Adding Dependant Application

genesis
MEDICAL SCHEME

Postal Address: Genesis Medical Scheme, P.O. Box 144, Observatory, 7935
Physical Address: 4th Floor, The Terraces, Black River Park, Fir Street, Observatory, 7925
Tel: 0861 JOINNOW (0861 564 6669) **Fax:** 021 447 4707 **Email:** genesis@genesismedical.co.za **Web:** www.genesismedical.co.za

A. Personal Particulars - Member

Title: (e.g. Mr / Mrs / Ms / Dr / Prof / Pastor, etc.) Initials:

Surname:

First names:

Identity number / Passport number: Membership number:

Current benefit option:

Residential address:
(Chosen *domicilium citandi et executandi*) Postal code:

Email address:

B. Dependant Information

When would you like cover to start? DDMMYYYY

For "Relationship to Member", please state spouse, partner, son, daughter, etc. DO NOT state child or adult.

	1	2
Title:	Initials:	Initials:
Surname:		
First name(s):		
Relationship to Member:		
ID no. / Passport no.: *(Please include copy of passport)*		
Date of birth / Gender:	DDMMYYYY M F	DDMMYYYY M F
Family doctor:		
Telephone:		
Doctor since:	DDMMYYYY	DDMMYYYY
Height?	CM	CM
Weight?	KG	KG
Smoker?	Y N How many per day?	Y N How many per day?
If **NO**, has he/she smoked in the last 24 months?	Y N How many per day?	Y N How many per day?

C. Dependant(s) Previous Medical Scheme Membership

Name of dependant(s)	Name of scheme	Membership number	Join date	End date	Reason for cancellation of membership

D. Medical History

To be completed by the Member in person in respect of all nominated dependant(s). It is important to note that if you do not provide full and complete answers, your membership of Genesis may be declared null and void. Please answer every question with a "X" in the appropriate box.

This section is extremely important. Any omission or misrepresentation of information may lead to refusal to admit any claims for treatment received, or termination of membership. All conditions, symptoms or disorders have to be declared, no matter how insignificant they may seem.

Has your new dependant(s) experienced any of the following conditions, symptoms or disorders, or sought or obtained any medical advice, treatment or counselling in respect thereof?

1. Raised blood fats e.g. cholesterol, stroke, high blood pressure, heart murmur, angina, heart attack or any other cardiac or blood disorder? Y N
2. Nephritis, kidney stones, congenital kidney disorders or any other urinary or kidney disorder? Y N
3. Difficulty with breathing, persistent cough, tuberculosis, asthma, bronchitis, croup, or any other disorders/conditions of the ear, nose or throat including recurrent sore throat and/or tonsillitis? Y N

4. Conditions of the joints, limbs and spine including rheumatism, arthritis, neck or back disorders or any physical disability? Y N
5. Diabetes, raised blood sugar, sugar in the urine, glandular disorder, or any endocrine disorder? Y N
6. Any lumps or growths (benign or malignant) or any other types of cancer, such as lymphomas (including Hodgkin's disease) and leukaemia, skin cancer, etc.? Y N
7. Epilepsy, migraine or any other neurological disorder? Y N
8. Gastric or duodenal ulcers, hiatus hernia, gall bladder or liver disorders or any other digestive system disorder? Y N
9. Any dental, chiropractic, optical or gynaecological treatment, advice, consultations, tests or hospitalisation? Y N
10. Advice, counselling, treatment or therapy for alcoholism, drug dependence, mental or emotional disorders including depression, bipolar mood disorder or psychosis? Y N
11. Medical advice, counselling or treatment in connection with HIV/AIDS or any sexually transmitted disease, e.g. hepatitis B, gonorrhoea or syphilis? Y N
12. Is your new dependant(s) pregnant? If so, what is the expected date of delivery? M M Y Y Y Y Y N
13. Does your new dependant(s) expect to seek medical advice or treatment in the next 6 months? Y N
14. The above questions are prompts and are not exhaustive. Should your new dependant(s) have had any previous surgery or any related or consequent or suspected condition(s) or symptom(s) which are not directly covered in these questions, you are nonetheless obligated to disclose it. Are you aware of any such conditions? Y N

Please complete this table IN FULL if you have answered "YES" in any of the above 14 questions.

Question no.	Name of dependant	Diagnosis	Date first diagnosed	Currently on treatment for this condition YES / NO	Date of last consultation, hospitalisation or medication taken for this disorder	Treating practitioner's name and telephone number

E. Member's Declaration (MUST BE SIGNED BY MEMBER PERSONALLY)

I, the undersigned principal member in good standing of Genesis Medical Scheme ("Genesis" or "the Scheme"), hereby make application to have the person(s) referred to in this Application Form admitted to the Scheme as my dependant(s).

I declare that my answers and the information supplied by me in this Application, whether in my own handwriting or not, are true, correct and complete in every respect. I undertake to advise the Scheme of any change in the state of health of my dependant(s) which occurs prior to commencement of their membership.

I understand that should this Application contain any false statement or fail to disclose any material information, the Board of Trustees of Genesis ("the Board") may, at its sole and absolute discretion, elect to regard my membership and/or that of all or some of my dependant(s) as *void ab initio*, as if it never happened. I understand that the consequence of this election on the part of the Board will be that I will be obliged to immediately repay to the Scheme all benefits received by or on behalf of me and that all or part of the contributions paid by me to the Scheme may be retained by the Scheme to offset any costs which the Scheme has incurred on my behalf.

In every other respect I agree to be bound to the declaration signed by me when I applied to membership of Genesis, including but not limited to, the binding force of the Rules of Genesis.

I acknowledge and confirm that I have not received any advice or opinions of whatsoever nature (including, but not limited to, advice which would fall under the ambit of the Financial Advisory and Intermediary Services Act 37 of 2002) or in whatsoever form (whether verbally, in writing or otherwise) from Genesis Medical Scheme ("Genesis" or "the Scheme"), its employees, consultants, independent contractors or any other person relating to the Scheme in relation to this Application and that only factual information relating to the Scheme has been provided to me to assist me with this Application. This Application is therefore not based on, or directly or indirectly influenced by, any advice or opinions which were provided to me by the Scheme, its employees, consultants, independent contractors or any other person relating to the Scheme.

Signed at: ____ on the ____ day of ____ year ____

Print name and surname of Member: ____

Signature of Member: ____

F. For Scheme Use:

Application for membership accepted subject to the following terms and conditions: