CompCare
Medical Scheme

NETWORX
APPLICATION FORM

Universal House, 15 Tambach Road, Sunninghill Park, Sandton
PO Box 1411 Rivonia 2128
Tel: +27 86 122 2777
E-mail: student@universal.co.za
Website: www.studentplan.co.za

Administrated by Universal Administrators (Pty) Ltd

ON CAMPUS USE

Name & Surname	Signatory	1. Quality Check	2. Card printed	3. Membership Certificate printed
d d m m y y y y		Yes / No	Yes / No	Yes / No

OFFICE USE - MEMBERSHIP DEPARTMENT

	Name & Surname	Signatory	d d m m y y y y
1. *Capturer*			
2. *Quality Check*			
3. *Card printed*			
4. *Membership Certificate printed*			

APPLICANT STATUS

New Applicant ☐ **Renewal** ☐ **Existing Membership Number**

NetworX Option ☐ Confirmation/Correspondence to be sent via: SMS ☐ Email ☐

Period of membership (months) Method of Payment: Cash R EFT Credit Card R

Start date d d m m y y y y End date d d m m y y y y

PERSONAL DETAILS *(To be completed in full)*

Surname

First name/s Gender Male ☐ Female ☐

Title Marital status Nationality Present age

Date of birth d d m m y y y y Passport no

South African Postal address Postal code

South African Physical address

Email address

Telephone (H) c o d e Telephone (W) c o d e

Study Institution Cell c o d e

Country of Origin Student no

Gross Monthly Income R Embassy

PLEASE NOTE: Copy of Institution acceptance letter, study visa, passport and proof of payment to be attached to this application form

MEDICAL DETAILS

Kindly circle the correct answer e.g. if you circle YES it means you have received OR intend to receive treatment and NO means you have not OR do not intend to receive treatment.

Please indicate and provide details of any medical treatment received*

Have you received treatment for Chronic and/or Acute conditions in the past twelve months?		Yes	No
Do you anticipate receiving any treatment for Chronic and/or Acute conditions in the next twelve months?		Yes	No
Have you been admitted to hospital in the 12 months prior to completing this application form?		Yes	No
Do you anticipate being admitted to hospital in the next 12 months?		Yes	No
Are you pregnant or suspect that you may be pregnant?	N/A	Yes	No

If you answered **"Yes"** to any of the above questions, please provide details below:

Name	Details of condition	Date of treatment	Degree of recovery

Explanation of *: *Please ensure that when completing this form, you provide complete, up to date and accurate information at all times. Any non-disclosure of material information or any other fraudulent act, may result in the cancellation or suspension of your membership. You may be guilty of an offence as provided for in the Medical Schemes Act No 131 of 1998 and liable on conviction to a fine or imprisonment or both.

In the event that I am hospitalised and the Scheme will need to communicate with someone on my behalf, I hereby nominate the following person and warrant that I have obtained their consent to share their personal details with the Scheme for this purpose:

Name and Surname _____ Relationship _____

Telephone details Tel: Code ( ) _____ Cell: _____

BANKING DETAILS

Account holder:	CompCare Wellness Medical Scheme	Account holder:	CompCare Wellness Medical Scheme	Account holder:	CompCare Wellness Medical Scheme
Bank:	Nedbank	Bank:	Standard Bank	Bank:	ABSA
Branch code:	194405	Branch code:	Rivonia 1255	Branch code:	632005
Acc number:	1944105972	Acc number:	422070912	Acc number:	4077182095
Swift no:	NEDSZAJJ	Swift no:	SBZAZAJJ	Swift no:	ABSAZAJJ

BANKING DETAILS FOR CLAIMS RE-IMBURSEMENT

CREDIT CARD AND FOREIGN BANK ACCOUNTS ARE NOT ACCEPTED

Name of account holder _____

Name of bank _____ Branch code ☐☐ - ☐☐ - ☐☐

Account number ☐☐☐☐☐☐☐☐☐☐☐

Type of account (please tick) Current ☐ Savings ☐ Transmission ☐

DISCLAIMER
It is the member's responsibility to advise the Scheme's administrator in writing of any change in banking details. Neither the scheme nor its administrator shall be held liable should an incorrect account be credited under any circumstances.

Signature of applicant _____

Authorised Signature of account holder required *(if different from applicant)* _____

DECLARATION

1. I, the undersigned hereby apply for membership of CompCare Medical Scheme and agree that all answers and information contained in this application completed by me or by any other person/s will be the basis of the proposed agreement.
2. I warrant that the contents of this application are true, correct and complete. No cover will be granted unless CompCare Medical Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
3. I agree to abide by and undertake to familiarise myself with the rules of the scheme as amended from time to time.
4. I understand that the scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998).
5. I agree to notify the scheme within 30 days in the event that any alteration in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk.
6. The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:
   - 6.1. For the purpose of considering application/s for membership, as well as any claims for benefits, CompCare Medical Scheme and any medical personnel authorised by CompCare Medical Scheme has the right to obtain or forward any medically relevant information including the HIV/AIDS status, which it may deem necessary from or to any medical practitioner or institution or nominee that possesses or needs such information, and that party may disclose such information to CompCare Medical Scheme and any party duly authorised by CompCare Medical Scheme.
   - 6.2. The information may be requested and supplied at any time, including after the death of the member or dependants, and will include accounts from service providers, indicating diagnoses, and medical or clinical reports when indicated. Such information will, however, be treated as confidential at all times by the party to whom it is supplied.
   - 6.3. By agreeing to sign the application form/s the applicant/member and dependants thereby waives his/her right to privacy in terms of the abovementioned clauses.
7. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the scheme.
8. Neither the applicant nor any of his/her dependant/s will be/are beneficiaries of another registered medical scheme, on the date of registration with CompCare Medical Scheme.
9. I hereby indemnify and hold harmless the scheme and administrator against any claims that may result due to the use of preferred providers.
10. I hereby give the scheme permission to communicate to me by SMS ☐ Email ☐
11. I hereby appoint the below mentioned broker as my Healthcare intermediary.

I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the scheme from liability and subject my membership to cancellation. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

Applicant signature _____ If the applicant is a minor, the Parent(s)/Legal Guardian(s) need to complete a CONSENT LETTER	**Date**

Employer/University/Embassy Signature		Date	
Brokerage name or broker name		Broker code	
Broker signature		Date	

Universal™

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