INGWE HEALTHPLAN

Student Application form

Section 1: Application details

New Application [x] Add Dependant [ ] Renewal [ ] Renewal only: Current Membership No.

Membership start date: 06 – 28 – 2010 Membership end date: 11 – 28 – 2010 Number of months: 5

Note: Only complete membership end date if you are paying upfront for your medical aid.

Broker Code Brokerage

Section 2: Main Member Particulars

Monthly Income: R

ID Number: Y Y M M D D Provider Code (Office Use)

Primary Healthcare Provider Name

Location

Country of Origin Passport Number

Name of Institution where studying: University of Witwatersrand

Campus: Johannesburg Student Number

Title Initials Surname

Date of birth: D D – M M – Y Y Y Y Registered first name

Cellphone number

E-mail address

Marital Status (mark with X where applicable): Single [ ] Married [ ] Divorced [ ] Widowed [ ] Common Law [ ] Gender M F

Telephone No.: 27117171066 Fax No.: 27834494949

Address in South Africa

Postal: IHRE @ Wits, c/o WIO, Univ of Witwatersrand, Slot 14 Mailing Office, Private Bag 3, Wits 2050, Johannesburg, South Africa Postal code

Residential Postal code

Section 3: Spouse/Partner

Title Initials Surname

Date of birth: D D – M M – Y Y Y Y Registered first name

Primary Healthcare Provider Name Gender M F

Location

Section 4: Dependants

If you have more than two dependants please list them on a separate page

Primary Healthcare Provider Name Gender M F

Location

Title Initials Surname

Date of birth: D D – M M – Y Y Y Y Registered first name

ID Number: Y Y M M D D Relation

Section 4: Dependants (continued)

Primary Healthcare Provider Name | Gender M F

Location

Title | Initials | Surname

Date of birth D D – M M – Y Y Y Y | Registered first name

ID Number Y Y M M D D | Relation

Section 5: Current Chronic Medication

Title | Initials | Surname

Name of medicine | Registered first name

Use of medication *from* M M – Y Y Y Y *to* M M – Y Y Y Y

If you require additional Chronic medication, please list those on a seperate page

Section 6: Choose a option

Please cross the option you choose (X)

	X Pioneer	Hospital plus	Capitation
Main member	R	R	R
Adult member	R	R	R
Child member	R	R	R
Total Payment	R	R	R

Section 7: Contribution paid by debit order

Only for South African Citizens

I hereby grant permission to Ingwe Health Plan's Administrators to collect the appropriate monthly contribution by debit order from 0 1 M M Y Y

Monthly Income R

Account holder's Name

Account Number

Name of bank | Branch code

Account type: Current | Savings | Transmission

This permission shall remain valid until cancelled by myself in writing. I hereby authorise the scheme to amend my debit order in the case of any change in contribution and/or membership status

Signature | **Date** D D – M M – 2 0 Y Y

Section 8: Medical Information

1. Any previous or expected surgery? Principal member, spouse and dependants

2. Any current medical conditions and/or medication? Principal member, spouse and dependants

3. Are you or your dependants pregnant or suspect you are pregnant? If Yes, please provide more details

Section 9: Statement by applicant

I ______________________________ hereby state that:

(a) should I be enrolled as a member of Ingwe, I will subject myself to the rules of Ingwe. The information furnished herein is completely true to the best of my knowledge and conviction. No relevant information has been omitted. If after my admission to Ingwe, it is found that any statement of information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to Ingwe all payments which Ingwe may have made on my behalf and to relinquish any claim to any benefits on the part of Ingwe. Should there by any deterioration or change in my state of health or in that any of my dependants before the date or event to be set by Ingwe for the commencement of membership or the date of acceptance of this application by Ingwe; or the date of receipt of the first contribution, (whichever date is the latest) Ingwe will be entitled to reconsider the application an propose new terms of admission or declare the membership null and void. Any monies paid to Ingwe in terms of this membership, before Ingwe is informed of the change, shall be forfeited and benefits paid by Ingwe, shall immediately be refunded in Ingwe.

(b) I irrevocably grant my persmission to any physician, person or party who may be in possession of, or obtain information concerning my health, or that of my dependants, to divulge such information to Ingwe, also after my death.

(c) I undertake to pay any amount due to Ingwe, on default.

(d) I will call Netcare 911 at 082 911, when I need an ambulance.

(e) I will call 0860 102 493 for Ingwe Client Service and 0800 002 449 for any pre-authorised treatment inquiries. I hereby state that I have read and understood the brochure.

(f) I understand that as member of Ingwe Health Plan I do not qualify for any benefits in terms of pregnancy, confinement and any related costs as these benefits are excluded from my benefits in terms of a 12 month condition specific exclusion as per Medical Schemes Act.

Request a medicine bag Yes [ ] No [X] **Please note: The minimum membership period to qualify for an emergency kit is six months.**

Terms and Conditions of use of the Ingwe medicine bag: If medicine bag chosen - the following terms and conditions will apply:

* By signing this declaration : The member indicates that he or she is requesting one emergency kit to be supplied to them and acknowledges that he / she has not, in any way, been forced to receive the emergency kit and therefore indemnify the Scheme and Administrator from any responsibilities in terms thereof. The member undertakes:

* To phone the Medical Advice Line on the toll free number 0800 002 449 before using any of the items.
* The items in the kit may not be sold to any party.

The member indicates that he/ she has read and understood the rules and procedures for utilising the Medical advice line and the emergency kit.

I hereby request my card and emergency kit to be distributed to: (Tick the appropriate block)

Postal address [ ] Institution [X]

I hereby grant permission to Ingwe Health Plan's administrators to forward any details relevant to my membership status, to me via SMS technology.

Please indicate the appropriate box. Yes [X] No [ ]

Name of bank:	Nedbank	Name of bank:	Standard Bank	Name of bank:	ABSA
Account holder	Ingwe Health Plan	Account holder:	Ingwe Health Plan	Account holder:	Ingwe Health Plan
Account no.:	1469009021	Account no.:	1657550	Account no.:	4060933128
Branch code:	146905	Branch code:	7205	Branch code:	632005
Branch name:	Commercial Northrand	Branch name:	Killarney	Branch name:	Killarney
Swift code:	NEDSZAJJ	Swift code:	SBZAZAJJ00720535	Swift code:	ABSAZAJJ

Signature of applicant ____________________

Signature of witness/broker ____________________ **Date** DD – MM – 20YY