

Late joiner penalties will be applied in respect of persons over the age of 35 years who were without medical scheme cover for the periods indicated hereunder:

1 - 4 years	@ 5%	x the relevant contribution	15 - 24 years	@ 50%	x the relevant contribution
5 - 14 years	@ 25%	x the relevant contribution	25+ years	@ 75%	x the relevant contribution.

Note: *It is illegal to belong to more than one medical scheme at the same time.*

I confirm that I will resign from my current medical scheme before becoming a member of Profmed. Yes ◯

6 DETAILS OF YOUR GENERAL PRACTITIONER

Do you consult a general practitioner? Yes ◯ No ◯ If yes, please provide the details of your general practitioner:

Name Telephone

7 MEDICAL HISTORY & HEALTH INFORMATION

This section must be completed for the main applicant, spouse/partner, and all listed dependants.

Please disclose all material information, which is any information that can substantively impact the Scheme's ability to comply with the Medical Schemes Act or its Rules or manage its risk or can substantively impact a decision by the Scheme in respect of a Beneficiary. It includes a full and honest disclosure of all information, including state of health, any medical symptoms, any medical advice, medical examinations, diagnostic procedures, diagnosis, care or treatment recommended or obtained during the period of 12 months before the date of this application, no matter how minor or insignificant they may seem to you. Failure to comply may result in membership cancellation, suspension or legal action. The Scheme reserves the right to request disclosures directly from dependants aged 18 years and older.

You must declare all information, regardless of whether it was previously disclosed or covered by another medical scheme.

DISCLOSURE OF MEDICAL HISTORY

Have you or any of your dependants received or been recommended for any medical advice, diagnosis, treatment or care for any of the following conditions?

Disclosure is not limited to the conditions listed below. These are provided as examples and do not represent a full list.

1. Any blood disease or condition (e.g. anaemia, haemophilia)?	Yes ☐	No ☐
2. Any psychological or psychiatric disease or condition (e.g. depression, anxiety, neurosis, tension, and or any drug, substance and/or alcohol abuse/dependency or rehabilitation)?	Yes ☐	No ☐
3. Any neurological disease or condition (e.g. epilepsy, fainting, paralysis, stroke, Alzheimer's, Parkinson's, multiple sclerosis)?	Yes ☐	No ☐
4. Any headaches or migraines?	Yes ☐	No ☐
5. Any transmissible disease (e.g. Hepatitis B, Hepatitis C)?	Yes ☐	No ☐
6. Any disease/affection of the skin (e.g. acne, eczema, psoriasis)?	Yes ☐	No ☐
7. Any affection of the bone system and/or joints (e.g. osteoporosis, rheumatism, gout, arthritis, back problems, hip problems, knee problems)?	Yes ☐	No ☐
8. Any affection of the muscular system (e.g. muscular dystrophy)?	Yes ☐	No ☐
9. Any affection of the heart or blood circulation system (e.g. hypertension, coronary heart disease, chest pains, irregular heart beat, rheumatic fever, heart failure, valve lesions)?	Yes ☐	No ☐
10. Any affection of the chest or respiratory system (e.g. asthma, bronchitis, chronic cough, TB or other lung diseases)?	Yes ☐	No ☐
11. Any affection of the digestive system, liver and gallbladder (e.g. gastric ulcers, hernia, poor digestion, gallstones, spastic colon)?	Yes ☐	No ☐
12. Any affection of the urinary system and/or sex organs (e.g. bladder infection, nephritis, kidney stones, prostatitis)?	Yes ☐	No ☐
13. Any affection/disorder of the eyes (e.g. cataracts, glaucoma)?	Yes ☐	No ☐
14. Any affection of the ears, nose or throat, irrespective of whether it is congenital or developed later (e.g. deafness)?	Yes ☐	No ☐
15. Any affection/disorder of the teeth or gums?	Yes ☐	No ☐
16. Any metabolic condition (e.g. Gaucher's disease, porphyria)?	Yes ☐	No ☐
17. Diabetes mellitus?	Yes ☐	No ☐
18. High cholesterol?	Yes ☐	No ☐
19. Any condition of the thyroid gland?	Yes ☐	No ☐
20. Any cancer, malignant or pre-malignant tumours?	Yes ☐	No ☐
21. Any other physical disease/condition, irrespective of whether it is congenital or developed later (e.g.spasticity, cleft palate)?	Yes ☐	No ☐
22. Do you suffer from chronic sinusitis?	Yes ☐	No ☐
23. Any affection of the female organs (e.g. womb, ovaries, abnormal Pap smears, breasts, endometriosis)?	Yes ☐	No ☐
24. Varicose veins?	Yes ☐	No ☐
25. A disease or condition for which you or any of your dependants have received a gratuity, pension, pay-out and/or guaranteed medical treatment from the Compensation Commissioner, Department of War Pensions or arising from the Motor Vehicle Insurance Act during the past 24 months?	Yes ☐	No ☐
26. Is any female member/dependant currently pregnant? If so, provide expected date of confinement below.	Yes ☐	No ☐
27. Do you or any of your dependants suffer from any chronic disease for which you and/or your dependants have to use chronic medication?	Yes ☐	No ☐
28. Are you aware of any existing condition(s) that may require medical or surgical treatment within the next 12 months?	Yes ☐	No ☐
29. Are you or any of your dependants currently undergoing any other medical and/or surgical treatment?	Yes ☐	No ☐
30. Have you or any of your dependants undergone any medical and/or surgical treatment?	Yes ☐	No ☐
31. Were you or your dependants subjected to any waiting periods, exclusions or penalties by your previous medical scheme?	Yes ☐	No ☐
32. Are there any other conditions or symptoms not detailed in any other question, that you or any of your dependants have experienced and for which you have not yet sought medical advice?	Yes ☐	No ☐

If you indicated yes to any of the questions in the medical questionnaire on the previous page, please provide full details of the condition below. If the space provided below is insufficient, please attach additional information to this application form.

Question number	Name of patient	Type of illness/condition	Date diagnosed	Date of first treatment	Date of last treatment	Last symptoms/consult/ hospitalisation	Treatment received and/or medication used

If you indicated yes to any of the questions in the medical questionnaire on the previous page, please provide the information of the treating practitioner/s below.

Question number	Treating practitioner	Treating practitioner telephone number

8 CONSENT TO RECEIVE MARKETING MATERIAL

I consent to Profmed's Administrator, PPS Healthcare Administrators, using my information for marketing purposes (including direct marketing) related to life and non-life insurance products (such as sickness benefits), investments, retirement benefits, and other financial or non-financial services offered by PPS Insurance Company Limited and its subsidiaries. I understand that I may withdraw this consent at any time.

Yes ◯ No ◯

9 DETAILS OF BROKER

Surname _____ Initials _____

Profmed broker no. _____

FSP no. _____ Business/company name _____

Signature of Profmed broker _____ Date D D M M Y Y Y Y

10 ADDITIONAL INFORMATION

DOCUMENTS

To facilitate the quick and efficient processing of your membership, use the tick boxes below to ensure all the applicable documents accompany this application form:

Copy of principal member's ID ◯

Copy of spouse/partner's ID ◯

Copy of certificate(s) of degree(s)/qualification(s) ◯

Membership certificate(s) of all previous medical scheme cover

Proof of study or dependence in respect of child dependants older than 21 years but younger than 28 years

Proof of study or dependence in respect of dependants 28 years or older

Members who apply for rates below the monthly threshold must provide the relevant documentation as required by the Scheme, reflecting the household earnings from all sources.

Additional information in respect of sections 1, 5 and 7 of this application form

Copy of latest salary advice in respect of Government employees

11 PRIVACY STATEMENT

HOW WE WILL PROCESS AND DISCLOSE YOUR PERSONAL INFORMATION AND COMMUNICATE WITH YOU

READ THIS SECTION CAREFULLY. EVERY TERM IS MATERIAL

1. The privacy and security of your personal information (which includes the personal information of your dependants) are important to Profmed. Profmed will only process personal information, which includes collect, use, store and share such information, in accordance with its Privacy Policy (available at www.profmed.co.za) and if the processing is permitted by law, for a legitimate interest or otherwise with your consent. Profmed will share your personal information with its contracted outsourced providers (such as its administrator and managed healthcare organisations) who assist it to administer your membership and provide you and your dependants with membership benefits.
2. All information required on this form is mandatory. Should any information be incorrect or incomplete, your application for membership might not be approved, your membership might be terminated subject to payment of a reasonable cancellation fee, or it might prevent Profmed from providing you and your dependants with benefits and services, including payment of claims. Profmed may require additional information about you and your dependants to assess your eligibility for Scheme membership, apply waiting periods and/or late joiner penalties, subject to the provisions of the Medical Schemes Act and the Scheme Rules, and for Profmed to exercise its rights and discharge its obligations in terms of the agreement with members.

12 TERMS & CONDITIONS APPLICABLE TO PROFMED

12.1) DEFINITIONS

"Scheme" refers to Profmed Medical Scheme (Registration No. 1194), registered with the Council for Medical Schemes.

"Administrator" refers to Professional Provident Society Healthcare Administrators (PPSHA), the appointed administrator and managed care provider for the Scheme.

12.2) SCHEME RULES

The rules of the Scheme record your rights and responsibilities for your membership and constitutes the contract between a member and the Scheme. They may change from time to time. You may access a copy or view the rules by logging onto **https://profmed.co.za/about-profmed-medical-aid/corporate-governance/rules-of-the-scheme/** When you sign this application, you confirm that you have read and understood these terms and conditions and you agree that you and those you apply for will be bound by these. Your application form will not be processed without your signature in this section. Please read the terms and conditions below carefully.

12.3) THE SCHEME AND ADMINISTRATOR MAY GET INFORMATION ABOUT YOU FROM OTHER RELEVANT SOURCES

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ("relevant sources") and further process such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers or financial advisers). We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete. You give your permission that the Scheme and Administrator may get any information that is relevant to your application.

12.4) DOMICILIUM AND COMMUNICATION

You must provide and maintain a valid physical address as your domicilium citandi et executandi (address for the serving of legal notices and documents). The Scheme and Administrator will serve legal notices and formal communications at this address, unless the parties have expressly agreed in writing to effect service electronically, in which case such notices may be delivered via the agreed electronic method. You are responsible for ensuring that both your physical and, where applicable, electronic contact details remain accurate at all times.

12.5) RECORDING OF COMMUNICATIONS

The Scheme and Administrator will record and retain telephone and other communications for quality assurance, regulatory compliance, and evidentiary purposes.

12.6) VERIFICATION FROM EXTERNAL SOURCES

By submitting this application, you expressly authorise the Scheme and Administrator to obtain and verify your personal information (and that of your dependants) from relevant external sources including healthcare providers, employers, financial intermediaries, and statutory entities for the purposes of processing this application, risk profiling, claims validation, and fraud prevention.

12.7) OBLIGATION TO UPDATE INFORMATION

You undertake to notify the Scheme in writing of any changes to personal, medical, or other information within 30 days of the change.

12.8) RIGHT TO TERMINATE MEMBERSHIP

The Scheme may terminate membership with immediate effect as provided for in the Medical Schemes Act and Rules in the event of:

12.8.1 Non-disclosure or misrepresentation of material information.
12.8.2 Submission of false or misleading information.
12.8.3 Failure to report changes in health or other relevant circumstances prior to the commencement of membership.
12.8.4 Termination may result in recovery of claims paid, reversal of cover, and/or criminal proceedings.

12.9) MONITORING AND NON-DISCLOSURE REVIEW

To mitigate risk of non-disclosure, the Scheme reserves the right to apply enhanced monitoring during the first 12 months of membership, including but not limited to:

12.9.1 All claims from new members with less than 24 months continuous cover and/or a break in cover exceeding 90 days.
12.9.2 Claims from previously uninsured individuals (i.e. no cover for 90+ days before application) or by requesting further clinical history prior to processing benefits or authorisations during this period.

12.10) CONTRIBUTION PAYMENT OBLIGATIONS

The main member is solely responsible for ensuring that monthly contributions are paid on time. In accordance with the Medical Schemes Act and the Scheme Rules, the Scheme may amend contributions and/or benefits, provided that members are given prior written notice. Failure to pay contributions may result in the suspension or termination of benefits.

12.11) DEBT RECOVERY

The Scheme reserves the right to recover any monies owed by a member or dependant, including amounts paid in error or as a result of misrepresentation. The member will be informed of any outstanding debt and afforded the opportunity to settle or dispute such amounts through formal channels.

13 DECLARATION & CONSENT BY THE APPLICANT

A) DECLARATION

1. I had adequate opportunity to read and understand the contents of this document and all my questions have been answered satisfactorily. The contents of this document have been explained to me in a language that I understand and all my questions have been answered satisfactorily.
2. I am applying for membership of Profmed and warrant that all the information supplied and statements made on this application form and any accompanying information, whether completed by me or on my behalf are, to the best of my knowledge and belief, correct and complete in every respect. I will advise Profmed as soon as any of the information changes.
3. I understand that acceptance of my membership by Profmed is subject to the Rules of Profmed and is conditional upon there having been no deterioration in the state of my health or that of my dependants between the date of completion of this application and the date of membership. I undertake to advise Profmed immediately of any deterioration occurring.
4. I understand that the information supplied on this application form, together with the supporting information, forms the basis of my membership of Profmed and that my membership is subject to the condition(s), exclusions and limitations of benefits in accordance with the Medical Schemes Act and the Rules of the Scheme. In particular, I understand the requirements and implications of Section 7 of this document and confirm that I have declared all medical conditions.
5. I understand that Profmed will inform me whether my application for membership has been successful and whether any underwriting condition(s) will be imposed.
6. I have read the Privacy Policy (available at www.profmed.co.za) of Profmed and I fully understand how Profmed will process my/our personal information, with whom it will be shared and our rights in respect of such information.
7. I guarantee that, to the extent that it may be required by law, I have the necessary authority or permission from my dependants to provide the consent, permissions and personal information on their behalf as set out in this document and as may be required from time to time by Profmed, and should I not have such authority or permission, I indemnify Profmed against any claim of whatsoever kind (including any action for damages) asserted or action taken against Profmed by any of my dependants.

B) CONSENT

1. I expressly authorise any healthcare service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to Profmed, or its contracted outsourced providers, on request, for any purpose directly related to our membership or which is authorised in terms of the Medical Schemes Act, the Scheme Rules or any other legislation, also after the death or termination of membership of any of us.
2. I authorise Profmed to deal with my dependants and me electronically and treat electronic communication (such as email, telephone, Profmed's digital App) as being the same as written authority and confirmation. I agree further that, where we choose to use electronic methods to transact with Profmed, we will carry the risk of such use.
3. I provide the consent of my own free will without any undue influence from any person whatsoever.

Signature of applicant _____ Date D D M M Y Y Y Y

This document is valid for 90 days from date of signing it.

ANNEXURE A

AUTHORITY AND MANDATE FOR DEBIT PAYMENT INSTRUCTIONS

Written authority and mandate is not necessary if the employer pays your TOTAL membership contribution, or if you pay your contributions by EFT.

A DEBIT ORDER DETAILS

Name of bank account holder

Physical address *(Please provide again even if provided elsewhere on this form)*

Name of bank | Branch name | Branch code

Account number | Type of account: CHEQUE | TRANSMISSION | SAVINGS

Amount: **AS PER THE MEMBERSHIP CERTIFICATE TO BE ISSUED** (This amount will differ depending on whether a late joiner penalty is applied and subject to the family structure i.e. number of dependants etc.)

Commencement date of debit order mandate: **1ST DATE OF THE DATE OF COMMENCEMENT OF MEMBERSHIP**

Debit order deduction date: **1ST DAY OF EACH MONTH**

Name of recipient: **PROFMED** | Description of name of the recipient as registered with the bank to be reflected on your bank statement: **PROFMED0001**

Profmed's registered address: **PROFMED PLACE, 15 ETON ROAD, PARKTOWN, 2193, JOHANNESBURG**

This signed Authority and Mandate refers to the application form dated: D D M M Y Y Y Y

I/We hereby authorise Profmed to issue and deliver payment instructions to First National Bank for collection against the above-mentioned account at the above-mentioned bank (or any other bank or branch to which I/we may transfer my/our account, of which I/we will inform Profmed accordingly) and continuing until this Authority and Mandate is terminated by me/us by giving you notice in writing of not less than 20 ordinary working days, and submitted to Profmed at contributions@profmed.co.za.

The individual payment instructions so authorised to be issued must be issued and delivered monthly.

The payment date is the 1st day of the month. If the 1st falls on a weekend or recognised South African public holiday, the payment will take place on the first working day thereafter. Furthermore, if there are insufficient funds in my account to meet the obligation, I understand that it is my responsibility to ensure that the outstanding amount is paid to Profmed within seven days of default.

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African banks. I also understand that details of each withdrawal will be printed on my bank statement. Such must contain a number, which must be included in the said payment instruction and if provided to me should enable me to identify the withdrawal. This number is displayed on this form in Section D.

B MANDATE

I/We acknowledge that all payment instructions issued by Profmed shall be treated by my/our above-mentioned bank as if the instructions have been issued by me/us personally.

C CANCELLATION

I/We agree that, although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel my membership of Profmed. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force if such amounts were legally owing to Profmed.

D WITHDRAWAL TRANSACTION REFERENCE NUMBER

This reference number is: **PROFMED0001**

Signature of account holder

Date: D D M M Y Y Y Y