HEALTH SQUARED MEDICAL SCHEME

Reference No: 1141

Application forms can be submitted via email to allnewbusiness@agilitydistribution.co.za

MEMBERSHIP APPLICATION FORM

Name & surname

ID number

This application form must be received by Health Squared within one month following the date on which it was signed. Failure to do so will result in this application being null and void. Incomplete application forms will not be accepted.

FOR OFFICE USE ONLY

Member number

Group reference number

Region

Date of commencement

D D M M Y Y Y Y

Applicable option

- ☐ **Cobalt**
- ☐ **Ultimate**
- ☐ **Millennium**
- ☐ **Optimum**
- ☐ **Prosper** — Primary Care Network Y N
- ☐ **Flex** — Primary Care Network Y N
- ☐ **Aspire** — Primary Care Network Y N
- ☐ **Rise**
- ☐ **Foundation (R0 - R8 880)**
- ☐ **Foundation (R8 881 - R15 580)**
- ☐ **Foundation (R15 581 - R18 700)**
- ☐ **Foundation (R18 701 +)**

A. DETAILS OF APPLICANT (Note: Please complete all sections in **BLACK** and attach copy of SA ID document / Passport)

Surname | Title

First name(s) *(in full)* | Initials

ID number | Date of birth (D D M M Y Y Y Y) | Gender **M** **F**

Race: African | Coloured | White | Asian | Indian | Other

Passport number | Income Tax number

Employer name

Occupation full details

Date of employment (D D M M Y Y Y Y) | Language

B. FAMILY MEMBERS TO BE INCLUDED (Note: Please attach copies of SA ID document / Passport:)

1) Dependent children or other members of immediate family in respect of whom the member is liable for care and support

1 Dependent type: Spouse / Partner / Dependent 1

Surname

First name(s) *(in full)*

Initials | Title | Gender **M** **F**

ID number

Passport number

Email

Contact No.

Date of birth (D D M M Y Y Y Y) | Age

Relationship to applicant: Married | Disabled | Full-time student | Child | Grandchild

Is your dependent financially dependent on you? **Y** **N**

Does your dependent earn an income? **Y** **N**

If yes, what is the monthly income?

2 Dependent 2

Surname

First name(s) *(in full)*

Initials | Title | Gender **M** **F**

ID number

Passport number

Email

Contact No.

Date of birth (D D M M Y Y Y Y) | Age

Relationship to applicant: Married | Disabled | Full-time student | Child | Grandchild

Is your dependent financially dependent on you? **Y** **N**

Does your dependent earn an income? **Y** **N**

If yes, what is the monthly income?

3 Dependent type: Spouse / Partner / Dependent 3

Surname

First name(s) *(in full)*

Initials | Title | Gender **M** **F**

ID number

Passport number

Email

Contact No.

Date of birth (D D M M Y Y Y Y) | Age

Relationship to applicant: Married | Disabled | Full-time student

Is your dependent financially dependent on you? **Y** **N**

Does your dependent earn an income? **Y** **N**

If yes, what is the monthly income?

4 Spouse / Partner / Dependent 4

Surname

First name(s) *(in full)*

Initials | Title | Gender **M** **F**

ID number

Passport number

Email

Contact No.

Date of birth (D D M M Y Y Y Y) | Age

Relationship to applicant: Married | Disabled | Full-time student

Is your dependent financially dependent on you? **Y** **N**

Does your dependent earn an income? **Y** **N**

If yes, what is the monthly income?

A child dependent who is self-supporting will have to enrol as a principal member.

C. CONTACT DETAILS

Residential address | Postal address

Code | Code

Telephone (W) | Cell | Alt. Cell

Telephone (H) | Fax

Email address

SMS correspondence **YES** **NO** | Email statement **YES** **NO** | Email newsletter **YES** **NO**

D. DETAILS OF PREVIOUS MEMBERSHIP - APPLICANT

(Should membership certificates not be attached at time of submission, waiting periods and/or late joiner penalty may be imposed)

Name of scheme ____ from D D M M Y Y Y Y to D D M M Y Y Y Y

Name of scheme ____ from D D M M Y Y Y Y to D D M M Y Y Y Y

Proof attached **YES** **NO**

Have you ever been declined, or had late joiner penalties, exclusions or waiting periods imposed by a medical scheme? **YES** **NO**

If yes please provide details: _____

_____

DETAILS OF PREVIOUS MEMBERSHIP - SPOUSE / PARTNER

(Should membership certificates not be attached at time of submission, waiting periods and/or late joiner penalty may be imposed)

Name of scheme ____ from D D M M Y Y Y Y to D D M M Y Y Y Y

Name of scheme ____ from D D M M Y Y Y Y to D D M M Y Y Y Y

Proof attached **YES** **NO**

Have you ever been declined, or had late joiner penalties, exclusions or waiting periods imposed by a medical scheme? **YES** **NO**

If yes please provide details: _____

_____

E. PLAN AND PRODUCT SELECTION (Please indicate with an X where applicable)

Only complete this section if plan selection was not made at employer group level on the Employer Application form or if your employer has allowed you to override the group option selection.

Rise	Flex	Prosper	Aspire	Cobalt	Optimum
	Primary Care Network Y N	Primary Care Network Y N	Primary Care Network Y N	Ultimate	Millennium

☐ Foundation Income category ☐ R0 - R8 880 ☐ R8 881 - R15 580 ☐ R15 581 - R18 700 ☐ R18 701+

Income category on the Foundation option will be based on the income of the spouse/partner if higher than that of principal member. Find attached to my application (please tick the appropriate box):

☐ Latest income tax return ☐ Commission / fee statement (submit 6 months statements)

☐ Latest salary advice ☐ Auditor / accountant's letter ☐ Certified Bank statements for the last 3 months (mandatory)

4.43. "Income", for the purposes of calculating contributions in respect of –

4.43.1. a member who is a Participating Employee – his total cost of employment, from all sources, including all allowances, incentives and emoluments (taxable or not);

4.43.2. an individual Member, including self employed individual Members, the higher of his or her Spouse's or Partner's (if applicable) total gross monthly earnings from all sources, including all allowances, incentives and emoluments (taxable or not);

4.43.3. a continuation Member – his gross monthly pensionable earnings and all income from other sources, including interest earned, (taxable or not);

4.43.4. for Members or dependents earning a commission, in full or in part of his / her total remuneration, the monthly contribution shall then be based on the average monthly income for the twelve (12) months prior to signing the application to be admitted as a Member or dependent. The Scheme, at the sole discretion of the Board of Trustees, reserves the right to call for such proof of income (including, but not limited to, bank statements, tax assessment and commission statements) as may be necessary;

The following documents are mandatory for Pensioner and Partner/Spouse:

- Certified Bank statements for the last 3 months (mandatory)
- Grinrod Bank Statement for the last 3 months (mandatory)
- Pension Fund Statement for the last 3 month (mandatory)
- Signed letter of undertaking (mandatory)
- Latest income tax returns if the member is not registered, a letter from SARS is required.

Should no proof of income be attached, you will be placed in the highest income bracket. Proof of income must be submitted annually before December each year. Members with registered Adult Dependents must complete the Household Income Verification form on page 9 and submit proof of income as per the form's specifications.

REFERENCE & CREDIT BUREAU CONSENT

I/We hereby consent to you or your administrator/s making enquiries to my/our credit records and references with any credit reference agency or any third party to confirm the details provided. I confirm that this consent shall apply in every respect to every director, shareholder, member and/or associate of the applicant. I/We irrevocable authorise **HEALTH SQUARED** or their administrator to obtain from any person any information that **HEALTH SQUARED** requires to assess the information contained in this application.

Signed at _____ on this _____ day of _____ / _____

SIGNATURE

Signature of Applicant

E. PLAN AND PRODUCT SELECTION (Continues)

Requested date of commencement of membership D D M M Y Y Y Y NOTE: SUBJECT TO UNDERWRITING

Did your intermediary supply you with a Membership Guide? **YES** **NO**

If answered "no", please indicate to which address we should post a Member Guide: **Residential** **Postal**

Name of dependent/s' doctor

Practice Number Telephone Date of first consult D D M M Y Y Y Y

Name of dependent/s' doctor

Practice Number Telephone Date of first consult D D M M Y Y Y Y

F. DETAILS OF CURRENT MEDICAL PRACTITIONER

1

2

NOTE: Please ensure that above details are correct and completed in full as this may delay application and authorisation processes.

G. SPECIFIC HEALTH QUESTIONS

State whether you or any of your dependents have, within the 12 month period ending on the date on which application is made, suffered from, been treated or are currently receiving treatment, or expect to receive treatment for any of the following illnesses including, but not limited to:

1. Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia, clotting disorders	**YES**	**NO**
2. Cancer, growths, abscess or tumours of any kind, whether benign or malignant	**YES**	**NO**
3. Cardiovascular (heart and blood vessels) disorders e.g. congenital heart conditions, chest pain, coronary artery disease / ischaemic heart disease, high blood pressure, valvular disease, arrythmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever, shortness of breath, palpitations, angina, deep vein thrombosis, pulmonary embolism, atheorsclerosis lymphatics	**YES**	**NO**
4. Ear, nose and throat disorders e.g. hearing / speech impairment, ear infections, sinus problems, nasal / throat surgery, ear discharge, hoarseness, mouth disorders, tonsils, adenoids, grommets, previous nasal injuries, upper airway infections, cleft lip / palate, epistaxis, hayfever / rhinitis, blocked nose	**YES**	**NO**
5. Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities, sugar in urine, nutritional disorders, metabolic syndrome, hypo / hyperglycaemic coma	**YES**	**NO**
6. Eye related disorders e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts, lens implants, infections, refractive and laser surgery, short or far sightedness, pterygium	**YES**	**NO**
7. Gastro-intestinal disorders e.g. recurrent indigestion, heartburn, reflux, ulcers, bowel disorders, gallbladder disorders, liver disorders and pancreas disorders, hiatus hernia, piles, anal fissures, rectal bleeding, ulcerative colitis or have you or any of your dependents, have a gastroscopy or colonoscopy, spleen disorders, Crohn's disease	**YES**	**NO**
8a. Gynaecological and obstetrical disorders e.g. ectopic pregnancy, caesarean section, fibroids, endometriosis, menstrual irregularities, abnormal papsmear, receiving hormone treatment, vaginal bleeding, laparoscopic surgery, dilatation and curettage, miscarriages pregnancy related problems, cysts, infertility, breast disorders	**YES**	**NO**
8b. Pregnancy - expected date of delivery D D M M Y Y Y Y	**YES**	**NO**
9. Male genitourinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system	**YES**	**NO**
10. Musculoskeletal disorders e.g. osteo-arthritis, rheumatoid arthritis, back problems, gout, osteoporosis, all joint problems e.g. knee, shoulder, bones, limbs, spine, fractures, carpel tunnel syndrome, bunion, spondylosis, hernia, kyphosis / scoliosis	**YES**	**NO**
11. Neurological disorders e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue, headache, migraine, polio, paralysis, Guillian-Barre, meningitis, Parkinson's disease, Alzheimer disease, dementia	**YES**	**NO**
12. Psychological disorders e.g. insomnia, anxiety, depression, stress, panic attacks, attention deficit disorder, post-traumatic stress, schizophrenia, bi-polar disorders, mood swings, attempted suicide, anorexia / bulimia nervosa	**YES**	**NO**
13. Renal (kidney) disorders e.g. blood in the urine, urinary tract stones, recurrent infections, kidney failure, bladder problems, dialysis, Addisons disease, nephritis	**YES**	**NO**
14. Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema, tuberculosis, persistent cough, allergies, chronic obstructive pulmonary disease, pneumoconiosis	**YES**	**NO**
15. Skin disorders e.g. eczema, psoriasis, melanoma, skin cancer, burns, acne, scars, keloids, growths, warts, ingrown toe nails	**YES**	**NO**
16. State whether you or any of your dependents, have received medical advice or treatment for any infectious and tropical disease e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitis, bilharzia, malaria, cholera	**YES**	**NO**
17. Do you or any of your dependents have any birth defects or hereditary disorders?	**YES**	**NO**

18. Have you or any of your dependents sought counselling or treatment for HIV or AIDS related infections or ever tested positive for HIV or AIDS?	**YES**	**NO**
19. Have you or any of your dependents been diagnosed and / or treated for an immune system problem?	**YES**	**NO**
20. Previous injuries and trauma including sports injuries?	**YES**	**NO**
21. Have you required rehabilitation following an event i.e. stroke or motor vehicle accident?	**YES**	**NO**

If "yes" answered to any of the questions above, please supply full details below

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current condition

If the space provided is insufficient please complete *addendum A*.

Addendum attached | **YES** | **NO**

SURGERY AND HOSPITAL ADMISSIONS

1. Please supply details of all surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependents have undergone in the past, and/or details of all planned surgical procedure(s) and ALL HOSPITAL ADMISSIONS that you or any of your dependents expect to undergo in the future.

Applicant	Surgical procedure / Hospital admission	Date	Reason	Doctor	Current condition

CHRONIC MEDICATION

1. Please supply details of any chronic medication (prescribed medicines used continuously for more than 3(three) months) currently prescribed for you or any of your dependents.
2. Do you or any of your dependents expect chronic medication to be prescribed in the next 12 months? **YES** | **NO**

   If so please supply details below.

Applicant	Prescribed medication	Medical condition	Date started / to be started

H. GENERAL HEALTH QUESTIONS

1.	Do you or any of your dependents expect to receive any treatment in the next 12 months and do you or your dependents expect to be, or are currently, hospitalised?	**YES**	**NO**
2.	Has any close blood relative (excluding dependents named in this application form) ever been diagnosed with heart disease, high blood pressure, high cholesterol, diabetes or any other hereditary disease?	**YES**	**NO**
3.	Do you or any of your dependents have incomplete dental treatment plans, dental implants, orthodontic treatment, dentures, wisdom teeth problems or do you or currently receive, or expect to receive, dental treatment in the next 12 months?	**YES**	**NO**
4.	Are you or any of your dependents currently involved in any third party or WCA claim that may include medical treatment? If so please provide below FULL details of injuries, surgery and investigative procedures for which claims will be, or have been, lodged.	**YES**	**NO**
5.	Investigations and / or specialised treatment (in and out of hospital)		
	a . Are you or any of your dependents currently undergoing, or expect to undergo investigations for any medical condition and / or symptoms not yet diagnosed?	**YES**	**NO**
	b. Are you or any of your dependents currently receiving or expect to receive specialised treatment (i.e. chemotherapy, radiotherapy, bone marrow transplant, mechanical ventilation, oxygen therapy, dialysis, psychotherapy or counselling)?	**YES**	**NO**
6.	In the past 12 months, have you or any of your dependents have any x-rays, electrocardiogram or other examinations, including genetic testing or tumour markers, operations or hospitalisations?	**YES**	**NO**

If yes answered to any of the questions above, please supply full details below.

Question	Applicant	Full details (including details of disorder, date diagnosed, nature and duration of treatment and consulting doctor's details)

If the space provided is insufficient, please complete *addendum A*.

HEIGHT AND WEIGHT

Applicant	Initials	Height cm	Weight kg
Spouse / Partner / Dependent 1	Initials	Height cm	Weight kg
Dependent 2	Initials	Height cm	Weight kg
Dependent 3	Initials	Height cm	Weight kg
Dependent 4	Initials	Height cm	Weight kg

N. B. Any misrepresentation or non-disclosure of medical material or factual information will render all benefits granted by the Scheme null and void. In addition, any payment made due to such actions will be recovered from the member by the Scheme.

I. PAYMENT METHOD

Payment Method	Debit order	Persal	Via employer	EFT
Billing Method	Advance	Arrears		

J. CONTRIBUTION COLLECTION DETAILS

HEALTH SQUARED ("the Scheme") is hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted, and similarly I authorise my bank to debit my account with amounts drawn against it by the Scheme.

I understand that the withdrawals hereby authorised will be processed by computer through a system known as ABSA / Debit Order / Multidata and I also understand that the details of each withdrawal will be printed on my bank statement or on an accompanying voucher.

I agree to pay any bank charges relating to this, ABSA / Debit Order / Multidata, instruction.

The authority may be cancelled by myself giving the Scheme / Agility Health (Pty) Ltd one calendar month notice in writing by the principal member, but I understand that I shall not be entitled to any refund of amounts which the Scheme has withdrawn while this authority was in force if such amounts were legally owning to the Scheme. Receipt of this instruction by the Scheme / Agility Health (Pty) Ltd shall be regarded as receipt thereof by my bank.

I further agree to advise the Scheme / Agility Health (Pty) Ltd in writing of any changes which may occur.

Signature of Account Holder SIGNATURE

K. BANKING DETAILS

Claim refunds can only be paid by direct credit to your bank account. All claims will be reimbursed at Scheme rate, unless otherwise indicated.

	Debit Order	**Claim Reimbursements**
Name of bank		
Account type	Cheque Transmission Savings	Cheque Transmission Savings
Name of account holder		
Account number		
Branch		
	Monthly debit order 1st 5th 6th	

L. MEMBER ACKNOWLEDGEMENT AND DECLARATION

General

1. *I, the undersigned applicant:*

1.1 Hereby apply for myself and my dependents to be registered on the **HEALTH SQUARED** ("the Scheme") and agree to abide by and undertake to familiarise myself with the Rules of the Scheme;

1.2 Warrant that the contents of this application and any other documents which may be required in support thereof are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and, should there be any change in the state of health or change in personal status by myself or any of my dependents from the date of signing this application form and the date of inception of the membership, notification of such change will be provided to the Scheme immediately upon occurrence of the change, in writing with full details of such condition / ailment as soon as I become aware of the circumstances. Such notification is to include all available medical reports relating to any health conditions in order to enable the Scheme to investigate the circumstances causing and/or contributing to such change;

1.3 Understand that the statement and answers provided form the basis of the contracts and any breach of my warranty or non disclosure of any information material to the assessment of this application shall render any contracts to which this application relates null and void and all contributions paid shall be forfeited;

1.4 Understand and accept that no benefit will be payable by the Scheme unless they are satisfied as to the validity of a claim and have received all requirements which they may deem necessary, including the result of such medical examinations and tests that they may require me or my dependents to undertake;

1.5 Consent to the Scheme addressing any requests for information, tests or examinations directly to any dependents of mine over the age of 18, with the same legal consequences as if the request had been addressed to me in my capacity as a member;

1.6 Acknowledge that it is my responsibility as a member to ensure that claims are submitted within the 4 month submission period (Rule 15.2).

1.7 Acknowledge that it is my responsibility as a member to ensure that the monthly contribution is received by the Scheme in terms of the rules of the Scheme;

1.8 Acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any contribution is not paid on the due date; and

1.9 Undertake to inform the Scheme within One (1) calendar month should the situation regarding the dependency of any of my dependents change (Rule 7.2.1).

1.10 Am familiar with and have full knowledge of the irrefutable conditions and benefits of the option elected, notwithstanding misrepresentation by any other party;

1.11 That neither myself nor my dependents are dependents of another medical scheme;

1.12 Hereby consent to all conversations between myself, the Scheme or any party being recorded;

1.13 Understand, acknowledge and accept that I may be contacted by the Scheme's panel of attorneys in order to verify the possibility of claims being recovered from third parties. I understand that I will not be liable for any costs herein and that any costs are deductable from the successful proceeds of any action.

1.14 Understand that by recovering from third parties I will contribute to the overall financial sustainability of the Scheme.

Authority

2. Accepting that I am curtailing my and my dependents right to privacy, but in order to facilitate the assessment of the risk and the consideration of any claim, I irrevocably authorise:

2.1 The Scheme / Panel of attorneys, whom I hereby so authorise and direct to give, any information which the Scheme deems necessary.

2.2 I further authorise and instruct the Scheme and any hospital concerned to give any information relating to myself and my dependents to the Medical Case Managers and/or Managed Care Organisation and their personnel appointed by the Scheme, for the purposes of ensuring that the members of the Scheme receive appropriate and necessary medical services while reducing inappropriate care and wastage of medical resources. I also consent to the processing of the information herein for purposes of marketing of value added or similar products and services.

2.3 I understand and accept that the above authorisation constitutes a partial waiver of my and my dependents right to privacy.

3. *declare that:*

3.1 I am liable for his/her family care.

3.2 Dependent children or other members of immediate family in respect of whom the member is liable for care and support.

3.3 My dependent(s) is/are not in receipt of remuneration.

3.4 My dependent(s) is/are not a member(s) or dependent(s) of another medical scheme.

4.4 By their signature hereto any of my dependents who have reached or are over the age of 18 declare themselves bound to the above terms

Termination

4. On termination of my membership of the Scheme:

4.1 One (1) calendar month written notice (Rule 12.2.1)

Signed at _____ on this _____ day of _____ / 2021

SIGNATURE

Signature of Applicant

M. INTERMEDIARY DECLARATION

1. *I, the undersigned hereby confirm that:*

1.1 The appointed intermediary is accredited at date of signing the application form

1.2 The appointed intermediary is licensed by the FSB in terms of the FAIS Act

1.3 The appointed intermediary has made his / her name, physical, postal address and contact number available

1.4 I am aware of commission payable by the Scheme on this transaction to the appointed intermediary

1.5 The appointed intermediary is contractually bound to the Scheme

1.6 There has been no material misrepresentation of facts by the appointed intermediary and that, in such an event, the appointed intermediary undertakes to refund all monies paid to the Scheme

1.7 I have been given all the relevant information with regards to the application information to the appointed intermediary

1.8 The advice given to me by the appointed intermediary was in my best interest and unprejudiced

N. INTERMEDIARY DETAILS

Name of Brokerage: Key West Brokers

Brokerage code: 128800

Address: 281 Jorrissen Street Monument

Krugersdorp

Code: 1739

Consultant / Agent sub-code:

Full name of consultant / agent: CHADU PLESSIS

Telephone number: 0119536053

Email address: CHRIS@KEYWESTBROKERS.CO.ZA

Fax number: 0865246551

SIGNATURE

Signature of Broker

SIGNATURE

Signature of Consultant

SIGNATURE

Signature of Applicant

O. SCHEME DECLARATION

1. *We hereby confirm that:*

1.1 The applicant and his / her dependent's personal and medical information (obtained from healthcare providers with applicant's consent) will be kept confidential

1.2 Both personal and medical information obtained will not be used or sold commercially

1.3 Data security measures are in place

1.4 Staff of **HEALTH SQUARED** as well as its contracted third parties are bound by confidentiality agreements

1.5 The Scheme and its contracted third parties use application information for the processing of the application, re-imbursement of claims to determine benefits and access levels of care in respect of managed healthcare principles

1.6 The Scheme's contractual agreements ensure the confidentiality of data management, Scheme administration and managed health care agreements

1.7 Should the Scheme assume responsibility for breach in confidentiality, the management thereof will be in accordance to Scheme rules and protocols

Signed at _____ on this _____ day of _____ / _____

SIGNATURE

Signature on behalf of Scheme

WHAT TO EXPECT WITH YOUR APPLICATION:

Upon receipt of the application:

1. We capture and check your details
2. If any details are missing, you will be contacted in writing or telephonically
3. We will advise you or your intermediary in writing, SMS or via an E-mail to inform you of your acceptance to join Health Squared

This correspondence may contain certain conditions:

1. You sign these terms of acceptance to confirm that you accept any waiting period/s or late joiner penalties (if we apply any) and return it to us
2. You will receive a membership pack in the post
3. This will contain details about your plan selection to get you started

If you do not hear from us within 7 (seven) working days after submission, please contact your financial advisor or call us on 0861 796 6400.

HEALTH SQUARED MEDICAL SCHEME

Reference No: 1141

HOUSEHOLD INCOME VERIFICATION - FOUNDATION MEMBERS

Name & Surname

ID Number

Telephone / Cell No:

Important: We cannot process your application form if you have not attached the correct documentation for us to verify your household income (Please indicate with an "X" where applicable). Please note that the income verification process is required to be updated yearly.

1. Working full-time: Number of persons in household

1.1 Certified personal Bank statements for the last 3 months (mandatory); **and**	
1.2. Salary advice for the last 3 months; or	
1.3. Letter from Employer, on a company letterhead or stamped with a company stamp, stating gross monthly income; or	
1.4. Letter of appointment *(when start date is not older than 30 days)*	

2. Studying full-time: Number of persons in household

2.1 Certified personal Bank statements for the last 3 months (mandatory); **and**	
2.2. Official proof of enrolment or registration showing that the dependent is studying full time (no student cards, statements, invoices or acceptance letters).	

3. Self-employed: Number of persons in household

3.1 Certified personal Bank statements for the last 3 months (mandatory); **and**	
3.2. Audited financial statements (not older than 12 months); or	
3.3. Latest income tax return; or	
3.4. Letter from accountant or auditor confirming the member's gross monthly income	

4. Unemployed: Number of persons in household

4.1 Certified personal Bank statements for the last 3 months (mandatory); **and**	
4.2. Latest proof of unemployment, retrenchment; or	
4.3. Latest income tax return (if the member is not registered, a letter from SARS is required)	

5. Disabled: Number of persons in household

5.1 Certified personal Bank statements for the last 3 months (mandatory); **and**	
5.2. A certificate from the Physician to prove disability must be attached; or	
5.3. Proof of disability grant; or	
5.4. Affidavit as per the prescribed form; or	
5.5 Official proof from SARS in the form of the ITR-DD form	

6. Pensioners: Number of persons in household

6.1. Grinrod Bank Statement of the last 3 months; or	
6.2. Pension Fund Statement of the last 3 months; **and**	
6.3 Latest income tax return (if the member is not registered, a letter from SARS is required); **and**	
6.4 Certified Bank statements for the last 3 months **(mandatory)**	

REFERENCE & CREDIT BUREAU CONSENT

I / We hereby consent to you or your administrator/s making enquiries to my/our credit records and references with any credit reference agency or any third party to confirm the details provided. I confirm that this consent shall apply in every respect to every director, shareholder, member and/or associate of the applicant. I / We irrevocable authorise **HEALTH SQUARED** or their administrator to obtain from any person any information that **HEALTH SQUARED** requires to assess the information contained in this application.

Income category on the Foundation option will be based on the income of the spouse/partner if higher than that of the principal member. Proof of income on the Foundation option needs to be submitted on an annual basis and failure to do so will result in premiums defaulting to the highest income category. The main member is responsible for the submission of the proof of income documents to the Scheme.

Signed at _____ on this _____ day of _____ / 2021

SIGNATURE

Signature of Applicant

Addendum A

G. SPECIFIC HEALTH QUESTIONS

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current Condition

G. GENERAL HEALTH QUESTIONS

Question	Applicant	Date	Disorder	Treatment	Consulting Doctor	Current Condition