MEMBERSHIP APPLICATION

Unit 5, Sunbird Office Park, Pasita Street, Tygervalley, 7530
E-mail: sales@cmp.co.za Web: www.cmp.co.za

Instructions:
1. Where appropriate, mark your selection with an X.
2. Please complete the form in full and check that all the information is complete prior to submitting to CMP Medical Aid.
3. Attach clear copies of all applicants' birth certificates or ID's or passports.
4. Email your completed and signed application form to **sales@cmp.co.za.**

Please ensure that you do not resign from your current medical scheme until written notification of acceptance is received from CMP Medical Aid.

A Applicant

PERSONAL DETAILS PRINCIPAL MEMBER

Title | Initials | Surname | First Names

Nickname | Maiden Name

Marital Status | Birth Date | Gender ☐ Male ☐ Female

ID or Passport No Attach copies | Income Tax No. (Your income tax no. must start with 0,1,2,3 or 9 and must be 10 characters in length.)

ADDRESS DETAILS

Home Address

POSTAL CODE:

Postal Address (If not same as above)

POSTAL CODE:

Tel No. (Home) | Tel No. (Work) | Cell No.

E-mail Address

EMPLOYMENT DETAILS

Employer

Address

POSTAL CODE:

Occupation | Employment Date

NEXT OF KIN

Title | Initials | Surname | First Names

Relationship to applicant | Tel No. (Work) | Cell No.

E-mail Address

B Dependant Details

DEPENDANT 1

Title | Initials | Surname | First Names

Nickname | Relationship to applicant | Gender ☐ Male ☐ Female

Cell no | ID or Passport No Attach copies | Birth Date

DEPENDANT 2

Title | Initials | Surname | First Names

Relationship to applicant | Nickname | Gender ☐ Male ☐ Female

Cell no | ID or Passport No Attach copies | Birth Date

DEPENDANT 3

Title | Initials | Surname | First Names

Relationship to applicant | Nickname | Gender ☐ Male ☐ Female

Cell no | ID or Passport No Attach copies | Birth Date

DEPENDANT 4

Title | Initials | Surname | First Names

Relationship to applicant | Nickname | Gender ☐ Male ☐ Female

Cell no | ID or Passport No Attach copies | Birth Date

DEPENDANT 5

Title | Initials | Surname | First Names

Relationship to applicant | Nickname | Gender ☐ Male ☐ Female

Cell no | ID or Passport No Attach copies | Birth Date

DEPENDANT 6

Title | Initials | Surname | First Names

Relationship to applicant | Nickname | Gender ☐ Male ☐ Female

Cell no | ID or Passport No Attach copies | Birth Date

C Previous Medical Scheme

Have you or any of your dependants been on a medical scheme before? (If "YES", please complete the table below) ☐ Yes ☐ No

Attach membership certificates from all previous medical schemes the applicants belonged to.

Membership No.	Date Joined	Date Terminated
Name of Scheme	Reason for Termination	

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D Medical Details of New Dependant Applicants only

Please complete the relevant information below. If the answer to any of the questions is "YES", please provide details on the following page. Should you have any relevant medical reports, please attach copies of these to this application.

Note: If you, your spouse, or any of your dependants do not disclose any relevant medical information, it may result in the termination of membership.

1. Please detail name and telephone number of your current doctor and that of your spouse or adult dependants and indicate how many years you have been consulting the respective doctor

Member Name	Current Doctor	Tel No.	Years
Member Name	Current Doctor	Tel No.	Years

2a	**Height** (metres)	**Weight** (Kgs)	**Tobacco Smoked** (qty & type per day)	**Alcohol consumed** (qty & type per week)
Principal Member				
Adult Dependant				
Adult Dependant				
Adult Dependant				
Adult Dependant				

2b Have you, your spouse or any of your adult dependants' weight changed by more than 5kgs in the last 12 months? ☐ **Yes** ☐ **No**

2c Have you, your spouse or any of your adult dependants' ever been advised to reduce alcohol or tobacco consumption? ☐ **Yes** ☐ **No**

D Medical Details (continued)

3 Chronic medication:

Please list **ALL** medication that you or your dependants have been prescribed on an on-going/repeated basis in the last 24 months?

Full Name	Condition	Name of medication	Name of Doctor

4 Have you, your spouse or any of your dependants ever experienced, or been treated for, or are currently suffering from any of the following conditions or symptoms?

a. **Blood Disorders** anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, thrombosis (blood clots), or any other ☐ Yes ☐ No

b. **Brain & Nerve Disorders** stroke, multiple sclerosis, epilepsy, migraine, paralysis, Paresis, Parkinson's Disease, or any other ☐ Yes ☐ No

c. **Cancer** a diagnosis of any form of cancer or pre-cancerous growth ☐ Yes ☐ No

d. **Cardiac & Vascular Disorders** angina (chest pain) / heart attack, heart failure, heart murmurs, rheumatic fever, high blood pressure, rhythm disturbance (palpitations), varicose veins, poor circulation, raised cholesterol, or any other ☐ Yes ☐ No

e. **Connective Tissue Disorders** systemic lupus erythematosis, scleroderma, dermatopolymyositis, mixed connective tissue disorder, or any other ☐ Yes ☐ No

f. **Dental Disorders** over/underbite problems, missing/skew teeth, false teeth, previous or ongoing dental treatment, or any other ☐ Yes ☐ No

g. **Eye & Ear Disorders** cataracts, glaucoma, retinitis, hearing/visual impairment, disorders of the cornea, or any other ☐ Yes ☐ No

h. **Gastro-Intestinal Disorders** peptic ulcers, hiatus hernia, heartburn, changed bowel habits, rectal bleeding, Crohn's Disease, ulcerative colitis, irritable bowel syndrome, or any other ☐ Yes ☐ No

i. **Gynaecological Disorders** ovarian cysts, endometriosis, fibroids, infertility, disorders of the cervix, menstrual disorders, miscarriage, or any other ☐ Yes ☐ No

j. **Kidney/Urinary Tract Disorders** renal failure, kidney stones, recurrent urinary tract or related infections, nephritis, prostate problems, blood/protein in urine, polycystic kidneys, or any other ☐ Yes ☐ No

k. **Liver/Pancreatic Disorders** hepatitis, cirrhosis, liver failure, gallstones, pancreatitis, or any other ☐ Yes ☐ No

l. **Mental Psychiatric Disorders** depression, anxiety, schizophrenia, eating disorders, ADHD, or any other ☐ Yes ☐ No

m. **Metabolic/Endocrine Disorders** diabetes, thyroid abnormalities, growth disorders, Cushing's Disease, Addison's Disease, or any other ☐ Yes ☐ No

n. **Musculoskeletal Disorders** arthritis, rheumatoid/osteo-arthritis, crystalline arthritis, myasthenia gravis, muscle weakness, gout, osteoporosis, back problems, operations, eg. slipped disc, backache, sciatica (pinched nerve), or any other ☐ Yes ☐ No

o. **Respiratory Disorders** asthma, emphysema, bronchitis, shortness of breath, persistent cough, coughing up blood, cystic fibrosis, sinusitis, allergic rhinitis, tonsillitis, ear infection or any other ☐ Yes ☐ No

p. **Skin Disorders** eczema, psoriasis, acne, hypertrophic scars (keloid), or any other ☐ Yes ☐ No

q. **Injuries** sport injuries, vehicle accident injuries, or any other ☐ Yes ☐ No

5 Have you, your spouse or any of your dependants been advised to undergo any form of medical treatment in the future? ☐ **Yes** ☐ **No**

6 Have you, your spouse or any of your dependants ever had, or are currently undergoing, or anticipating any specialist dental treatment, eg. orthodontic, periodontic, prosthodontic, maxillo facial procedures or treatment for impacted wisdom teeth? ☐ **Yes** ☐ **No**

D Medical Details (continued)

7a Are you, your spouse or any of your dependants currently pregnant? ☐ Yes ☐ No

If so, what is the expected date of delivery?

7b Supply the last period date for all female applicants, 13 years and older

Full Name	Last Period Date

8 Have you, your spouse or any of your dependants received advice. councelling or treatment for alcoholism or drug dependancy? ☐ Yes ☐ No

9 Have you, your spouse or any of your dependants undergone any surgery or hospital treatment in the 24 month period prior to application? ☐ Yes ☐ No

10 Have you, your spouse or any of your dependants been involved in a MVA (motor vehicle accident), sustained any injury on duty, or contracted a work related disease within the 24 month period prior to this application? ☐ Yes ☐ No

11 The above questions are prompts and are not exhaustive. Should you, your spouse or your dependants have any condition and symptom which is not directly covered by these questions, but which is material to our consideration of the risk, you are nonetheless obliged to disclose it. Are you aware of any such condition? ☐ Yes ☐ No

If the answer to any of questions 4-11 is "YES", please provide full details below.

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

Question Number | Member Name | Diagnosis

Date Diagnosed | Currently on treatment for this condition ☐ Yes ☐ No | Date of last consultation, hospitalisation or medication taken for this disorder

Doctor's Name & telephone number

Question Number | Member Name | Diagnosis

Date Diagnosed | Currently on treatment for this condition ☐ Yes ☐ No | Date of last consultation, hospitalisation or medication taken for this disorder

Doctor's Name & telephone number

Question Number | Member Name | Diagnosis

Date Diagnosed | Currently on treatment for this condition ☐ Yes ☐ No | Date of last consultation, hospitalisation or medication taken for this disorder

Doctor's Name & telephone number

Question Number | Member Name | Diagnosis

Date Diagnosed | Currently on treatment for this condition ☐ Yes ☐ No | Date of last consultation, hospitalisation or medication taken for this disorder

Doctor's Name & telephone number

E Plan Choice

COMPLETE AND SELECT ONE OPTION ONLY

Required Registration Date	

☐ **A. MyHealth 200 - no MSA included**

				TOTAL
Principal Member	**R3,197**	X	1	R3,197.00
Adult Dependant	**R3,197**	X		R
Minor Dependant	**R564**	X		R
				R

☐ **B. MyHealth 100 Saver - MSA included**

		MSA				**TOTAL**
Principal Member	R2,778	R335	**R3,113**	X	1	R3,113.00
Adult Dependant	R2,778	R335	**R3,113**	X		R
Minor Dependant	R417	R50	**R467**	X		R
						R

☐ **C. MyHealth 200 Plus - MSA included**

		MSA				**TOTAL**
Principal Member	R8,750	R390	**R9,140**	X	1	R9,140.00
Adult Dependant	R8,750	R390	**R9,140**	X		R
Minor Dependant	R1,412	R64	**R1,476**	X		R
						R

I confirm that I have read the CMP Medical Aid Benefits Brochure and that I am familiar with the terms and conditions of the benefit option chosen.

Initial _____

F Debit Order Agreement

Bank Name

Account Type ☐ Current ☐ Savings

Branch Code

Account No. (No credit cards)

Account Holder

I, the undersigned hereby authorise and instruct you to debit my account at the above mentioned bank, or any other bank which my account may be transferred to, monthly and/or as adjusted from time to time, being my monthly medical scheme subscriptions, payable on the first business day of each month.

R

Signed at

Date

Signature of **Account Holder**

Only the Applicant may cancel this debit order by giving 30 (thirty) days written notification, with the understanding that they shall have no claim with respect to amounts already debited to the account at the date of cancellation.

G Banking Details (For refund purposes e.g. claims.)

Bank Name

Account Type ☐ Current ☐ Savings

Branch Code

Account No. (No credit cards)

Account Holder

I, the undersigned hereby request and authorise that you deposit any medical scheme related amounts which may accrue to me into the bank account as detailed above (or any bank to which I may transfer my account). I agree that **CMP Medical Aid** shall not be liable for any delay in the funds being received by me and I waive any claim that I may have against **CMP Medical Aid** as a consequence of such delay. The completeness and accuracy of the details as stated on this form shall be my sole responsibility. I agree to advise **CMP Medical Aid** in writing of any changes which may occur.

Signed at

Date

Signature of **Applicant**

H Conditions, Undertaking and Warranties

1. This is an application for membership in respect of myself and/or my spouse and/or my dependants listed in this document and I acknowledge that the application is made in terms of the Rules and Benefit Options of CMP Medical Aid and that my membership contract is constituted in terms of the Rules, to which I am bound and understand.
2. I warrant that the information contained in this application form and any other document provided by me in terms of this application are true and correct and that I have disclosed all information to CMP Medical Aid that may be relevant to CMP Medical Aid In assessing the risk to CMP Medical Aid, whether it be its overall exposure arising from my membership or any other person deriving benefits in terms of this application.
3. I acknowledge that the Board of Trustees of CMP Medical Aid may cancel from date of application the membership of any person deriving benefits in terms of this application if any non-disclosure is discovered and hold me liable for any benefits received by me after the effective date of cancellation.
4. The disclosure requirements in terms of this application shall continue from the date of this application and without limiting the aforesaid, I shall disclose to CMP Medical Aid any relevant medical information between the date of application and the date of registration to CMP Medical Aid.
5. I consent to CMP Medical Aid addressing any request for information, tests or examinations directly to any dependant of mine over the age of 21 (twenty one), with the same legal consequences as if the request had been addressed to me in my capacity as the principal member.
6. I understand that my, my spouse and/or my dependant's confidential health and personal information will only be used for the purposes as outlined by CMP Medical Aid in this application form and/or legislation. In the event of CMP Medical Aid wishing to use my, my spouse and/or my dependants confidential information for purposes other than those outlined in this application form and/or legislation, CMP Medical Aid is required to obtain further consent from myself, my spouse and/or dependants.
7. I will inform CMP Medical Aid of **any** changes in my, my spouse and/or dependant's health or personal status, as required by CMP Medical Aid's Rules, within **30 days** of the change in circumstances.
8. I consent to all conversations between myself and CMP Medical Aid being recorded electronically or otherwise.
9. CMP Medical Aid has data security measures in place that prevent personal and health information being used for purposes of unrelated company business, nor can it be sold for commercial purposes. These measures do allow for certain persons within the organization and contracted third parties to access beneficiary personal and health information for the purposes of carrying on business.
10. These measures may change from time to time depending on how legislation can/may change. These measures of security and access are also audited by independent external auditors to ensure that they comply with industry rules, the Companies Act and auditing standards.

Signed at

Date

Signature of **Applicant**

I Sales Consultant/Broker Details

Name

Tel No. (Work)

Cell No.

E-mail Address