

**ON CAMPUS USE**

Name & Surname	Signatory	1. Quality Check	Yes	No	3. Membership Certificate printed	Yes	No
d d m m y y y y		2. Card printed	Yes	No			

**OFFICE USE - MEMBERSHIP DEPARTMENT**

1. Capturer	Name & Surname	Signatory	d d m m y y y y
2. Quality Check	Name & Surname	Signatory	d d m m y y y y
3. Card printed	Name & Surname	Signatory	d d m m y y y y
4. Membership Certificate printed	Name & Surname	Signatory	d d m m y y y y

**APPLICANT STATUS**

**New Applicant**  **Renewal**  **Existing Membership Number**

NetworX Option  Confirmation/Correspondance to be sent via: Fax  Email

Period of membership  (months) Method of Payment: Cash  R EFT  Credit Card  R

Start date  End date

**PERSONAL DETAILS** *(To be completed in full)*

Surname

First name/s  Gender Male  Female

Title  Marital status  Nationality  Present age

Date of birth  Passport no

South African postal address  Postal code

South African physical address

Email address

Telephone (H)  Telephone (W)

Facsimile  Cell

Study Institution  Student no

Country of Origin  Embassy

Gross Monthly Income  R

**PLEASE NOTE: Copy of Institution acceptance letter, passport and proof of payment to be attached to this application form**

**MEDICAL DETAILS**

Kindly circle the correct answer e.g. if you circle YES it means you have received OR intend to receive treatment and NO means you have not OR do not intend to receive treatment.

Please indicate and provide details of any medical treatment received.

Have you ever received treatment for Chronic and / or Acute conditions?	Yes	No
Have you received treatment for Chronic and / or Acute conditions in the past twelve months?	Yes	No
Do you anticipate receiving any treatment for Chronic and/or Acute conditions in the next twelve months?	Yes	No

If you answered "Yes" to any of the above questions, please provide details below:

Name	Details of condition	Date of treatment	Degree of recovery

## MEDICAL DETAILS (Continued)

Selected Doctor name (a list of contracted Doctors in your area can be found on [www.universal.co.za](http://www.universal.co.za))

Name of Doctor:  Practice No.:   
Contact No.:

## BANKING DETAILS

Account holder: CompCare Wellness  
Medical Scheme  
Bank: Nedbank  
Branch code: 194405  
Acc number: 1944105972  
Swift no: NEDSZAJJ

Account holder: CompCare Wellness  
Medical Scheme  
Bank: Standard Bank  
Branch code: Rivonia 1255  
Acc number: 422070912  
Swift no: SBZAZAJJ

Account holder: CompCare Wellness  
Medical Scheme  
Bank: ABSA  
Branch code: 632005  
Acc number: 4077182095  
Swift no: ABSAZAJJ

## BANKING DETAILS FOR CLAIMS RE-IMBURSEMENT

**CREDIT CARD AND FOREIGN BANK ACCOUNTS ARE NOT ACCEPTED**

Name of account holder   
Name of bank  Branch code  -  -   
Account number   
Type of account (please tick) Current  Savings  Transmission

### DISCLAIMER

It is the member's responsibility to advise the administrator in writing of any change in banking details. Neither the scheme nor its administrator shall be held liable should an incorrect account be credited under any circumstances.

Signature of applicant \_\_\_\_\_  
Authorised Signature of account holder required (if different from applicant) \_\_\_\_\_

## DECLARATION

- I, the undersigned hereby apply for membership of CompCare Wellness Medical Scheme and agree that all answers and information contained in this application completed by me or by any other person/s will be the basis of the proposed agreement.
- I warrant that the contents of this application are true, correct and complete. No cover will be granted unless CompCare Wellness Medical Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
- I agree to abide by and undertake to familiarise myself with the rules of the scheme as amended from time to time.
- I understand that the scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998).
- I agree to notify the scheme within 30 days in the event that any alteration in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk.
- The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:
  - For the purpose of considering application/s for membership, as well as any claims for benefits, CompCare Wellness Medical Scheme and any medical personnel authorised by CompCare Wellness Medical Scheme has the right to obtain or forward any medically relevant information including the HIV/AIDS status, which it may deem necessary from or to any medical practitioner or institution or nominee that possesses or needs such information, and that party may disclose such information to CompCare Wellness Medical Scheme and any party duly authorised by CompCare Wellness Medical Scheme.
  - The information may be requested and supplied at any time, including after the death of the member or dependants, and will include accounts from service providers, indicating diagnoses, and medical or clinical reports when indicated. Such information will, however, be treated as confidential at all times by the party to whom it is supplied.
  - By agreeing to sign the application form/s the applicant/member and dependants thereby waives his/her right to privacy in terms of the abovementioned clauses.
- I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the scheme.
- Neither the applicant nor any of his/her dependant/s will be/are beneficiaries of another registered medical scheme, on the date of registration with CompCare Wellness Medical Scheme.
- I hereby indemnify and hold harmless the scheme and administrator against any claims that may result due to the use of preferred providers.
- I hereby give the scheme permission to communicate to me by SMS  Email
- I hereby appoint the below mentioned broker as my Healthcare intermediary.

I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the scheme from liability and subject my membership to cancellation. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

<b>Applicant signature</b> _____ If the applicant is a minor, the Parent(s) / Legal Guardian(s) need to complete a CONSENT LETTER	<b>Date</b>
Employer/University/Embassy Signature	Date
Brokerage name or broker name	Broker code
Broker signature	Date



CompCare Wellness Medical Scheme is administered by Universal Healthcare Administrators (Pty) Ltd

Tel: +27 86 122 2777 / Fax: 086 645 4727 / E-mail: [student@universal.co.za](mailto:student@universal.co.za) / website: [www.studentplan.co.za](http://www.studentplan.co.za)

**PLEASE NOTE: Copy of Institution acceptance letter, passport and proof of payment to be attached to this application form**