Pick n Pay
Medical scheme

Main member application form

(To be sent to your wages/salary department)

PLEASE NOTE: If any of the information is missing, this application cannot be processed.

IMPORTANT POINTS:

- Fill in your details correctly and completely.
- Choose the correct option.
- Complete your and your dependants' medical history.
- Sign and date the form.
- Remember to include your dependants' identity numbers.
- Return this form to your wages/salary department.

PLEASE COMPLETE IN BLOCK LETTERS.

Section A: Main member details

Employee number

Employer start date (DD/MM/YYYY)

Cost code (first six digits)

Join medical scheme from (DD/MM/YYYY)

Tax reference number

Title Initials Gender ☐ Male ☐ Female

Surname

First names

ID/Passport number (certified copy of ID/passport must be attached)

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other

☐ Do not wish to disclose

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

Contact numbers Work

Home

Cell phone

Home address

Postal code

Email address

Section B: Option selection – only one box may be ticked

☐ **Plus Option**

☐ **Primary Option**

Section C: Dependants on your membership card – details and documents required

Please complete the contact number, postal address and email address fields of your spouse/dependant that is 18 years or older.

Spouse

Title | Initials | Gender ☐ Male ☐ Female

Surname

First names

ID/Passport number

Date of birth (DD/MM/YYYY)

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

Relationship to applicant (e.g. wife)

Contact number

Postal address

Postal code

Email address

Dependant 1

Title | Initials | Gender ☐ Male ☐ Female

Surname

First names

ID/Passport number

Date of birth (DD/MM/YYYY)

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

Relationship to applicant (e.g. son)

Contact number

Postal address

Postal code

Email address

Dependant 2

Title | Initials | Gender ☐ Male ☐ Female

Surname

First names

ID/Passport number

Date of birth (DD/MM/YYYY)

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

Relationship to applicant (e.g. son)

Contact number

Postal address

Postal code

Email address

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

Section C: Dependants on your membership card – details and documents required (continued)

Dependant 3

Title | Initials | Gender ☐ Male ☐ Female

Surname

First names

ID/Passport number

Date of birth (DD/MM/YYYY)

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

Relationship to applicant (e.g. son)

Contact number

Postal address

Postal code

Email address

Dependant 4

Title | Initials | Gender ☐ Male ☐ Female

Surname

First names

ID/Passport number

Date of birth (DD/MM/YYYY)

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

Relationship to applicant (e.g. son)

Contact number

Postal address

Postal code

Email address

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

Notes:

1. For any dependant you must attach a certified copy of his/her identity document before he/she can be added to your medical scheme.
2. Waiting periods may apply for any new applications – please check the rules of the Scheme.
3. Late joiner penalties may be applied – please provide proof of membership of previous medical schemes if you want to avoid these penalties. (See Section E on page 4)
4. For financial dependants an affidavit must be attached indicating that the dependant is financially dependent on you.
5. To add a spouse as a dependant, the dependant must be married to the main member or an affidavit must be attached that indicates the permanence of the relationship, e.g. marriage under customary law/partner/common-law spouse.
6. To pay the child dependant rate, the child must be under 21 years old.

   Exceptions are: (i) students at accredited learning institutions – proof of this must be attached; or
   (ii) dependants who are mentally and/or physically disabled – medical report must be attached.

   These dependants may remain on the Scheme over the age of 25, but will be charged the full adult dependant contribution rate.

Section D: Calculation of your monthly contribution and company subsidy

Member type	No.	Core benefits	Late joiner penalties	Salary group (A-G)		Company contributions **(only applicable to salary bands E – G)**
Main member	1	*			*	
Spouse		*			*	
Child dependants		*			*	
Financial dependants (over 74 years n/a)						n/a
Total deductions		+		=		

PLEASE NOTE: Only job grades E – G qualify for a company subsidy. Employees in grades A – D will have the company contribution factored into the total cost to company.

Section E: Previous medical scheme membership details (for new members)

Name of medical scheme

Period of membership from (DD/MM/YYYY) to (DD/MM/YYYY)

Name of medical scheme

Period of membership from (DD/MM/YYYY) to (DD/MM/YYYY)

Certificates of membership of previous medical schemes are required stating the period of membership and any waiting periods or late joiner penalties.

Section F: Banking account details for medical claims refunds

Name of bank

Branch name

Branch code

Account number

Type of account ☐ Savings ☐ Current ☐ Transmission

Section G: State of health and general information

Have you or your dependants received diagnosis, treatment or care for any of the following in the last 12 months? Please answer questions by writing **'YES'** or **'NO'**, depending on your circumstances, in the spaces provided.

PLEASE NOTE: HIV/AIDS status should not be disclosed on this form. To enrol on the confidential HIV/AIDS management programme, please call the toll-free line on 0860 767 633 – option 5.

1. Any disorder of the heart, e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?
2. High blood pressure or disease of the blood vessels or circulatory disorder, e.g. cramps during exercise, stroke, high cholesterol or hardening of the arteries?
3. Any respiratory or lung disease, e.g. asthma, bronchitis, persistent cough or tuberculosis?
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?
5. Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis, venereal disease or impotence?
6. Any nervous or mental complaint, e.g. epilepsy, blackouts, anxiety state or depression?

Section G: State of health and general information (continued)

Please answer questions by writing **'YES'** or **'NO'**, depending on your circumstances, in the spaces provided.

7. Any type of nerve ailments, e.g. loss of sensation, numbness or paralysis?
8. Ear, nose or throat disorder, e.g. ear discharge, defective vision, deafness or hoarseness?
9. Disorder or disease of skin, muscles, bones, joints, limbs or spine, e.g. psoriasis, arthritis, gout, slipped disc or other back trouble?
10. Diabetes, hormonal imbalance, glandular or metabolic disease, thyroid or blood disorders?
11. Cancer, growth or tumour of any kind?
12. Any other illness, disorder, operation or accident, e.g. fractured nose, breathing disorders, mammary hypertrophy (enlarged breasts with associated side effects) or congenital abnormalities?
13. Are you or your dependants currently undergoing or expecting to undergo any medical, dental or surgical treatment?
14. Have any exclusions been imposed by any medical scheme on which your dependants have been registered?
15. Are any of your dependants pregnant?

    If **'YES'**, please state the expected date of confinement: _____ (DD/MM/YYYY)

If your answer was 'YES' to any of the questions on pages 4 and 5, please provide full particulars in the space below. If the space is insufficient, provide particulars in the form of attachments.

Question number	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

Section H: Shortfalls or above-tariff portions of claims payable from accumulated Medical Spending Account (MSA)

Do you want shortfalls or above-tariff portions of claims to be paid from your accumulated MSA? ☐ Yes ☐ No

Section I: Direct marketing

I NAME AND SURNAME OF MEMBER

hereby give my consent to PICK N PAY MEDICAL SCHEME's Administrator for me to receive direct marketing of complementary products and services offered by Momentum Metropolitan Holdings Limited and its subsidiaries by means of electronic communication.

☐ **Tick here if you do not wish to receive any direct marketing.**

Section J: Declaration by the applicant

We request your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of PICK N PAY MEDICAL SCHEME. PICK N PAY MEDICAL SCHEME and its Administrator, Momentum Health Solutions, a division of Momentum Metropolitan Holdings, will keep your personal information confidential and will adhere to 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.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, the PICK N PAY MEDICAL SCHEME can unfortunately not process your application for membership. Please read the statements below and sign your acceptance thereof.

1. I authorise and give consent to PICK N PAY MEDICAL SCHEME and the Administrator to collect, store, collate, process, share and further process my personal information, including my health information and that of my dependants, for purposes of my PICK N PAY MEDICAL SCHEME membership risk profiling and management, administration of my membership and as set out in this section.

2. I authorise and give consent to PICK N PAY MEDICAL SCHEME and its Administrator to share my personal information, including health information, and that of my dependants, with any entity (including an entity forming part of Momentum Metropolitan Holdings and its subsidiaries) with whom I and/or my dependants have a contractual relationship or have applied to for a product or service. This personal information will be processed and/or used for further processing in order to administer the products or services.

3. If I have consented to the disclosure of my personal information, PICK N PAY MEDICAL SCHEME or the Administrator may provide my 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 PICK N PAY MEDICAL SCHEME or the Administrator that requires them to do so.

4. I acknowledge that I must give PICK N PAY MEDICAL SCHEME and the Administrator all information and evidence they may require from time to time. I authorise PICK N PAY MEDICAL SCHEME and the Administrator to obtain from any person, including any medical doctor or other healthcare provider who has attended to me or my dependants in the past, or who will attend to me or my dependants in the future, any information PICK N PAY MEDICAL SCHEME may require concerning me or any of my dependants in assessing any risk or claim in relation to this application, my membership of PICK N PAY MEDICAL SCHEME and risk profiling or management. I consent to that person providing, and instruct that person to provide, PICK N PAY MEDICAL SCHEME and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.

5. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.

6. I have the right to object, on reasonable grounds relating to my particular situation, to the processing of my personal information, unless processing is required by law.

7. I have the right to request my personal information that is in the possession of PICK N PAY MEDICAL SCHEME and the Administrator, provided that I furnish adequate identification.

8. I have the right to request PICK N PAY MEDICAL SCHEME and the Administrator, where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.

Section J: Declaration by the applicant (continued)

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

10. My personal information will be shared between PICK N PAY MEDICAL SCHEME, the Administrator and contracted third parties, both locally and outside the Republic of South Africa, who require this information for purposes related to my membership of PICK N PAY MEDICAL SCHEME, and:
    - to grant me access to interact with PICK N PAY MEDICAL SCHEME on its website; and
    - to provide any credit bureau or registered credit provider with my credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).

11. Consent is given with the clear understanding that the designated service providers and/or contracted third parties will be bound by the same confidentiality agreement that exists between the Scheme and its Administrator and/or managed care providers, as well as their employees.

12. I confirm that my dependants have provided me with the appropriate permission to disclose their personal and clinical information to the PICK N PAY MEDICAL SCHEME for the purposes set out above and any other related purposes.

13. Penalties and waiting periods may apply to late joiners.

I hereby make application to be admitted as a member and agree to abide by the rules of the Scheme.

I hereby authorise my employer to deduct the monthly contribution and any other amounts due to the Scheme (including member's portions) from my salary/wage and to pay such amounts to the Scheme on my behalf and that all refunds will be paid into my bank account as specified on the payroll programme and I accept that on resignation, all refunds due to me will be paid by electronic transfer from the Scheme.

PICK N PAY MEDICAL SCHEME has the right to take such steps as it deems necessary to recover any amounts owing to the Scheme after my resignation. This may include, but is not limited to handing my account over to a debt collection agency, who will take further action. It is understood that this debt collection agency will be bound by the same confidentiality agreement as stipulated in clause 6 above.

I accept that should I be joining the Scheme voluntarily as an existing employee (neither a new employee, nor someone coming on from a spouse's medical scheme), I or my dependants will be exposed to a general waiting period of three months. For any pre-existing conditions within the last 12 months, a waiting period of 12 months may be applied.
I accept the above clauses regarding the exchange of confidential information.

I hereby declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement will render my membership null and void.

Signature of applicant

Date DD/MM/YYYY

Section K: Declaration by the salary/wage officer and stamp

This employee's medical scheme membership application has been scrutinised by me and I am not aware of any facts other than those stated that should be made known to the Scheme.

Checked by:

HR/salary/wage officer	PLEASE PRINT NAME	
Signature		
Date	DD/MM/YYYY	Billing code stamp

10/2023