TRANSFER 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 proof of banking details.
4. Email your completed and signed application form to **sales@cmp.co.za.**

A Applicant

PERSONAL DETAILS PRINCIPAL MEMBER

Membership No. | Group No. | Required Registration Date

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 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.

D 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**

E 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 I, my spouse and/or my dependent'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 dependent'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.

Signed at

Date

Signature of **Applicant**