MEDICAL NEEDS ANALYSIS CHECKLIST and CLIENT ADVICE RECORD:

1.	Client name:		
2.	Client Contact Number:		
3.	Client Email Address:		
4.	Representative Name:		
5.	Representative Contact number:		
6.	Representative Email Address:		
7.	Are you currently or have you been members of a medical scheme? If so, for how long were you members of that scheme and when did the membership stop?	Y	N

Name of medical scheme:	Duration of membership:	Start and end dates:

8.	How old are you and your dependants?		

Name:	Age:	Relationship:

9.	Which area do you reside in?		

Province:	City:

10.	Is there currently any chronic medication that is being used? If so, for which conditions:	Y	N

Name of patient:	Condition:	Medication Name:

11.	Would you be comfortable with a medical aid option that uses/has:								
Savings	Y	N	Set and separate benefits for out of hospital providers	Y	N	Network Pharmacies	Y	N
Network Hospitals	Y	N	Contributions based on income	Y	N	Network Doctors	Y	N

12.	Are there any specific benefits you require from the medical scheme that cover is required for or are there any procedures planned in the near future that cover is required for?

Patient name:	Procedure / Benefit required	Date of procedure:

13.	Are there any specific benefits you require from the medical scheme that cover is required for?								
GP Consultations	Y	N	Basic Dentistry	Y	N	Specialised Dentistry	Y	N
Optical Benefits	Y	N	Paediatric benefits	Y	N	Maternity Benefits	Y	N
Specialist Consultations	Y	N	Physiotherapy benefits	Y	N	Mental Health Benefits	Y	N
Chronic Medication	Y	N	Acute Medication	Y	N	Over the counter Medication	Y	N
Orthopaedic Benefits	Y	N	Oncology Benefits	Y	N	Casualty benefits	Y	N
Other:								

14.	Other items discussed:					
Benefits of the scheme	Y	N	General Waiting Periods	Y	N
Condition specific waiting periods	Y	N	Late joiner penalty	Y	N
Product exclusions	Y	N	Network Providers	Y	N
Other:					

15.	Summary of advice

Product Recommended	Motivation

16.	General Comments

17.	Client Declaration		
I confirm that I received a letter of introduction in respect of the above Financial Services Provider and/or its representative.		Y	N
All my needs were discussed and that I understand the product and the underlying benefits and restrictions.		Y	N
I confirm that all documentation furnished to me by the provider/representative was completed in full before I signed them.		Y	N
I was given a provisional estimate of the monthly contributions of the recommended product and was fully informed of any and all possible Late Joiner Penalties, Waiting periods and Exclusions that may have an impact on my medical aid membership.		Y	N
Client Name:	Representative Name:		
Client Signature:	Representative Signature:		
Date Signed:	Date Signed:		