



FOR OFFICE USE ONLY

Member number

APPLICATION FOR MEMBERSHIP

PLEASE COMPLETE IN BLOCK LETTERS

INSTRUCTIONS

It is imperative that all sections of this application form be completed in full. Failure to do this may cause a delay in the processing of the application, as the incomplete form will be returned to the applicant.

If you require assistance in completing this form, please contact the Client Service Department on 0860 104 121.

PLEASE SELECT YOUR OPTION

Primary Option Standard Option

1. APPLICANT'S INFORMATION

Identity number (copy of identity document to be attached to the application form.)

Surname

First names

Title Date of birth

Gender Male Female Employee/pension number

Marital status Single Married Separated Divorced Widow/er Co-habitee

Date of marriage

Telephone number (h) (w)

Fax number Cell number

E-mail address

Postal address Code

Physical address Code

2. EMPLOYMENT DETAILS

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Company name Employee number

Company address

Date of employment

Scheme admission date

3. BANK DETAILS FOR DIRECT CREDIT OR REFUND

Account holder

Account number Account type Current

Name of bank Transmission

Branch and town Savings

Branch code

I hereby request and authorise you to credit any medical aid benefits which may accrue to me to the account mentioned above.

Signature _____

Date

4. DEPENDANT CLASSIFICATION AND PROOF REQUIRED

DEFINITION OF DEPENDANT	DOCUMENTATION REQUIRED
Spouse	Marriage certificate
Natural child	ID, birth certificate, if > 21 years adult dependant affidavit
Student	If over 21 then provide ID, proof of registration at educational institution
Natural child with different surname to principal member	ID, full birth certificate, affidavit >21 years
Stepchild	ID, affidavit (proof of stepchild), affidavit >21 years
Adopted child	ID, affidavit (proof of adoption)
Disabled child	ID, recent doctor's report of disability, proof of state grant/pension
Traditional spouse	ID, affidavit (proof of traditional marriage)
Polygamous spouse	ID, affidavit (proof of polygamous marriage)
Parents/siblings/child over 21 of principal member	ID, affidavit, proof of income
Common-law partner	ID, affidavit
Same gender partner	ID, affidavit

5. DEPENDANTS' INFORMATION

	SURNAME	FIRST NAME	ADULT/ CHILD		IDENTITY NUMBER/ DATE OF BIRTH										GENDER		RELATIONSHIP (i.e. spouse, son, etc.)			
			Adult	Child	1	2	3	4	5	6	7	8	9	10	11	12		M	F	
1			A	C														M	F	
2			A	C														M	F	
3			A	C														M	F	
4			A	C														M	F	
5			A	C														M	F	
6			A	C														M	F	
7			A	C														M	F	
8			A	C														M	F	
9			A	C														M	F	
10			A	C														M	F	

6. PREVIOUS MEDICAL AID MEMBERSHIP HISTORY (PLEASE ATTACH COPIES OF ALL PREVIOUS MEDICAL AID CERTIFICATES.)

Are or were you or any of your nominated dependants members of a registered medical aid scheme(s) during the last two years? YES NO

If "YES", a certificate of membership (not a membership card) must be attached to this application. Immediate benefits may be granted if you were a member of a registered scheme(s) for two or more years prior to joining FISHING INDUSTRY MEDICAL SCHEME. If not, a waiting period may be imposed.

CURRENT MEDICAL AID MEMBERSHIP

PREVIOUS MEDICAL AID MEMBERSHIP

(If more, use separate page.)

Name of scheme	<input type="text"/>	<input type="text"/>
Member number	<input type="text"/>	<input type="text"/>
Date of commencement	<input type="text"/>	<input type="text"/>
Date of cessation	<input type="text"/>	<input type="text"/>
Exclusions imposed	<input type="text"/>	<input type="text"/>

7. QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please complete all the required information by inserting a tick in the relevant box. If the answer to any question is "YES", provide details overleaf.

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

1. Have you or any of your dependants ever had any of the following?
 - 1.1 Any disorder/dysfunction of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)? YES NO
 - 1.2 High blood pressure or disorder/dysfunction of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder/dysfunction)? YES NO
 - 1.3 Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis/persistent cough, tuberculosis)? YES NO
 - 1.4 Any disorder/dysfunction of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, hepatitis B or persistent diarrhoea)? YES NO
 - 1.5 Any disorder/dysfunction of the kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)? YES NO
 - 1.6 Any nervous or mental disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)? YES NO
 - 1.7 Any ear, nose or throat disorder/dysfunction (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment, chronic sinusitis)? YES NO
 - 1.8 Any disorder/dysfunction of muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)? YES NO
 - 1.9 Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder/dysfunction? YES NO
 - 1.10 Any lumps, growths (benign or malignant), types of cancers (including Hodgkins and leukaemia) skin cancers or skin disorders/dysfunctions? YES NO
 - 1.11 Any tropical diseases (e.g. bilharzia, malaria, cholera)? YES NO
 - 1.12 Any other condition, illness, disease, disorder/dysfunction, disability or accident which required medical, radiological, surgical, pathological or dental investigations during the past 12 months? YES NO
 - 1.13 Been tested for or received or expected to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or an AIDS-related condition or any sexually transmitted infection (e.g. hepatitis B, gonorrhoea or syphilis)? YES NO
 - 1.14 A weight change or the weight of your dependants changed by more than 5kg over the last 12 months? YES NO
2. Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? YES NO
3. Do you or any of your dependants currently use medication on a daily basis? YES NO
4. Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire relating to past or present diseases, accidents, operations, tests or other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months? YES NO
5. Are you or any of your dependants expecting to undergo any medical procedure, operation, confinement or receive any major dental treatment during the next 12 months? YES NO

If you answered "YES" to any of the questions above, please complete details overleaf in full. If additional space is required, please complete a separate sheet of paper and attach it to the application.

