

E UNDERWRITING QUESTIONS

PLEASE ANSWER "YES" OR "NO" FOR EVERY QUESTION ("Y" or "N")

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholesterol or lipids, Ischaemic heart disease, Heart failure, Angina, Stroke (CVA) or Peripheral vascular disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Obstructive lung disease (asthma, emphysema or COAD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Diabetes (insulin or non-insulin dependant diabetes mellitus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Hypo or hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Arthritis, i.e. osteo and rheumatoid arthritis or gout and all related musculoskeletal conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Osteoporosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Gastro-Oesophageal reflux disease (gord/heartburn) or stomach and duodenal ulcers (please circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8*	Immune deficiency states i.e. HIV/AIDS*, immunoglobulin deficiencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Anaemia or abnormalities of clotting mechanism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Hormone replacement therapy, endometriosis or ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Depression and/or anxiety disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Any nervous or mental complaint e.g epilepsy, blackouts, paralysis or headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Glaucoma, cataracts or any other disorders of the eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Parkinson's disease or Multiple Sclerosis (please circle where applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Hyperplasia of prostate (BPH) or prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Inflammatory Bowel Disease (Crohn's Disease or Ulcerative Colitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Urinary tract infection or calculi (kidney) stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Back or neck related conditions (lumbago, sciatica, injury, spasm etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Are you pregnant, if so how many weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Have you had any surgical procedure during the past 12 months or planning a surgical procedure for the following 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Are you on any medication at present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical aid claim within the next 12 months.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Skin conditions/disorders e.g Acne, Eczema, Psoriasis etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	Ear, nose or throat disorders, e.g. ear discharge, recurrent tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	Infectious diseases e.g Tuberculosis. Shingles, measles etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	Malignant neoplasms (Cancer, growths or malignant tumours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	Benign Neoplasms (non malignant tumours/growths)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	Specialised dentistry /maxillo facial treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	Have you had or are you expecting to have Plastic or reconstructive surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Should you be HIV-positive and not wish to disclose this on your application form, please note that once you have received your membership (contract) number we require you to please fax confirmation of your HIV/Aids status to our HIV/Aids Department on 086 609 3792 or (012) 675 3848. Please note that this may result in you receiving a second card from the Scheme depending on whether your application will require underwriting as per current legislation.

Question No.	Nature and duration of complaint and full details of treatment being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment ?

NB: Failure to disclose any pre-existing conditions could result in benefits being limited, excluded and /or membership terminated.

F Option Selection

Please confirm your selection - tick the relevant box:

NB: The correct choice of option is important, as changes may only be made annually for 1 January each year.

TopMed Traditional	<input type="checkbox"/>
TopMed Savings	<input type="checkbox"/>
TopMed Professional	<input type="checkbox"/>
TopMed Hospital Plan	<input type="checkbox"/>

TopMed Network (please tick your salary band below)		
Salary Band	< R4000	<input type="checkbox"/>
	R4001 - R7000	<input type="checkbox"/>
	R7001 - R13000	<input type="checkbox"/>
	> R13000	<input type="checkbox"/>

Please provide your last 3 months' bank statement and the following supporting documents as proof of income:

- If employed – payslip or most recent tax year's IRP5 certificate
- If individual – income for both member and spouse
- If pensioner – proof of annuity and employer pension or State Older Person's Grant

Banking Details of Applicant

(For direct payment of monies DUE to members.)

Name of Account Holder

Bank Name

Branch Number

Account Number

Account Type (C=Current, T=Transmission, S=Savings)

Banking Details Of Applicant

(For collection of contributions)

Name of Account Holder

Bank Name

Branch Number

Account Number

Account Type (C=Current, T=Transmission, S=Savings)

G Application checklist

Please enclose the relevant documentation with this form.

Important: Registration will be delayed should this application be incomplete or the required documents not attached, as it will be returned to you.

Copy of recent salary statement and/or latest SARS return (For PERSAL and/or Network members)

Original cancellation letter to previous medical scheme (for PERSAL members)

Membership certificate(s) or affidavit of previous medical scheme(s)

H Declaration by applicant

I, the undersigned, apply for the membership as set out in this application for myself (and the registration of my dependants).

I acknowledge that I (and my dependants) will not be considered as members of TopMed until I receive written confirmation of membership. The scheme, or its agents may from time to time do the following in respect of me (and any of my dependants):

- Request and receive any medical and medically related information that is relevant to consider this application and any claim-related benefits for me (and any of my dependants for whom this application is accepted). Such information may be obtained from any healthcare provider or healthcare facility.
- Communicate any medical and medically related information from any healthcare provider or healthcare facility to the scheme's contracted healthcare management company. The purpose of this exchange is to ensure that the most cost-effective and high quality medical care benefits are obtained for all members of the scheme.

I further give my permission for:

- The required information to be requested, communicated and received at any time. This may even be after my death (or that of any of my dependants).
- Any failure to comply with a financial duty towards the scheme to be registered with a credit bureau.

I warrant that the information in this application, whether it is in my own handwriting or not, is complete and correct. This also applies to information in other documents provided by me, any of my dependants, or healthcare provider or healthcare facility. If any information is not complete or correct the Scheme may cancel my membership in full. The scheme may also cancel my membership in full if the incomplete or incorrect information pertains to any of the dependants. Otherwise the Scheme may cancel the registration of the dependant regarding whom the information was incomplete or incorrect. In either case, I shall forfeit the full contributions already paid to the Scheme, or the contributions for the dependant who has been removed from my membership. If my membership is cancelled in full, I shall also pay back to the Scheme all benefits paid out to me and any of my dependants. If a dependant is removed from my membership, I shall pay back all benefits paid for such a dependant.

I undertake to advise TopMed of any change in my state of health (or that of any of my dependants) which occurs prior to my receiving written acceptance of this application.

If any of the medical details that I have supplied in this application change before my membership starts, the Scheme may reconsider my application. The Scheme, at its own discretion and even after my membership has started, may reconsider the full application, or only that of a certain dependant. If this is the case, the terms as explained in this declaration will apply.

I understand that the relationship between me (and any of my dependants) and the Scheme is controlled by the rules of the Scheme. I undertake to familiarise myself (and any of my dependants) with the rules of the Scheme, as well as the changes that are made to the rules from time to time.

Signature of Applicant: _____

Date signed

Signature of Employer: _____

Date signed

Employer Stamp:

Join Date

