

MEMBERSHIP APPLICATION

NOTE:

- Please attach a copy of the following:
 - Copy of ID of Principal Member and all dependants
 - Copy of Payslip or proof of income for Trail Option
 - Copy of Membership Certificate of previous medical scheme if applicable

Please complete in **Black Ink** and use large block letters. Where there are **YES/NO** questions mark **[Y]** for Yes and **[N]** for No. Where there are tick boxes, mark with an X.

A: PLAN SELECTION

TRAIL Income less than R5500
 TRAIL Income R5501- R7500
 TRAIL Income R7501+
 LANE
 AVENUE
 TERRACE

B: EMPLOYER DETAILS

Name of employer
 Existing PATHFINDER employer number (if applicable)
 Employee number(if applicable)

C: PRINCIPAL MEMBER DETAILS

Surname
 First name(s)
 Initial(s) Title Gender M F Date of birth
 ID number Tel (h)
 Tel (w) Cell
 Fax Marital Status
 Physical Address
 Code
 Postal Address
 Code
 E-mail Address
 Preferred means of correspondance
 Mail
 Email
 Fax
 Tel(h)
 Tel(w)
 Cell
 SMS

Trail Members - Elected PATHFINDER Network GP

D: DEPENDANT DETAILS

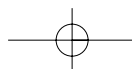
Please complete a physical address and Elected Pathfinder Network GP if any of your dependants are NOT living with you.

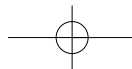
Name and Surname
 Date of birth Gender M F Husband/wife etc Living with you Y N
 Physical Address#
 Code

Trail Members - Elected PATHFINDER Network GP Tel

Name and Surname
 Date of birth Gender M F Husband/wife etc Living with you Y N
 Physical Address#
 Code

Trail Members - Elected PATHFINDER Network GP Tel





Name and Surname

Date of birth Gender M F Husband/wife etc Living with you Y N

Physical Address#

Code

Trail Members - Elected PATHFINDER Network GP Tel

Name and Surname

Date of birth Gender M F Husband/wife etc Living with you Y N

Physical Address#

Code

Trail Members - Elected PATHFINDER Network GP Tel

E: OTHER DETAILS

1. Have you or your adult dependants had 2 years continuous membership of any medical scheme(s) without a break of more than 3 months? Y N

2. Please provide details of your medical scheme membership for the past 2 years. **(Attach membership certificate)**

1. Medical Aid name Scheme

Membership Number from to

Reason for termination

2. Medical Aid name Scheme

Membership Number from to

Reason for termination

3. Medical Aid name Scheme

Membership Number from to

Reason for termination

3. Have you, your spouse or any of your dependants ever been refused cover or offered cover on special terms by a life insurance company or medical scheme? Y N

If "yes" please state the name of the company, your policy number and reason

4. Choose your commencement date between A or B

A. Specified date of commencement of PATHFINDER membership

OR

B. The 1st of the month of acceptance Y N

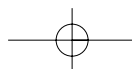
F. MEDICAL DETAILS

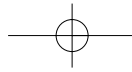
Have you or any of your dependants ever been subject to any of the following conditions? `if "Yes", state full details of each instance in the space provided at the end of this question on page 4.

Please provide detailed names and telephone numbers of your consulting doctor.

Current doctor Tel Years

According to the Medical Schemes Act No 131 of 1998 Section 29 A, a medical scheme may impose certain waiting periods prior to paying benefits. These waiting periods are dependant upon the time period that a member did not belong to a medical scheme prior to application. In order to determine the waiting peroid applicable to certain benefits, on all proposed beneficiaries, please provide the following information in respect of all conditions for which medical advise, diagnosis, care or treatment was received.





1. Has your weight, the weight of your spouse or any of your adult dependants changed by more than 5kg in the last 12 months? Y N

2. Have you, your spouse or any of your adult dependants ever been advised to reduce alcohol or tobacco consumption? Y N

3. Are you or any of your dependants currently undergoing any form of routinely prescribed treatment, or have you or any of your dependants undertaken any form of routinely prescribed treatment in the past? Y N

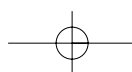
4. Have you, or any of your dependants ever experienced, or been treated for, or are you currently suffering from any of the following conditions? Y N

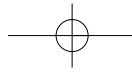
- | | | |
|---|--|---|
| a. Mental/Emotional Disorders | eg. Anxiety, depression, schizophrenia, anorexia, any other eating disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |
| b. Central/Periphera nervous system Disorders | eg. Brain and spinal cord disorders, stroke, multiple sclerosis, epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c. Eye disorders, Hearing Impairment | eg. Glaucomea, retinitis, other visual disorders, hearing or speech impairment or Speech Disorders | <input type="checkbox"/> Y <input type="checkbox"/> N |
| d. Cardiovascular Disorders | eg. Heart conditions that have required treatment surgery, angina(chest pain), rheumatic fever, coronary artery disease(heart attack), cardia failure, murmurs, high blood pressure, rhythm disturbances, raised cholestrol. | <input type="checkbox"/> Y <input type="checkbox"/> N |
| e. Respiratory Disorders | eg. Difficulty in breathing, shortness of breath, persistant cough, tuberculosis, croup asthma, sinusitis, bronchitis, haemoptysis(coughning up blood) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| f. Gastro-Intestinal Disorders | eg. Peptic ulcer, hiatus hernia, oesophagitis(heartburn), colitis, alteration of bowel habits or bleeding disorders of the liver, gallbladder, spleen or pancreas, ascites | <input type="checkbox"/> Y <input type="checkbox"/> N |
| g. Kidney or Urinary tract related Disorders | eg. Polycystic kidneys, haematuria(blood in urine), nephritis, prostatitis, nephrectomy renal failure, renal stones, recurrent urinary tract infection | <input type="checkbox"/> Y <input type="checkbox"/> N |
| h. Gynaecological Disorders | eg. Ovarian cysts, menstrual disorders, endometriosis, fibroids, or enlarged uterus, infertility, disorders of the cervix | <input type="checkbox"/> Y <input type="checkbox"/> N |
| i. Lumps or Growths | eg. Benign or malignant growths of any type, including skin lesions | <input type="checkbox"/> Y <input type="checkbox"/> N |
| j. Blood Disorders | eg. Anaemia, Leukemia, bleeding disorders | <input type="checkbox"/> Y <input type="checkbox"/> N |
| k. Endocrine disorders syndrome, | eg. Diabetes or hypo-thyroidism, growth disorders, Cushing's syndrome Addison's syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N |
| l. Connective Tissue and Skin Disorders | eg. Systematic lupus erythematosus, scleroderma, keloid or hypertrophic scars | <input type="checkbox"/> Y <input type="checkbox"/> N |
| m. Musculoskeletal Disorders | eg. Rheumatism, arthritis, disorders of the spinal structure, myasthenia or any physical disability, any back problems, eg. slipped disk, back ache, sciatica(pinched nerve) | <input type="checkbox"/> Y <input type="checkbox"/> N |

5. Have you or any of your dependants ever had, or are you or any of your dependants currently undergoing, or anticipating any specialist dental treatment, eg. orthodontic, periodontic, prosthodontic, maxillo facial procedures or treatment for impacted wisdom teeth? Y N

6. a. Have you or any of you dependants ever had counselling, treatment or advise for sexually transmitted diseases? Y N

b. Have you or any of your dependants ben diagnosed with, or received treatment in connection with HIV or the AIDS virus? Y N





7. Do you or any of your dependants have any congenital, hereditary or physical disabilities? Y N

8. Has any parent or sibling of any of the proposed members to be covered ever suffered from porphyria, cancer, mental illness, retinitis pigmentosa, diabetes, stroke, chest pain, raised cholestrol or any other hereditary disorder? Y N

9. Are any of the proposed family members currently pregnant? Y N

10. Have any proposed family members received advice, counselling or treatment for alcoholism or drug dependency? Y N

11. Do you or your dependants participate in any hazardous sports or persuits eg., mountaineering, paragliding, bungeejumping, scuba diving, etc.? Y N

12. The above questions are prompts and are not exhaustive. Should you or your dependants have any condition and symptom which is not directly covered by these questions, but which is material to our consideration of the risk, you are nonetheless obliged to disclose it. Are you aware of any such condition? Y N

13. Have you undergone any surgery or hospital treatment in the last 2 years? Y N

14. Do you or any of your dependants expect treatment, hospitalisation etc. in the next 12 months for any conditions? Y N

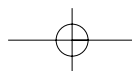
If yes give full details.

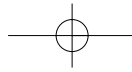
Name	Condition	Treatment Cost

If any question is answered "yes" please supply full details below.

If the space provided is not sufficient, please attach additional information to the application.

Question Nr	Member Name	Full details of disorder, date diagnosed, duration of treatment and the consulting doctor's name, address and tel. no.	Degree of recovery	Average monthly cost of medication





G. CLAIM PAYMENT DETAILS

Name of bank Branch
 Account type Branch Code
 Name of account holder
 Account number

I agree to advise PATHFINDER Medical Scheme in writing of any changes which may occur.

Signature of account holder

H. CONTRIBUTION PAYMENT DETAILS (IF NOT PAID OVER BY EMPLOYER)

Note: Contributions are payable monthly in advance.

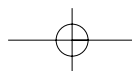
Name of bank Branch
 Account type Branch Code
 Name of account holder
 Account number
 Debit order date 1st 15th 25th

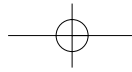
PATHFINDER Medical Scheme may debit this bank account with the amount due in terms of this contract, wherever it may be conducted, in accordance with the PATHFINDER Medical Scheme debit order system. I further agree to advise PATHFINDER Medical Scheme in writing of any changes that may occur.

It is my sole responsibility as a member to ensure that the monthly contribution is received by PATHFINDER Medical Scheme and understand that membership may be suspended or cancelled if contributions are outstanding.

Signature of Account holder

Name





I. CONDITIONS, UNDERTAKINGS AND WARRANTIES

1. **I apply for my dependants and myself to join the PATHFINDER** Medical Scheme administrated by the MX Group of Companies, and agree to abide by and to familiarise myself with the rules of the Scheme, which are available on request.
2. Any breach of any warranty or non-disclosure of any information by myself or my dependants relevant to this application shall render any contracts to which this application relates null and void, and all contributions paid by me shall be forfeited to the scheme. In such events PATHFINDER Medical Scheme shall be entitled to reclaim any amounts which they may have paid to me or any person on my or my dependants' behalf under such contracts.
3. I will notify PATHFINDER Medical Scheme should any alteration, in any circumstances on which the assessment of their risk is based, occur after the date of this application and before the date of PATHFINDER Medical Scheme's acceptance of the risk. I acknowledge that failure to do so shall render any contracts to which this application relates null and void, and in such event PATHFINDER Medical Scheme shall be entitled to reclaim any amounts which have been paid to me or any person on my or my dependants' behalf under such contracts. I understand that failure to declare any medical conditions may result in a pre-authorisation being declined or additional waiting periods being imposed or my membership could be cancelled with no refund in contribution being received.
4. I shall notify PATHFINDER Medical Scheme should I, or any of my dependants require hospitalisation for a non-emergency event. I understand that failure to do so could result in benefits being declined or reduced.
5. No benefit will be payable by PATHFINDER Medical Scheme unless they are satisfied as to the validity of a claim and have received all the information they may require from me or my dependants.
6. I give consent to PATHFINDER Medical Scheme to address any request for information, tests or examinations directly to any dependant of mine (over the age of 21), with the same legal consequences as if the request had been addressed to me in my capacity as a principal member.
7. I authorise PATHFINDER Medical Scheme to obtain from any person any information, which they may require in their sole and absolute discretion concerning myself or any dependant of mine in assessing any risk or claim relating to this application. I direct the person concerned to provide PATHFINDER Medical Scheme with such information requested.
8. It is my sole responsibility as a member to ensure that the monthly contribution is received by PATHFINDER Medical Scheme and understand that membership may be suspended or cancelled if contributions are outstanding.
9. On termination of my membership from PATHFINDER Medical Scheme:
 - 9.1 I shall repay PATHFINDER Medical Scheme any amount owing by me.
 - 9.2 I understand that should contributions to (PHSA) exceed claims paid from this account the excess will be paid to me, or will be transferred to my new medical aid savings account in accordance with the Medical Scheme's Act.
10. I consent to all conversations between myself and PATHFINDER Medical Scheme being recorded and all information obtained through these conversations forming part of PATHFINDER Medical Scheme's records. I further consent to all of these recordings remaining the sole property of PATHFINDER Medical Scheme.
11. I undertake to obtain the necessary consent from any dependant of mine to whom these conditions may apply and indemnify PATHFINDER Medical Scheme against any claim which may arise as a result of my failure to do so.
12. I warrant that the contents of this application are correct and complete.
13. I acknowledge that should this application be submitted via the Internet it is solely for purposes of convenience and neither I nor PATHFINDER Medical Scheme (subject to its sole discretion) shall rely on the information herein contained without me first providing PATHFINDER Medical Scheme with a signed hard copy of this application. I further agree that the hard copy submitted pursuant to an Internet application shall constitute an offer on my part for membership of the PATHFINDER Medical Scheme.
14. I acknowledge that I must provide one month's (calendar month) written notice to cancel my membership. Any cancellation received by the Scheme before the 5th of a particular month will be accepted for that month. Cancellations received after the 5th will result in membership being cancelled the following month. I furthermore understand that I may not be on two medical schemes at any given time and understand that any new membership can only commence after my membership with any other medical scheme has been cancelled.

Signed at _____ on _____ day of _____ 20_____

Principal Member signature _____

J. Intermediary details

Broker Code number(s)

Broker house Code number(s)

PATHFINDER consultant Code number(s)

Broker Signature _____

Brokers Contact details Tel (w): Cell:

Membership Card to be forwarded to: Member Broker Employer

