

LIBERTY MEDICAL SCHEME

We care. **For you**

Private Bag X35
Claremont, 7735
Contact Centre 0860 002 163
New Groups fax 021 657 7661
www.libmed.co.za

Employer Group Registration Form

Thank you for your request to participate in the Liberty Medical Scheme (LMS) on behalf of your employees.

Kindly return the following completed and signed form care of your Financial Adviser (if applicable) or send them directly to Liberty Medical Scheme: email newgroups@libertyhealth.co.za or fax 021 657 7661.

Please attach a copy of quotation and underwriting terms.

SECTION 1 – DETAILS OF EMPLOYER GROUP

FOR OFFICE USE ONLY

Group code	<input type="text" value="L"/> <input type="text" value="B"/> <input type="text" value="T"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
New group registration	<input type="checkbox"/> Existing group change <input type="checkbox"/>

Company Details (to be completed by Employer)

*Denotes compulsory information

Company name*	<input type="text"/>
Physical address*	<input type="text"/>
	Postal code <input type="text"/>
Postal address*	<input type="text"/>
	Postal code <input type="text"/>
Email address	<input type="text"/>
Proposed registration date of Employer Group	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/>

NB: The date of commencement of your benefits may differ from your registration date.

Company contact person*	<input type="text"/>
Telephone number*	<input type="text"/>
Fax number*	<input type="text"/>
Email address*	<input type="text"/>
Alternative contact person	<input type="text"/>
Telephone number	<input type="text"/>
Fax number	<input type="text"/>
Email address	<input type="text"/>

SECTION 2 – CONTRIBUTION PAYMENTS DETAIL (TO BE COMPLETED BY EMPLOYER GROUP)

***Denotes compulsory information**

Please note contributions are payable monthly in advance, no later than the third of the month.

Please attach a cancelled cheque or bank statement for bank identification purposes. If more than one payer, per paypoint, please complete this form, per payer/paypoint.

Employer name*

Employer number*

We hereby request and authorise you to draw against our account with the bank mentioned below (or any bank or branch to which we may transfer our account) the amount required by you in payment of the monthly contributions due in respect of the Liberty Medical Scheme on the first of the month. If the first of the month falls on a public holiday or Sunday, the deduction will be taken on the first business day thereafter.

All such withdrawals from our bank account by the Scheme shall be regarded as authorised by us.

We understand that the withdrawals hereby authorised will be processed by computer through a system known as ABC (Automated Clearing Bureau), and we also understand that the details of each withdrawal will be printed on our bank statement or on an accompanying voucher.

This authority may be cancelled by us, giving you thirty days notice in writing. We understand that we shall not be entitled to any refund or amounts, which you withdrew while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt hereof by your bank (whichever it is or may be).

The details of our bank account are as follows:

Bank*

Branch name*

Branch code*

Account number*

Type of Account holder*

Name of Account holder*

Signed at _____ on this _____ day of _____ 20 _____

_____	_____	_____
Full name of Authorised Signatory	Signature of Authorised Signatory	Capacity/Designation
_____	_____	_____
Full name of second Authorised Signatory	Signature of second Authorised Signatory	Capacity/Designation

SECTION 3 – EMPLOYER GROUP DECLARATION

***Denotes compulsory information**

Full name of Authorised Signatory* _____

Capacity/Designation* _____

Name of participating employer* _____

- We have applied to participate in the LIBERTY MEDICAL SCHEME (“the SCHEME”) administered by V Medical Administrators (Pty) Ltd (Vmed) and agree to be bound by the terms and conditions consisting of:
 - The rules and associated documents of the Medical Scheme administered or offered by Vmed, from time to time, to provide benefits for members of the SCHEME.
 - The terms and conditions of any policy of assurance associated with the SCHEME.
 - Any application for membership of, or participation in, the SCHEME or for any Benefits provided by the SCHEME and any information submitted in support of such application.
 - The contents of any contribution schedule, member claims statement, policies, benefit schedule, annexures or other documents making up part of the SCHEME; which may relate to any Benefits for which we (or any member, as the case may be, of the SCHEME) have applied.
- We accept the quotation that has been made available to us by our appointed Financial Adviser in terms of Section 4.
- In respect of all the Members (including such Members’ dependants, where applicable) on whose behalf we have applied for membership of

the SCHEME or for any benefits, we warrant that we are fully authorised to sign this Scheme Authority form and to make such application. We further warrant that a bona fide employer/employee relationship exists between ourselves and the Member at the time of such application.

We accept that the provisions of this Scheme Authority form are binding on us and on all such Members and undertake to notify them of the existence and contents of this Scheme Authority form. Our failure to notify any Member will in no way affect the validity or operation of the Scheme Authority and the SCHEME.

4. We warrant that we have obtained consent from Members (including such Members' dependants, where applicable) on whose behalf we have applied for membership of the SCHEME to collect, process and share their personal information, and in doing so irrevocably authorise the Scheme to collect, process and share such personal information with any contracted Third Party Provider in order to allow the Scheme to fulfill its functions, duties and obligations. We warrant and agree that this authorisation shall remain in force after the Member's (including such Members' dependants, where applicable) death and we warrant that the parties understand that this may partially limit their right to privacy.
5. We confirm that all information provided in terms of any application for membership of, or participation in, the SCHEME, or for any benefits provided by the SCHEME, is true and correct and that all material facts have and will continue to be disclosed. We accept that all Benefits provided by the SCHEME are dependent on the correctness of such information and that any breach of our contractual obligation may lead to any contract being declared void. We agree that any loss incurred by any party as a direct or indirect result of our failure to notify the SCHEME of any membership amendments/changes will be for our account and that neither Liberty Medical Scheme, nor any person or entity acting on their behalf, shall be liable for such loss.
6. We accept that the provision of any Benefits by the SCHEME will be subject to any applicable current and future legislation. We further accept that such benefits may be subject to the SCHEME being able to assure such Benefits in whole or in part, and will be subject to such terms and conditions as may be imposed by any assurer in this regard.
7. We accept that the SCHEME will not become operative unless and until any initial contributions required have been received. We agree to pay over the total monthly contributions (Employer and Employee portion), payable in advance, to the SCHEME in respect of every member by no later than the third day following the contribution due date of each month.
8. We undertake to ensure that the payments made can be reconciled to all contributions due to the SCHEME.
9. We understand and agree that all risk and liability in respect of monies submitted to the SCHEME (whether by cheque or otherwise), shall remain with us until such time that we can conclusively prove receipt thereof by the SCHEME.
10. We agree to pay over the total contribution payable to the SCHEME in respect of any member when such member has left our employ and on whose behalf the SCHEME has paid claims after such resignation date, due to our failure to notify the SCHEME, in writing and within the notice period as set out in the Scheme's rules, of such resignation.
11. We agree that Vmed will provide SCHEME Benefits and any person or entity authorised by them may deal electronically with all transactions relating to the SCHEME.
12. We agree that any person who electronically gathers or records information provided by us or any Member, or electronically processes any transaction or Benefits amendment requested by us or such Member, does so on our behalf. Any knowledge that such person may have of any facts or any representation or promise that such person may make, and which is not contained in the electronic records held by Vmed in regard to our participation in the SCHEME, shall not be binding on Vmed.
13. We agree to notify the SCHEME of any changes, which would affect member or dependant records, within 30 days of such change and per the prescribed procedure and forms.
14. We understand that the SCHEME is established for the benefit of the Members and that we (the Participating Employer) are not entitled to benefit directly therefrom. We confirm that no representations have been made to induce us to participate in the SCHEME.
15. We agree that all the provisions of this Scheme Authority form will apply in respect of all Members on whose behalf we have applied for Membership of the SCHEME and on whose behalf we may apply for such membership in the future. They will also apply equally in respect of any future requests for additions or amendments to the Benefits provided by the SCHEME and to any other future transactions related to the SCHEME.
16. Unless we object in writing within 14 days from receipt of confirmation of our participation in the Scheme, it will be deemed that we have accepted the contents of any contribution schedule, member claims statement, policies, benefit schedule, annexures or other documents making up part of the Scheme. In the event of us objecting, Vmed reserves the right to adjust the terms of the Scheme. Thereafter, we agree that this Scheme Authority form, all Scheme documentation and Vmed computer records, together with any amendments thereto will form the basis and record of our participation in the SCHEME.
17. We agree to abide by the 'Rules for termination of Medical Scheme' by giving the SCHEME 3 month's written notice of our intention to resign as an Employer Group. In such an event, the membership of all members, including continuation and direct paying members and pensioners linked to the group shall terminate concurrently.

18. We understand that if any guarantee of benefits is given by the SCHEME for a member who has left our employment or has been transferred, and where such notice of termination has not been given to the SCHEME following the prescribed procedures, that we will be responsible to the SCHEME for reimbursement of guaranteed benefits.

19. Marketing:

In an effort to keep you updated on activities at Liberty Medical Scheme (LMS), we have been sending you various types of marketing and health related product communications in the form of emails, sms's and post. We would like to ensure receiving these communications are more convenient for you and we request that you complete the section below and return it to the Scheme.

Do you wish to receive LMS marketing communications?

 Y N

If yes, how would you like to receive them?

Email Y N SMS Y N Post

 Y N

We consent to LMS marketing products, services and special offers being sent to me from time to time.

 Y N

We consent to LMS sharing my membership information with any Third Party Provider contracted to LMS for the delivery of healthcare services to allow the Scheme to fulfil its functions.

 Y N

We consent that such contracted Third Party may contact me from time to time regarding their products, services and special offers.

 Y N

Signature of Authorised Signatory _____

Signed at _____ on this _____ day of _____ 20 _____

SECTION 4 – FINANCIAL ADVISER AUTHORITY

Exclusive Financial Adviser Y N

Financial Adviser Name

Financial Adviser Code

Cellphone number

Email address

Should the above information change, we will notify the SCHEME in writing.

Signature of Financial Adviser _____

Date Y Y Y Y M M D D

Please note that in the event of any modification or variation of this standard form Liberty Medical Scheme will regard this form as being invalid and of no force and effect.