

D. DEPENDANT INFORMATION

For relationship, please state husband, wife, partner, son, daughter or other. Please include copy of passport or ID document for each dependant.

Title Surname First name(s) Relationship to applicant Identity/Passport no. Date of birth/Gender	<div style="display: flex; justify-content: space-between;"> <input type="text"/> Initials <input type="text"/> </div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y M F	1	<div style="display: flex; justify-content: space-between;"> <input type="text"/> Initials <input type="text"/> </div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y M F	2
Title Surname First name(s) Relationship to applicant Identity/Passport no. Date of birth/Gender	<div style="display: flex; justify-content: space-between;"> <input type="text"/> Initials <input type="text"/> </div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y M F	3	<div style="display: flex; justify-content: space-between;"> <input type="text"/> Initials <input type="text"/> </div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y M F	4
Title Surname First name(s) Relationship to applicant Identity/Passport no. Date of birth/Gender	<div style="display: flex; justify-content: space-between;"> <input type="text"/> Initials <input type="text"/> </div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y M F	5	<div style="display: flex; justify-content: space-between;"> <input type="text"/> Initials <input type="text"/> </div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y M F	6

E. PREVIOUS MEDICAL SCHEME MEMBERSHIP

Please complete the following table of prior Medical Scheme membership.

Name of Main Member and Dependants	Name of Scheme	Membership Numbers	Join Date	End Date

Insufficient prior membership may lead to the imposition of Late Joiner Penalties.

F. MEDICAL HISTORY

To be completed by the Applicant in person in respect of himself/herself and all nominated dependants. It is important to note that if you do not provide full and complete answers your membership of the Scheme may be declared null and void. Please answer every question by ticking "yes" or "no".

Have you, your spouse, or any of your dependants experienced any of the following in the past 10 years?

- | | | |
|---|----------------------------|----------------------------|
| 1. High Cholesterol, stroke, high blood pressure, heart murmur, angina, heart attack, or any other cardiac or blood disorder? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Nephritis, kidney stone, congenital kidney disorders or any other urinary or related kidney disorder? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis, croup, or any other disorders/conditions of the ear, nose or throat including recurrent sore throat and/or tonsillitis? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Conditions of the joints or spine, including rheumatism, arthritis, neck or back disorders or any physical disability? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Diabetes, sugar in the blood or urine, glandular disorder, or any related endocrine disorder? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

F. MEDICAL HISTORY (CONTINUED)

6. Any lumps, growths, benign or malignant, or types of cancers, including Hodgkin's disease and leukaemia, skin cancer, etc. Y N
7. Epilepsy, migraine or any other neurological disorder? Y N
8. Ulcers, hiatus hernia, gall bladder or liver disorders or any other digestive system disorder? Y N
9. Any dental, chiropractic, optical or gynaecological treatment, advice, consultations, tests or hospitalisation? Y N
10. Advice, counselling, treatment or therapy for alcoholism, drug dependence, mental or emotional disorders? Y N
11. Medical advice, counselling or treatment in connection with HIV/AIDS or any sexually transmitted disease, e.g. hepatitis B, gonorrhoea or syphilis? Y N
12. Has any of your close relatives ever suffered from porphyria, cancer, mental illness, diabetes, stroke, chest pain, raised cholesterol, heart disorder or any other hereditary disease? Y N
13. Are you or any of your dependants pregnant? If so, what is the expected date of delivery? Y N
14. For other than routine treatment, do you, your spouse or any of your dependants expect to seek medical advice or treatment in the next 6 months? Y N
15. The above questions are prompts and are not exhaustive. Should you or any of your nominated dependants have any condition or symptom which is not directly covered in these questions, you are nonetheless obligated to disclose it. Are you aware of any such conditions? Y N

If you answered "YES" to any questions above, please supply full details below.

If the space provided is not sufficient, please attach additional information to this application.

Question no.	Name of Patient	Diagnosis	Date First Diagnosed	Currently on treatment for this condition		Date of last consultation, hospitalisation or medication taken for this disorder	Treating practitioner's name and telephone number
				YES	NO		
				<input type="checkbox"/> Y	<input type="checkbox"/> N		
				<input type="checkbox"/> Y	<input type="checkbox"/> N		
				<input type="checkbox"/> Y	<input type="checkbox"/> N		
				<input type="checkbox"/> Y	<input type="checkbox"/> N		
				<input type="checkbox"/> Y	<input type="checkbox"/> N		
				<input type="checkbox"/> Y	<input type="checkbox"/> N		

G. ADDITIONAL HEALTH INFORMATION

Did you or any of your nominated dependants seek any medical advice or take any medication or receive any medical treatment or advice for any of the conditions disclosed above during the past 12 months? If "YES" then please provide full details below:

Name of patient	Medical Condition	Date of diagnosis	Date of last treatment	Name/s of medication/treatment and average monthly cost

H. DEBIT ORDER AUTHORISATION

Name of bank

Type of Account Cheque Savings Transmission Other (confirm) _____

Branch Branch code

Name of account holder

Account number Month of first deduction

Signature of account holder

H. DEBIT ORDER AUTHORISATION (CONTINUED)

I, by virtue of my signature that appears above, hereby authorise and request GENESIS MEDICAL SCHEME ("Genesis") to draw against my account (wherever it may be conducted) in accordance with its Debit Order System which is operated in conjunction with the Banks/Building Societies and I authorise the Bank/Building Society (whichever is applicable) to pay and debit my account with all such debts as if each one had been signed by me personally. This request applies to all amounts that may be due by me to Genesis in terms of the Rules of Genesis. I understand that either I or Genesis can terminate this request by written notification to the other party at any time, but that the termination will have no effect on withdrawals already made by the Bank/Building Society and credited to Genesis. I further understand and undertake that Genesis will receive all payments, in terms of this request, without prejudice to its rights. Should the Bank/Building Society for any reason reclaim from Genesis any amounts paid in terms of this request, I undertake to refund such amounts to Genesis immediately upon demand. I personally undertake to advise Genesis of any changes which occur in the Bank/Building Society information shown above. I understand further that the effective lodgement date for all debit orders will be the first business day of each month.

I. CLAIM REIMBURSEMENT DETAILS

Are your bank details for your debit order deduction and the account for claim payments the same? Y N

If "NO", please complete the following section:

Name of bank	<input type="text"/>																												
Type of Account	<input type="checkbox"/> Cheque	<input type="checkbox"/> Savings	<input type="checkbox"/> Transmission	<input type="checkbox"/> Other (confirm) _____																									
Branch	<input type="text"/>														Branch code	<input type="text"/>													
Name of account holder	<input type="text"/>																												
Account number	<input type="text"/>														<input type="text"/>														
														Signature of account holder															

J. APPLICANT'S DECLARATION (MUST BE SIGNED BY THE APPLICANT PERSONALLY)

I, the undersigned, hereby make application to be admitted as a member of the Genesis Medical Scheme ("Genesis" or "the Scheme") and if admitted, I agree to abide by the Rules of the Scheme. I declare that my answers and the information supplied by me in this application, whether in my own handwriting or not, are true, correct and complete in every respect. I understand that should this Application contain any false statement or fail to disclose any material information, the Board of Trustees of Genesis ("the Board") may, at its sole and absolute discretion, elect to regard my membership of Genesis as void ab initio. I understand that the consequence of this election on the part of the Board will be that I will be obliged to immediately repay to the Scheme all benefits received by or on behalf of me and that all or part of the contributions paid by me to the Scheme may be retained by the Scheme to offset any costs which the Scheme has incurred on my behalf. I understand that a further consequence of the election will be that the Rules of Genesis will be of no application to me and I will have no right of recourse against the Scheme in terms of its Rules.

I undertake to give notice to the Scheme of my intention to terminate my membership in accordance with the Rules of the Scheme. I understand that confirmation of acceptance of membership is subject to the approval by the Management of the Scheme.

I hereby authorise my employer, where appropriate, to deduct from my salary each month the specified contributions and other indebtedness to the Scheme. I understand that I am nevertheless responsible for any contributions due to the Scheme.

I irrevocably authorise my doctor or any other person, who may be in possession of any information concerning my health or that of any of my nominated dependants to disclose, even after my or their death, such information to the Scheme.

I undertake to advise the Scheme of any change in my state of health or that of my dependants which occurs prior to my receiving written acceptance of this application. I also agree that any amounts due by me may be set off against any amount due to me by the Scheme. I authorise Genesis and/or its administrator (collectively "Genesis") to accept facsimile documents from me and to act according to instructions conveyed to Genesis by means of facsimile message.

I confirm that I am familiar with the conditions and benefits of the benefit option chosen.

Notwithstanding representation by any other party, I understand that my benefits and contributions are those contained in the Rules of the Scheme, as amended from time to time.

Signed at on the day of year

Signature of applicant

K. INTERMEDIARY DETAILS

Introducers name Genesis Broker code

I confirm that the Applicant has personally completed this Application Form, and has fully understood the choice made.

Intermediary Signature Accreditation number Date

L. DECLARATION BY TRUSTEE/PRINCIPAL OFFICER

I hereby confirm that this Application for Membership has been accepted subject to the terms and conditions imposed by Genesis Medical Scheme and accepted by the Applicant. This is to certify that the member's contribution is in accordance with the Rules of the Scheme amended from time to time and with the tariff approved by the Registrar of Medical Schemes.

Notes _____

Signature _____

Date

ADDENDUM TO APPLICATION FORM

1. I, _____ the undersigned, (identity number _____), do hereby confirm that I am in the process of making application to become a member to Genesis Medical Scheme (the "**Scheme**"), by, inter alia, completing an application form(s) (the "**Application Form**") as required by the Scheme (the "**Application**").

2. I agree that this addendum to the Application Form (this "**Addendum**") will be deemed to form part of the Application Form for all intents and purposes and that the terms of, and acknowledgements in, this Addendum will be binding on me in the same manner as the terms of, and acknowledgements in, the Application Form. The Application Form and this Addendum will form one indivisible application to become a member of the Scheme.

3. I acknowledge and confirm that I have not received any advice or opinions of whatsoever nature (including, but not limited to, advice which would fall under the ambit of the Financial Advisory and Intermediary Services Act 37 of 2002) or in whatsoever form (whether verbally, in writing or otherwise) from the Scheme, its employees, consultants, independent contractors or any other person relating to the Scheme in relation to the Application and that only factual information relating to the Scheme has been provided to me to assist me with the Application. The Application is therefore not based on, or directly or indirectly influenced by, any advice or opinions which was provided to me by the Scheme, its employees, consultants, independent contractors or any other person relating to the Scheme.

Signed at _____ on _____ 2010

Signature.....