APPLICATION FOR MEMBERSHIP

Imperial™ Motus Med

FOR OFFICE USE ONLY	MEMBER NUMBER	REGISTRATION DATE (DD/MM/YYYY)

PLEASE COMPLETE IN BLOCK LETTERS.

Maximum of two membership cards issued on application.

PLEASE NOTE THAT THIS FORM MUST BE SUBMITTED TO YOUR PAYROLL DEPARTMENT.

Instructions: It is imperative that all sections of the application form be completed in full. Failing to do so will cause a delay in the processing of the request, as the incomplete form will be returned to the applicant.

A. APPLICANT'S INFORMATION

ID/Passport number (copy of ID/passport required)

Surname

First name(s)

Date of birth DD/MM/YYYY Gender ☐ Male ☐ Female

Title ☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Other If other, please specify:

Nickname

Language ☐ English ☐ Afrikaans Weight Height Smoker ☐ Yes ☐ No

Marital status ☐ Single ☐ Married: effective date DD/MM/YYYY ☐ Separated

☐ Divorced: effective date DD/MM/YYYY ☐ Widow/er

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

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

Telephone numbers Work Home

Cell number

Email address

Physical address

Code

B. EMPLOYMENT DETAILS

Region/pay point name

Region/pay point number Salary/employee reference number

Occupation

Gross monthly income R Income tax reference number

☐ Basic plus benefits ☐ Cost to company

B. EMPLOYMENT DETAILS – CONTINUED

Date of employment DD/MM/YYYY

Employment type ☐ Permanent full-time staff ☐ Management ☐ Permanent part-time staff ☐ Pensioner

Promotion ☐ Yes ☐ No Effective date DD/MM/YYYY

Date of medical scheme entry DD/MM/YYYY

C. BANK DETAILS FOR DIRECT DEPOSITS OR REFUNDS

Name of account holder

Name of bank

Account number

Branch name

Eight-digit branch code

Account type ☐ Current ☐ Savings ☐ Transmission ☐ Cheque

I hereby request and authorise Imperial and Motus Medical Aid to credit any medical scheme refunds that may accrue to me to the above-mentioned account.

Signature of account holder

Date DD/MM/YYYY

D. DEPENDANT INFORMATION

Please complete the cell number, email and physical address fields of your spouse/partner/dependant that is 18 or older.
See Annexure D1 for dependant classification and the proof that is required in each instance.

1. Surname Date of birth DD/MM/YYYY

First name(s)

ID/Passport number Cell number

Relationship to applicant (e.g. wife or son) Gender ☐ Male ☐ Female

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Email address

Physical address

Code

2. Surname Date of birth DD/MM/YYYY

First name(s)

ID/Passport number Cell number

Relationship to applicant (e.g. wife or son) Gender ☐ Male ☐ Female

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Email address

Physical address

Code

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

D. DEPENDANT INFORMATION (CONTINUED)

3. Surname | Date of birth | DD/MM/YYYY

First name(s)

ID/Passport number | Cell number

Relationship to applicant | (e.g. wife or son) | Gender | Male | Female

Race* | African | Coloured | Indian/Asian | White | Other | Don't wish to disclose

Email address

Physical address

Code

4. Surname | Date of birth | DD/MM/YYYY

First name(s)

ID/Passport number | Cell number

Relationship to applicant | (e.g. wife or son) | Gender | Male | Female

Race* | African | Coloured | Indian/Asian | White | Other | Don't wish to disclose

Email address

Physical address

Code

5. Surname | Date of birth | DD/MM/YYYY

First name(s)

ID/Passport number | Cell number

Relationship to applicant | (e.g. wife or son) | Gender | Male | Female

Race* | African | Coloured | Indian/Asian | White | Other | Don't wish to disclose

Email address

Physical address

Code

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

Annexure D1: Dependant classification

DEPENDANT DEFINITION	DOCUMENTS REQUIRED	DOCUMENTS ATTACHED	
Adopted child	Court order and ID or birth certificate (if over 21 and a student, provide proof of registration)	Yes	No
Common-law partner	Affidavit and ID	Yes	No
Customary spouse	Affidavit and ID	Yes	No
Foster child	Court order and ID or birth certificate (if over 21 and a student, please provide proof of registration)	Yes	No
Natural child	ID or birth certificate (if over 21 and a student, provide proof of registration)	Yes	No
Parents of member	Affidavit and ID	Yes	No
Same-sex partner	Affidavit and ID	Yes	No
Sibling	Affidavit and ID	Yes	No
Spouse	Marriage certificate and ID	Yes	No
Stepchild	Marriage certificate and ID or birth certificate (if over 21 and a student, provide proof of registration)	Yes	No
Grandchild	Affidavit and ID (parent of grandchild should be a registered dependant of the principal member)	Yes	No

NOTE: Please remember to indicate if documents are attached.

E. MEDICAL SCHEME OPTION

Please indicate which plan you prefer by ticking one of the boxes below – you may only choose one.

☐ Imperial Motus Med Health Plan ☐ Imperial Motus Med Budget Plan

NOTE: If you chose to be on the Imperial Motus Med Budget Plan, please provide the details of one or two general practitioners (GPs) you would like to make use of below. A list of network GPs is available at www.imperialmotusmed.co.za.

If your choice of GP differs from your dependant's choice, please make a copy of this page and provide the details of one or two GPs of their choice.

Choice of GP applies to:

☐ Main member only ☐ Whole family ☐ Dependant only

Applicable dependant's name

General practitioner 1

General practitioner's name and surname

Practice number

Physical address

Code

Telephone number

Email address

General practitioner 2

General practitioner's name and surname

Practice number

Physical address

Code

Telephone number

Email address

NOTE: Please note that your membership cannot be activated without your choice of a general practitioner.

F. CONSENT AND COMPLIANCE FOR IMPERIAL AND MOTUS MEDICAL AID (IMPERIAL MOTUS MED) TO PROCESS PERSONAL OR PERSONAL HEALTH INFORMATION IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT

In order to effectively offer the benefits of Imperial Motus Med, your consent is hereby provided to Imperial Motus Med with the acknowledgement and acceptance of the following conditions of personal and personal health information usage:

- share your personal and personal health information electronically, with all suppliers required to effectively administer and manage your medical scheme benefits, claims and inquiries;
- store your personal and personal health information in a secure storage facility;
- use your personal and personal health information to optimise your Imperial Motus Med benefits;
- use your personal and personal health information to facilitate benefits in emergency medical situations; and
- retain your personal and personal health information during your membership and in terms of the allowable statutory limits thereafter.

Consequence of providing consent to sharing your personal and personal health information

You acknowledge that, once your personal and personal health information is shared by Imperial Motus Med with any required supplier, Imperial Motus Med will not have any control over your personal and personal health information once it has been shared and Imperial Motus Med will not be responsible for the security of your personal and personal health information. Imperial Motus Med and the Administrator complies with the relevant and necessary data protection laws, so while your personal and personal health information is under Imperial Motus Med's control, the necessary safety and security measures will be applied.

F. CONSENT AND COMPLIANCE FOR IMPERIAL AND MOTUS MEDICAL AID (IMPERIAL MOTUS MED) TO PROCESS PERSONAL OR PERSONAL HEALTH INFORMATION IN TERMS OF THE PROTECTION OF PERSONAL INFORMATION ACT – CONTINUED

To enable Imperial Motus Med to legally share your personal and personal health information with relevant third parties, it is imperative, by law, that you accept these conditions and sign this consent.

Right to withdraw consent
You have the right to engage with Imperial Motus Med to withdraw consent for a specified supplier, subject to Imperial Motus Med's ability to continue to effectively offer the benefits of the Scheme.

Examples of the type of information Imperial Motus Med can make available to a third party are given in the table below:

PERSONAL EXAMPLES	BENEFIT EXAMPLES	FINANCIAL EXAMPLES	MEDICAL EXAMPLES
✓ Membership number ✓ Date of birth ✓ ID number ✓ Beneficiary details ✓ Physical address ✓ Contact details, e.g. email address and telephone numbers ***For your beneficiaries:*** ✓ *Date of birth* ✓ *ID number*	✓ Plan type ✓ Benefit limits ✓ Waiting period details ✓ Wellness benefits ✓ Medical shortfall cover ✓ Multiply ✓ HealthSaver	✓ Tax certificates ✓ Tax reports ✓ Banking details ✓ Total contribution and breakdown	✓ Chronic condition indicator and/or condition ✓ Prescribed minimum benefit chronic condition details ✓ Confirmation of claims paid ✓ Claims transaction history ✓ Hospital procedures ✓ Procedure codes ✓ Procedures done in doctor's rooms paid from hospital benefit

Complaints
If you have a complaint relating to the processing of your personal and personal health information, you agree to refer it to Imperial Motus Med to resolve it in terms of its internal complaints process first. If you are not satisfied with the outcome of the complaint, you understand you may refer the complaint to the Information Regulator, who can be contacted on 012 406 4818 or via email at inforeg@justice.gov.za.

Consent
For these purposes and to comply with its statutory obligations, you hereby agree to the processing and storage of your personal and personal health information by Imperial Motus Med, as well as to the transmission of information as required. Imperial Motus Med will process the personal and personal health information in a proper and careful manner. Furthermore, Imperial Motus Med will take appropriate technical and organisational measures to sufficiently safeguard personal and personal health information and to preserve the confidential nature of your personal and personal health information in compliance with the Protection of Personal Information Act.

All other terms and conditions, as per the registered Scheme rules, remain unchanged.

Full name of member _____ Signature _____

G. DECLARATION BY THE APPLICANT (MUST BE COMPLETED)

I, the undersigned, hereby make application to be admitted as a member of Imperial and Motus Medical Aid (hereafter referred to as the Scheme). If admitted, I agree to abide by the rules of the Scheme. I declare that any false statement in the above application and the attached medical history form or the non-disclosure of any material information will render my membership null and void and that any amounts paid towards the Scheme will be forfeited to the Scheme. I warrant that the above answers are true, correct and complete in every aspect. I undertake to advise the Administrator of any change in my state of health or that of my dependants, which may occur prior to my receiving written acceptance of this application, and that such notification will give the Scheme the right to reconsider the application and to propose new terms of acceptance. I am also aware that my membership will not commence unless the Scheme specifically notifies me in writing of its acceptance of the risk.

The Scheme and its duly authorised service providers are hereby authorised to obtain from any person any necessary information which they, in their sole and absolute discretion, may require concerning:
- any assessment relating to my or my dependants' health status and/or health risk; and
- my and my dependants' previous medical scheme membership.

I consent to any person in possession of the above information or evidence being authorised and directed to provide it to the Scheme and its duly authorised service providers upon request.

I hereby authorise any hospital, physician or any other person who has attended or examined me or any of my registered dependants to furnish the Scheme or its duly authorised service suppliers with all information in respect of any illness or injury, medical history, consultations, prescriptions or treatment and copies of all hospital or medical records. A photostat or facsimile of this authorisation will be considered as effective and valid as the original.

I am aware of the fact that on joining the Scheme during the course of a calendar year, the maximum benefits to which I may be entitled will be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular benefit year.

G. DECLARATION BY THE APPLICANT (MUST BE COMPLETED) – CONTINUED

I also agree that any amounts due by me may be offset against any amount due to me by the Scheme. I hereby authorise my employer to deduct from my salary and pay the Scheme all amounts that may be due by me to the Scheme directly or on my behalf.

Upon termination of my membership of the Scheme, I agree that any amount due to the Scheme by me may be deducted from any amounts due to me by my employer group.

I declare that neither I nor my nominated dependants are covered by any other medical scheme.

I undertake to cancel my Scheme membership or that of my nominated dependants immediately upon becoming a member or a dependant of another medical scheme.

I confirm that I am familiar with the conditions and benefits of the Scheme.

Signed at _____ on the _____ of _____ _____
DAY MONTH YEAR

Signature of applicant _____ Signature of HR representative _____

COMPANY STAMP

HUMAN RESOURCES CHECK LIST

SECTION	DESCRIPTION	PLEASE INDICATE BELOW THAT THE APPLICATION FORM HAS BEEN COMPLETED IN FULL AND THAT THE REQUIRED DOCUMENTS ARE ATTACHED	
Section C: Bank details for direct deposits or refunds	The member's full bank details have been completed	☐ Yes	☐ No
Annexure D1: Dependant classification	All required documents/proof is attached	☐ Yes	☐ No
Section K: Medical scheme history	Membership certificate of previous medical scheme cover is attached	☐ Yes	☐ No

MEDICAL HISTORY FORM

Imperial™ Motus Med

FOR OFFICE USE ONLY	MEMBER NUMBER	REGISTRATION DATE (DD/MM/YYYY)

PLEASE COMPLETE IN BLOCK LETTERS.

H. APPLICANT

Surname of applicant

First name(s) of applicant

Date of birth DD/MM/YYYY

I. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS

Please provide the required information by ticking the relevant boxes with a 'yes' or 'no' below. If the answer to any question is 'yes', please provide details in section J overleaf.

I understand that if I do not provide full details of all the medical conditions known to me at the time of this application or before acceptance of this application, my membership will be declared null and void.

1.	Are you or any of your dependants currently pregnant? If so, for how many months have you/she been pregnant? Number of months ____ Name and surname of person ____	☐ Yes	☐ No
2.	Have you or any of your dependants ever had any of the following?		
2.1	Any disorder of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	☐ Yes	☐ No
2.2	High blood pressure or diseases of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder)?	☐ Yes	☐ No
2.3	Any respiratory or lung trouble (e.g. asthma, bronchitis, persistent cough, tuberculosis)?	☐ Yes	☐ No
2.4	Any disorder of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, hepatitis B or persistent diarrhoea)?	☐ Yes	☐ No
2.5	Any disease or disorder of the kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)?	☐ Yes	☐ No
2.6	Any nervous or mental complaint (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety state or depression)?	☐ Yes	☐ No
2.7	Any ear, eye, nose or throat disorder (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment or chronic sinusitis)?	☐ Yes	☐ No
2.8	Any disorder or disease of the muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)?	☐ Yes	☐ No
2.9	Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder?	☐ Yes	☐ No
2.10	Any lumps, growths (benign or malignant), types of cancers (including Hodgkin's disease and leukaemia), skin cancer or skin disorders?	☐ Yes	☐ No
2.11	Any tropical disease (e.g. bilharzia, malaria and cholera)?	☐ Yes	☐ No
2.12	Any other condition, illness, disease, disorder, disability or accident that required medical, radiological, surgical, pathological or dental investigation during the past twelve months?	☐ Yes	☐ No
2.13	Been tested for or received or expect to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or any AIDS-related condition or any sexually transmitted disease (e.g. hepatitis B, gonorrhoea or syphilis)?	☐ Yes	☐ No

I. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS – CONTINUED

3.	Have or are you or your dependants receiving surgical, medical, major dental (implants), chiropractic, optical or gynaecological treatment, procedures, advice or tests?	☐ Yes	☐ No
4.	Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause?	☐ Yes	☐ No
5.	Do you or any of your dependants currently use medication on a daily basis?	☐ Yes	☐ No
6.	Has your weight or the weight of your dependants changed by more than 5 kg in the last 12 months?	☐ Yes	☐ No
7.	Do you or any of your dependants suffer from any other ailment or disease at present?	☐ Yes	☐ No
8.	Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/ questionnaire relating to past or present diseases, accidents, operations or other conditions including pregnancy for which advice has been sought or treatment has been received or recommended during the past five years?	☐ Yes	☐ No
9.	Are you or any of your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months?	☐ Yes	☐ No

If you require additional space, please complete a separate sheet of paper and attach it to the application. Please attach the relevant medical reports. **Please note:** Your HIV status should not be disclosed in this form. To enrol on the YourLife Programme for HIV management, please contact **0860 109 793** or email **yourlife@imperialmotusmed.co.za. All correspondence is 100% confidential.** Please note that this may result in you receiving a second membership card from the Scheme pending whether your application will require underwriting, as per current legislation.

J. ADDITIONAL MEDICAL INFORMATION

		1.	2.	3.
Question number				
Name of attending doctor				
Name of person suffering from the illness				
Type of illness/condition (diagnosis)				
Date on which the illness began				
Frequency of attacks (hourly/daily/weekly/monthly)				
Date of last attack				
If hospitalised, when and for how many days				
Duration of illness or condition				
Treatment and/or type of medication received in the past	Treatment			
	Medication			
Current treatment and/or type of medication received	Treatment			
	Medication			
Approximate monthly cost of treatment/medication	Treatment			
	Medication			
Details of operations previously performed				
Operations and/or treatment needed in future				

J. ADDITIONAL MEDICAL INFORMATION – CONTINUED

		4.	5.	6.
Question number				
Name of attending doctor				
Name of person suffering from the illness				
Type of illness/condition (diagnosis)				
Date on which the illness began				
Frequency of attacks (hourly/daily/weekly/monthly)				
Date of last attack				
If hospitalised, when and for how many days				
Duration of illness or condition				
Treatment and/or type of medication received in the past	Treatment			
	Medication			
Current treatment and/or type of medication received	Treatment			
	Medication			
Approximate monthly cost of treatment/medication	Treatment			
	Medication			
Details of operations previously performed				
Operations and/or treatment needed in future				

K. MEDICAL SCHEME HISTORY (PLEASE ATTACH COPIES OF ALL PREVIOUS MEMBERSHIP CERTIFICATES)

Are or were you or any of your nominated dependants beneficiaries of a registered medical scheme? ☐ Yes ☐ No

If 'yes', a membership certificate – **not a membership card** – from the previous medical scheme must accompany this application. The entry date, as well as the cancellation date, must be indicated on the certificate.

Failing the above, waiting periods, unexpired waiting periods and late-joiner penalties may be imposed.

Was a late-joiner penalty imposed? ☐ Yes ☐ No

If 'yes', please provide details of penalty rate

Reason for termination of membership/de-registration as dependants:

K. MEDICAL SCHEME HISTORY (PLEASE ATTACH COPIES OF ALL PREVIOUS MEMBERSHIP CERTIFICATES) – CONTINUED

Details required if applicant was a member or dependant of another medical scheme.
Certificates of membership of previous medical schemes are required – **not a membership card**.

Name of applicant _____ Name of scheme _____
Period of membership: from _____ DD/MM/YYYY to _____ DD/MM/YYYY

Name of applicant _____ Name of scheme _____
Period of membership: from _____ DD/MM/YYYY to _____ DD/MM/YYYY

Name of applicant _____ Name of scheme _____
Period of membership: from _____ DD/MM/YYYY to _____ DD/MM/YYYY

Name of applicant _____ Name of scheme _____
Period of membership: from _____ DD/MM/YYYY to _____ DD/MM/YYYY

Name of applicant _____ Name of scheme _____
Period of membership: from _____ DD/MM/YYYY to _____ DD/MM/YYYY

Have you ever been a member of Imperial Motus Med? ☐ Yes ☐ No

If so, please state your previous membership number: ☐☐☐☐☐☐☐☐☐☐☐

L. YOUR PREFERRED METHOD OF RECEIVING WRITTEN COMMUNICATION

Please tick your preferred method of receiving written communication for the following communication items. Please choose only one method of delivery for each item.

Personalised letters	☐ Email	☐ Post	
Claims statements*	☐ Email	☐ Post	☐ Cell phone
Claims processed	☐ Email	☐ Post	☐ Cell phone

*You need a cell phone that can access the internet to receive your statements via SMS.

M. DECLARATION BY THE APPLICANT (MUST BE COMPLETED)

I declare that the above information is correct.

Signed at _____ on the _____ of _____ _____
DAY MONTH YEAR

Signature of member _____