MEDLEX HEALTHCARE CENTRE

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MEDLEX HEALTHCARE CENTER INTEGRATIVE HEALTH AND WELLNESS

APPLICATION FOR **MEMBERSHIP**

PERSONAL PARTICULARS

APPLICANT

Title [ ] Initials [ ] Gender Male [ ] Female [ ]

First name/s [ ]

Surname [ ]

Date of birth [ ] DD/MM/YYYY

Identity/Passport number [ ] Country of issue [ ]

BURS income tax number [ ]

Please tick the applicable box Single [ ] Married [ ] Common law [ ] Divorced [ ]
Separated [ ] Widow(er) [ ]

CONTACT DETAILS

Physical address [ ]
[ ]
[ ] Postal code [ ]

Postal address [ ]
[ ]
[ ] Postal code [ ]

Telephone number (h) [ ] Telephone number (w) [ ]

Cell phone number [ ]

Email address [ ]

Please tick your preferred method of communication Email [ ] Post [ ]

If no selection is made and a valid email address is provided, all correspondence and statements will be emailed. Should there be no valid email address, correspondence and statements will be posted.

SPOUSE/PARTNER

Note: A marriage certificate or affidavit confirming co-habitation or proof of customary union is required.

Title [ ] Initials [ ] Gender Male [ ] Female [ ]

First name/s [ ]

Surname [ ]

Date of birth [ ] DD/MM/YYYY

Identity/Passport number [ ] Country of issue [ ]

Relationship [ ]

Telephone number (h) [ ] Telephone number (w) [ ]

Cell phone number [ ]

Email address [ ]

Please note: The membership reserves the right to request additional information if required.

PERSONAL PARTICULARS (CONTINUED)

*** If a dependant is not living with you, please provide a physical address.**

Please attach a copy of each dependants ID, passport or birth certificates for children. The Scheme may contact you should there be outstanding information or if further documentation is required.

Provisions of the Protection of Personal Information Act (POPIA) which came into effect from 1 July 2020, requires that all medical schemes communicate directly with dependants who are 18 years and older.

DEPENDANT 1

First name/s

Surname | Relationship

Gender | Male | Female | Contact telephone number

Date of birth | DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

DEPENDANT 2

First name/s

Surname | Relationship

Gender | Male | Female | Contact telephone number

Date of birth | DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

DEPENDANT 3

First name/s

Surname | Relationship

Gender | Male | Female | Contact telephone number

Date of birth | DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

DEPENDANT 4

First name/s

Surname | Relationship

Gender | Male | Female | Contact telephone number

Date of birth | DD/MM/YYYY

Identity/Passport number | Country of issue

Email address

Physical address*

Postal code

BANKING DETAILS OF APPLICANT (ONLY IF MEMBER PAYS THE CONTRIBUTIONS). * Please see important note on page 11

Please do not provide credit card details. Medlex Health Care is not allowed to record your credit card details.

Name of account holder

Name of bank

Branch name

Branch code

Account number

Type of account Current ☐ Savings ☐

Please use this account for claims refunds Yes ☐ No ☐

Signature of account holder

BANKING DETAILS OF APPLICANT (FOR CLAIMS REFUNDS IF IT IS DIFFERENT TO THE DETAILS ABOVE)

This section must only be completed if claims refunds should be paid into an account different from the account above.
Please do not provide credit card details. Medlex Health Care is not allowed to record your credit card details.

Name of account holder

Name of bank

Branch name

Branch code

Account number

Type of account Current ☐ Savings ☐

Signature of account holder

The Board of Trustees is entitled to alter or rescind any rule or annexure in terms of the Scheme rules.

EMPLOYER INFORMATION

Name of employer		
Employer number		
Applicant's employee number		
Applicant's occupation		
Date of permanent employment		DD/MM/YYYY
Date membership is to start		DD/MM/YYYY
Income/Salary	P	
Business telephone number		
Employer email address		

ALL INFORMATION PROVIDED HEREIN IS CERTIFIED CORRECT

It is hereby confirmed that the applicant is your employee and commenced employment on the date indicated above.

Signed on behalf of the employer		Date	DD/MM/YYYY
Name of signatory			
Designation			

DETAILS OF FINANCIAL ADVISOR (WHERE APPLICABLE)

Broker name	
Broker number	
Brokerage name	
Brokerage number	

Signature		Date	DD/MM/YYYY

Disclaimer: The Scheme will only pay the agreed commission to the Scheme's accredited brokerages.

The Scheme has an agreement with certain brokerages and not with individual brokers. Commission is therefore paid to the accredited brokerage for the servicing of members.

WAITING PERIODS AND PENALTIES

The general waiting period is three months (all benefits) and/or a 6-month waiting period on the pre existing sickness and late-joiner premium penalties.