

LIBERTY MEDICAL SCHEME

We care. **For you**

Private Bag X35
Claremont, 7735
Contact Centre 0860 002 163
New Business fax 021 657 7651
www.libmed.co.za

Application for Membership 2012

Important:

- Please write clearly using capital and block letters.
- It is compulsory for fields marked with * to be completed.
- Applications activated with terms accepted **after** the monthly cut-off for New Business (20th of the month), might be subject to Contribution arrears.
- Please submit completed forms to: newbusiness@libertyhealth.co.za or fax: **021 657 7651**.
- Backdating will NOT be permitted.
- Please note that if you are not satisfied with any of the Terms on receipt of your Welcome letter, you may cancel this application within the first 30 days of membership. **Any contributions paid will be refunded providing no benefits have been utilised.**
- Existing members who wish to register additional dependant(s), please complete the Dependant Registration form.

FOR ADMINISTRATIVE USE ONLY

Membership number

Group number

Interchangeability

SECTION 1 – DETAILS OF PRINCIPAL MEMBER

Please leave a space between names. * Denotes Compulsory Information

Surname*

Maiden name (if applicable)*

Title* First name(s)*

Initials* Date of birth*

Gender* Marital status*

SA ID number*

Telephone (Home)* (Work)*

Fax Cell*

Email

I agree to receiving correspondence via email

Preferred communication

(By choosing email you will receive your communication quicker with less environmental impact.)

Postal address* Postal code

Physical address* Same as postal

If No Postal code

Smoker* Weight * kg Height* cm

SECTION 2 - CHOICE OF OPTION DETAILS

Join Scheme from

Indicate option with 'X' in the appropriate box

- Platinum Complete Titan
 Platinum Saver Gold Saver Bona Plus
 Platinum Focus Gold Focus

Payment from Medical Savings Facility (MSF) for day-to-day claims

Excess amounts (the difference between the Liberty Medical Scheme reimbursement rate and the amount charged by a healthcare provider), as well as amounts claimed in excess of benefit sub-limits for day-to-day claims except for medicine, will automatically be paid from a positive balance in your Medical Savings Facility. Only the Liberty Medical Scheme rate will accumulate to your Threshold level. This may impact your Threshold Benefit and result in a higher Self-Payment Gap.

Contribution to Medical Savings Facility

Only the following options have a saving facility included in the total contribution:
 Platinum Complete 15% Titan 15% Platinum Saver 10% Gold Saver 15%

SECTION 3 – EMPLOYMENT DETAILS

Are you applying as:

- Individual Member Employer Group Member Persal Member

Name of Employer

Telephone number Fax

Email

Date of employment Employee/Persal number

(Persal number for government employees. Please attach a clear copy of your latest salary slip)

(Please ensure your employer completes this declaration if this application form is not submitted together with an Employer Group Registration form)

EMPLOYER DECLARATION

- We confirm that the applicant detailed in Section 1 is an employee of our organisation.
- The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised Signatory

Designation

Date

COMPANY STAMP

SECTION 4 – DEPENDANTS TO BE REGISTERED

- It is compulsory to complete this section if you have any dependants you would like to add and provide copies of supporting documentation.
- The granting of dependant membership is strictly subject to the rules and approval of the Scheme.
- Please complete ID numbers in full.

* Denotes Compulsory Information

Dependant 1

Title* Initial(s)* Surname*

First name(s)* (as per identity document)

Marital status Gender* Date of birth*

Relationship to Principal member* (For example mother, child. Where your child is not your biological child, please state relationship. For example adopted child, foster child. Please provide legal proof)

ID number* Smoker* Weight* kg Height* cm

Is your dependant: married? financially dependent on you? disabled a full-time student?

Does your dependant earn an income? How much does your dependant earn each month?

| DEPENDANTS ACCEPTED BY LMS AND DOCUMENTS REQUIRED FOR REGISTRATION | | | | | | | | | |
|--|---------------|--------------|---------------------------------|-----------------------------------|-----------------------------------|--|-------------------------------|------------------|------------------------|
| Document(s) Required | Lawful Spouse | Life Partner | Biological Parent of Member *** | Biological Siblings of Member *** | Member's Own Minor Children ***** | Adult Children, Incl. Stepchildren *** | Permanently Disabled Children | Stepchildren *** | Adopted Children ***** |
| Copy of ID/Birth Certificate/hospital confirmation reflecting the baby's name | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Copy of Marriage Certificate | ✓ | | | | | | | | |
| Copy of Membership Certificate(s)/Affidavit detailing previous membership history* | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | |
| Affidavit confirming financial dependency of Biological Parent(s)** | | | ✓ | ✓ | | | | | |
| Proof of income if employed**** | | | ✓ | ✓ | | ✓ | | | |
| Proof of studies (current proof of registration at a recognised educational institution) | | | | | | ✓ | | | |
| Affidavit confirming financial dependency of Adult Dependant(s)** | | | | ✓ | | ✓ | | | |
| Copy of the Doctor's disability report | | | | | | | ✓ | | |
| Proof of legal adoption | | | | | | | | | ✓ |

* **Copy of Membership Certificate(s)/Affidavit detailing previous membership history** (registration date, benefit date, resignation date, any/all waiting periods and exclusions, all registered dependants). Membership cards or copies thereof will not be accepted. If not attached, the Late Joiner Penalty may apply.

** **LMS Affidavit templates are available on www.libmed.co.za.**

*** **Subject to Annual Review**

- **Biological Parents of Member:** Fathers-in-law and mothers-in-law are not accepted
- **Biological Siblings:** Biological siblings > 21 will be charged adult rates
- **Adult Children, incl. Stepchildren:** > 21 and up to and including the age of 26 will be charged adult rates unless a full-time student at a recognised institution or disabled.

**** **Proof of income must be provided as follows:**

- Copy of dependant's most recent payslip or salary advice or government grant card
- Commission statements for the last 12 months
- Copy of dependant's latest SARS income tax return
- Written confirmation of income from dependant's human resources department, on a company letterhead
- If unemployed, your Unemployment Insurance Fund (UIF) blue book or a discharge certificate from your previous employer or affidavit stating "zero income".

***** **Member's own newborn children:** If registration with LMS takes place within 30 days of the birth no waiting period is imposed. (The "Dependant Registration form" is available on the website: www.libmed.co.za).

***** **Adopted Children:** No waiting period is imposed if registration with LMS is completed within 30 days of the adoption. (The "Dependant Registration form" is available on the website: www.libmed.co.za).

SECTION 5 – PREVIOUS MEDICAL SCHEME MEMBERSHIP

Please provide details of previous medical scheme membership.

Please attach relevant Proof of Membership. This may be a sworn affidavit detailing previous membership history (registration date, benefit date, resignation date, any/all waiting periods and exclusions, all registered dependants). Membership cards or copies thereof will not be accepted. *If not attached, or sufficient proof provided, the Late Joiner Penalty may still apply.*

| Scheme name | Membership number | Are/were all your dependants registered? | | Are you still a member? | | Date joined | | | Date left | | | Reason for leaving | | | | | | | |
|-------------|-------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | Y | N | Y | N | Y | Y | Y | M | M | D | | Y | Y | Y | M | M | D | D |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION 6 – UNDERWRITING INFORMATION

Please ensure that you have completed Section 5.

If you answer “no” to any question in 6.1, you must complete all the medical questions in Section 6.3.

SECTION 6.1

I confirm that all dependants named on this application:

- are currently or have been members of a registered South African Medical Scheme for at least the past 24 months, and Y N
- have not had a break in membership of more than 90 days since resigning from that registered South African Medical Scheme Y N

If you answered “yes” to both of the above questions, please answer the questions in Section 6.2.

If you answered “no” to any question in Section 6.1 you must complete Section 6.3.

SECTION 6.2

For any dependant named on this application form:

- Have they been admitted to hospital in the last 12 months before this application? Y N
- Are they currently taking regular medicine or reasonably expecting to need medicine? Y N
- Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment? Y N

If you answered “yes” to any questions in 6.2, we will apply a three-month general waiting period to your application and you do not have to complete Section 6.3.

During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme Rules.

If you feel that a three-month general waiting period should not be applied and you want to provide us with additional information, please complete Section 6.3.

If you have answered “no” to all of the questions in Section 6.2, your application will be reviewed as per your risk profile to determine if a three-month waiting period will be imposed.

Please note that Late Joiner Penalties might apply.

SECTION 6.3 – HEALTH QUESTIONNAIRE

All sections below to be completed by applicant - failure to do so will delay processing. Please give full details on the questions below. Questions pertain to all additional dependants.

NOTE: If you answered “YES” to any of the questions in this section, and if the space provided to complete your answer is not sufficient to disclose the necessary information, please provide additional information on separate pages.

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|--|--|--|--|--|--|--|--|--|---------------------------------------|--|--|---------|--|--|--|--|--|--|-------------|--|--|--|--|
| Current family doctor | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name and surname | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone | | | | | | | | | | | How long has he/she been your doctor? | | | year(s) | | | | | | | | | | | |
| Postal address | | | | | | | | | | | | | | | | | | | | | Postal code | | | | |

Have you/your spouse or any of your dependants ever received medical advice, diagnosis, care or treatment for any of the following conditions in the last 12 months?

| | | | | | | | | | | | | | |
|---------------------------------------|--|-------------------|---|--|---|---|---|--------------------------------|---|---|---|-------|--|
| 1. Heart & Circulation | Chest pain/Angina; Heart attack; Heart failure; Heart valve defects; Rheumatic fever; High blood pressure (Hypertension); High cholesterol; Heart murmurs; Circulatory problems/disorders; Varicose veins; Deep Vein Thrombosis (DVT) or any other heart or circulatory problems | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Name: | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Tel: | |
| 2. Breathing & Respiratory | Asthma; Difficulty with breathing; Bronchospasm; Tuberculosis (TB); Coughing up blood; Emphysema; Pneumonia; Cystic Fibrosis; Phthisis; Chronic bronchitis; Shortness of breath or any other breathing problems | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Name: | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Tel: | |
| 3. Bladder & Kidneys | Blood in urine; Kidney failure; Polycystic Kidneys; Kidney or bladder infections; Kidney removal (Nephrectomy); Kidney stones; Abnormal Kidney or urine tests or any other bladder or kidney problems | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Name: | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Tel: | |
| 4. Reproductive Organs | Endometriosis; Infertility; Ovarian Cysts; Hysterectomy; Abnormal Pap Smears; Laser treatment; Cervix and Breast Biopsies; Fibro-adenosis of the Breast; Laparoscopies; receiving Hormone Replacement Therapy (HRT); Prostate infections or surgery; Prostate enlargement or any other reproductive problems | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Name: | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Tel: | |
| 5. Digestive System | Duodenal Ulcers; Gastric Ulcers; Peptic Ulcers; Hiatus Hernia; Colon problems; Crohn's Disease; Ulcerative Colitis; Gall Bladder problems; Liver problems or any other digestive system problems | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Name: | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Tel: | |
| 6. Ear, Nose & Throat | Deafness; Ear infections; Sinus problems; Nasal surgery; Throat surgery; Orthodontics; Dental surgery; Speech impairments; Harelip; Cleft Palate or any other nose or throat problems | | | | | | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Name: | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y | Y | Y | Y | M | M | D | D | Tel: | |

| | | | | | | | | | | | |
|------------------|------------------|---|---|--|----------------------------|----------------------------|---|--------------------------------|----------------------------|----------------------------|-------|
| 7. Eyes | | Blindness (partial or full); Eye surgery; Lens implants; Cataracts; Glaucoma; Retinitis Pigmentosa; Retinal Detachment; Impaired vision or any other eye or eyesight problems | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Tel: |

| | | | | | | | | | | | |
|---------------------|------------------|--|---|--|--|--|---|--------------------------------|--|--|-------|
| 8. Endocrine | | Diabetes ("high blood sugar"); Underactive Thyroid; Overactive Thyroid; Thyroid surgery; Cushing's Syndrome; Addison's Disease; Pituitary Gland problems or any other glandular problems | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | Tel: |

| | | | | | | | | | | | |
|------------------------------|------------------|--|---|--|----------------------------|----------------------------|---|--------------------------------|----------------------------|----------------------------|-------|
| 9. Back & Muscles | | Neck or back problems or operations; Recurrent back pain; Osteoporosis; Ankylosing Spondylitis; Rheumatoid Arthritis; Osteo-Arthritis; Paget's Disease or any other bone or skeletal disorders | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Tel: |

| | | | | | | | | | | | |
|-------------------------|------------------|---|---|--|----------------------------|----------------------------|---|--------------------------------|----------------------------|----------------------------|-------|
| 10. Neurological | | Epilepsy; Stroke (CVA); Migraine; Brain injuries; Spinal Cord injuries; Paralysis; Cerebral Palsy; Multiple Sclerosis; Mental retardation; Narcolepsy; Motor Neurone Disease; Parkinson's Disease; Alzheimer's Disease or any other neurological problems | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Tel: |

| | | | | | | | | | | | |
|--------------------------|------------------|---|---|--|----------------------------|----------------------------|---|--------------------------------|----------------------------|----------------------------|-------|
| 11. Psychological | | Depression; Anxiety; Psychosis; Suicide attempts; Bipolar Disorders; Manic Depression; "Stress"; Schizophrenia; Tourette's Syndrome; Anorexia Nervosa; Received advice, counselling or hospitalisation for Alcohol or Drug abuse; Attention Deficit Disorder; Bulimia or any other psychological problems | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Tel: |

| | | | | | | | | | | | |
|----------------------------------|------------------|--|---|--|----------------------------|----------------------------|---|--------------------------------|----------------------------|----------------------------|-------|
| 12. Tumours & Growths | | Benign or Malignant growths or lumps or tumours including: Melanoma; Lymph Gland Cancer; Leukaemia and Breast Cancer or any other tumours, growths and cancers | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Tel: |

| | | | | | | | | | | | |
|------------------|------------------|---|---|--|----------------------------|----------------------------|---|--------------------------------|----------------------------|----------------------------|-------|
| 13. Blood | | Blood or bleeding disorders e.g. Haemophilia; Christmas factor deficiency; Platelet or any other blood clotting disorders | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Tel: |

| | | | | | | | | | | | |
|------------------|------------------|--|---|--|----------------------------|----------------------------|---|--------------------------------|----------------------------|----------------------------|-------|
| 14. Skin | | Eczema; Acne; Dermatomyositis; Pemphigus; Psoriasis; Scleroderma or any other skin disorders | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |
| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | | | | Practitioner/specialist | | | |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Name: |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> Y | <input type="checkbox"/> M | <input type="checkbox"/> M | <input type="checkbox"/> D | <input type="checkbox"/> D | Tel: |

| | | |
|--|--|---|
| 15. Sexually Transmitted Diseases | Advice, treatment or counselling for any of the following: HIV/AIDS; Syphilis; Gonorrhoea; Herpes; Genital Ulcers; Pelvic Infectious Disease (PID); Genital Warts; Hepatitis B or any other sexually transmitted disease or disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |
|--|--|---|

| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | Practitioner/specialist |
|-----------|-----------|------------|---|-----------------------------------|----------------------------|
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Name: <input type="text"/> |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Tel: <input type="text"/> |

| | | |
|----------------------|--|---|
| 16. Treatment | Are you, your spouse or any of your dependants expecting any treatment/procedures/hospitalisation within the next 12 months? | <input type="checkbox"/> Y <input type="checkbox"/> N |
|----------------------|--|---|

| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | Practitioner/specialist |
|-----------|-----------|------------|---|-----------------------------------|----------------------------|
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Name: <input type="text"/> |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Tel: <input type="text"/> |

| | | |
|----------------------------|--|---|
| 17. Hospitalisation | Have you, your spouse or any of your dependants, been hospitalised in the last five (5) years? | <input type="checkbox"/> Y <input type="checkbox"/> N |
|----------------------------|--|---|

| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | Practitioner/specialist |
|-----------|-----------|------------|---|-----------------------------------|----------------------------|
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | Name: <input type="text"/> |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | | Tel: <input type="text"/> |

| | | |
|----------------------|---|---|
| 18. Pregnancy | Are you/ your spouse/ any of your dependants currently pregnant? If the answer to this question is "Yes", when is the expected date of delivery? | <input type="checkbox"/> Y <input type="checkbox"/> N |
|----------------------|---|---|

| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | Practitioner/specialist |
|-----------|-----------|------------|---|-----------------------------------|----------------------------|
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Name: <input type="text"/> |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Tel: <input type="text"/> |

| | | |
|-------------------------|---|---|
| 19. Disabilities | Do you, your spouse or any of your dependants have disabilities not mentioned in the above questions 1 to 18? | <input type="checkbox"/> Y <input type="checkbox"/> N |
|-------------------------|---|---|

| Dependant | Condition | Medication | Receiving treatment | Date of treatment/hospitalisation | Practitioner/specialist |
|-----------|-----------|------------|---|-----------------------------------|----------------------------|
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Name: <input type="text"/> |
| | | | <input type="checkbox"/> Y <input type="checkbox"/> N | Y Y Y Y M M D D | Tel: <input type="text"/> |

DECLARATION FOR HEALTH INFORMATION:

- I warrant that the information I have provided pertaining to me and my dependants is true, correct and complete and that I have not concealed, withheld or misstated any material facts. Should there be any non-disclosure or material misrepresentations, I accept that my membership may be terminated and that I may forfeit my contributions to the Scheme. Liberty Medical Scheme also has the right to claim damages in respect of any loss or damage it may suffer due to my non-disclosure or misrepresentation.
- I undertake to promptly advise the Scheme of any change in status of health of myself or any of my dependants that occurs prior to my receiving acceptance of this application. I acknowledge that not doing so may lead to the Scheme reconsidering the basis of my membership application.
- I accept that waiting periods or late joiner penalties may be applied, based on prior medical scheme membership information I supplied, as provided for in the Medical Schemes Act (Act No.131 of 1998).

Signature of Principal member

Date

SECTION 7 – BANKING DETAILS OF PRINCIPAL MEMBER

- Use this account for ALL transactions: debit order instruction to collect contributions as well as to deposit claim refunds
- Use this account ONLY for debit order contribution collections

Full name of account holder

Name of bank

Branch name Branch code

Account type CHEQUE TRANSMISSION SAVINGS

Account number

Note:

- Please note that the default effective/lodgement date for all debit orders will be on the first business day of the month
- Credit card details are not acceptable

Principal member's signature _____ Date

Account holder's signature _____ Date
(if different from Principal member)

- Use this account for savings/claim refunds only

Full name of account holder

Name of bank

Branch name Branch code

Account type CHEQUE TRANSMISSION SAVINGS

Account number

Principal member's signature _____ Date

Account holder's signature _____ Date
(if different from Principal member)

DECLARATION FOR BANKING DETAILS

1. I instruct Liberty Medical Scheme to electronically collect contributions and to deposit claims and savings funds, via the ACB electronic system, using the information provided above. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorize Liberty Medical Scheme to reverse any erroneous transactions and/or rectify any electronic transfer of funds without prior notice.
2. I authorise Liberty Medical Scheme to debit my bank account for contributions and any other amounts that may become due by me.
3. I authorise the Scheme to contact my bank, should it need to verify any of my bank account details. I also agree to advise the Scheme in writing of any changes to my banking details. Failure to do so will result in me being liable for any subsequent banking charges incurred.
4. I authorise the Scheme to collect, process and share my personal banking details with any contracted Third Party Provider in order to allow the Scheme to fulfill its functions, duties and obligations.
5. I hereby confirm that the bank account details in Section 7 above are correct.
6. Upon joining the Bona Plus option, I hereby authorise Liberty Medical Scheme to furnish my bank account details to CareCross. I authorise CareCross to pay any medical scheme benefits that may be due to me, to this bank, or any other, to which I might change the account.

Signature of Principal member

Date

SECTION 8 – DECLARATION BY PRINCIPAL MEMBER

All information disclosed in this form is subject to the provisions of the Medical Schemes Act No. 131 of 1998 as amended.

1. I, the undersigned, hereby apply for myself and my dependants to join the Liberty Medical Scheme (the Scheme) and declare that this application and declarations together with the statements made by me, whether in my handwriting or not, are true and correct and agree that such statements together with any forms, reports or other information completed or supplied by me or any party on my behalf shall form the basis of the contract.
2. It is further agreed and understood that, notwithstanding any statement made to the contrary by any person, membership will not commence and no liability whatsoever will attach to Liberty Medical Scheme as a result of this application (completed in full with supporting documentation attached), unless and until the first contribution has been paid and received by Liberty Medical Scheme and express written notice of acceptance of the risk is given by Liberty Medical Scheme. The Underwriting Acceptance letter shall be valid for a period of three months only from date of registration.
3. Scheme Rules and Benefits:
 - I agree to be bound and to abide by the Scheme rules, standard terms, conditions and any rules ordinarily used by Liberty Medical Scheme for the type of benefits for which I have applied, and that Liberty Medical Scheme shall not be bound in any way by any representations or undertakings made or given by any person or agent save as contained in the registered rules of the Scheme.
 - I understand that certain benefits in the first year of my membership, once membership has been confirmed by the Scheme, are pro-rated and that I will not be entitled to a full year's cover if I join or change my existing option after 1 January of a year.
4. Contributions and amounts owed to The Scheme:
 - I acknowledge that it remains my responsibility to ensure that the monthly contribution, or other amounts due, are received by the Scheme.
 - I accept that the Scheme has the right to amend monthly contributions and benefits from time to time.
 - I accept that should contributions, or other amounts due be unpaid, that this will result in the suspension of my own and my dependants' benefits and if they remain outstanding, that the Scheme will discontinue my membership.
 - I also accept that I will be responsible for the legal costs associated with the recovery of arrears.
5. Disclosure of information:
 - I declare that no material fact has been withheld, misstated or concealed by me and that I will disclose all material facts prior to acceptance of the risk and I agree that any misstatement and/or omission of any material information will render my membership null and void, and in such an event all monies paid in respect thereof shall be forfeited.
 - I understand that should there be any additional information required by the Scheme that is not received within 14 days, that the Scheme has the authority to suspend my application for membership.
 - I indemnify Liberty Medical Scheme and its trustees, agents and administrator against any claim, of whatever nature, which may be made against them as a result of or arising out of the disclosure of any test results or medical information.
 - I irrevocably authorise any medical practitioner, hospital, medical institution or other person to disclose information which may be related to my own, or my dependants', past or future occupation, physical or mental health, including the results of any tests, to Liberty Medical Scheme, its administrator or managed health care agent and I agree that this authorisation shall remain in force after my/their death/s.
 - I irrevocably authorise the Scheme to collect, process and share my personal information with any contracted Third Party Provider in order to allow the Scheme to fulfil its functions, duties and obligations. I agree that this authorisation shall remain in force after my/their death/s and understand that this may partially limit my right to privacy.
6. Resignation:
 - I hereby acknowledge that any credit extended by Liberty Medical Scheme to myself or my dependants whilst being members of Liberty Medical Scheme will become payable in full upon resignation of my membership of the Scheme and that interest may be charged on all amounts due and owing to Liberty Medical Scheme.
 - I further acknowledge that on resignation of membership, any amounts owing to the Scheme will be deducted from any amounts due to me by my Employer.
 - For this purpose I hereby permit Liberty Medical Scheme to advise my employer of any amounts due to the Scheme where applicable.
 - I, the undersigned, confirm that I understand that it is illegal to belong to more than one registered medical scheme at a time and that all my dependants and I will resign our current medical membership with my/our current scheme prior to joining Liberty Medical scheme.
 - I understand that according to the rules, I may resign my membership of the Scheme on giving one calendar month written notice and that all rights to benefits cease after the last day of my membership.
7. Personal Contact details:
 - I understand that Liberty Medical Scheme may provide written notification to my email address or postal address, failing which, my broker's email address as supplied by my broker, of changes to its Rules.
 - I consent to my telephone conversations with the Liberty Medical Scheme being recorded and forming part of the Scheme's records.
 - I also agree that such records shall remain the sole property of Liberty Medical Scheme.
 - I consent to the use of all contact details given in this application, by Liberty Medical Scheme, or any appointed agent(s) of the Scheme, to send me information pertaining to my membership (confidential or other).
 - I undertake to inform the Scheme, in writing, of change of contact details.
8. Marketing:

In order to keep you updated on activities at Liberty Medical Scheme (LMS), we would like to communicate, where necessary, via emails, sms's and post. Do you wish to receive LMS marketing communications?

| | | | | | | |
|--|-------|---|-----|---|------|---|
| | Email | <input type="checkbox"/> Y <input type="checkbox"/> N | SMS | <input type="checkbox"/> Y <input type="checkbox"/> N | Post | <input type="checkbox"/> Y <input type="checkbox"/> N |
|--|-------|---|-----|---|------|---|

If yes, how would you like to receive them?

| | | | | | | |
|--|-------|---|-----|---|------|---|
| | Email | <input type="checkbox"/> Y <input type="checkbox"/> N | SMS | <input type="checkbox"/> Y <input type="checkbox"/> N | Post | <input type="checkbox"/> Y <input type="checkbox"/> N |
|--|-------|---|-----|---|------|---|

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

I 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

I consent that such contracted Third Party may contact me from time to time regarding their products, services and special offers. Y N
9. I hereby appoint the financial adviser, who has submitted this application on my behalf, to be my nominated financial adviser.
10. I Further accept that the provisions of any previous declaration made in respect of the Scheme has been read and understood by me and will also apply mutatis mutandis to and form part of this application.

Signed at _____ on this _____ day of _____ 20____ Signature of Principal member _____

SECTION 9 – TO BE COMPLETED BY FINANCIAL ADVISER (INTERMEDIARY)

Name and surname

Financial Adviser's Commission code

Are you accredited with the Council for Medical Schemes? Y N

If "YES" please provide Accreditation number Date accredited

Branch name Cell

Office Telephone Other number

Email address

Secondary email address (e.g. Broker Consultant)

Additional instructions by financial adviser (intermediary) to Liberty Medical Scheme administration

Financial Adviser's Signature _____

Date

Record of Advice (Applicable to Agents and Franchise brokers only)

Analysis date

Produced for

ID number

Option that matches your needs based purely on our life stages segmentation

Day-to-day cover required

Non-PMB Chronic Cover required

Threshold Cover required

Option that matches your needs based on our life stages segmentation and considering the above specific health and financial needs.

Recommended LMS Option

Actual LMS Option chosen

Reason for choosing other option _____

RECORD OF ADVICE – I DECLARE THAT:

1. I am appointed by the client to provide advice about this application.
2. I have a valid contract with Liberty Medical Scheme.
3. I am responsible for providing the applicant with:
 - my name, physical address, postal address and telephone number
 - impartial advice that is in his or her best interest
4. I am accountable for any advice given to the applicant about completion of this application form and joining the Scheme.

Financial Adviser's Signature

Date