

Please tick appropriate option(s)

Hospital
 Fundamental
 Progressive
 Prestige

A. EMPLOYER DETAILS (Note: Please complete all sections in **BLACK** ink)

Employer Name

Registration No. Employer Contact Person

Telephone No. Title Fax No.

Email Address

Alternative Email Address

Postal Address

Code

Physical Address

Code

Nature of Business

B. GROUP ELIGIBILITY DETAILS

Note: With the exception of pensioner members, members must be actively at work at the commencement date of this contract. Where this is not the case, confirmation of cover will be deferred until such time as the applicant is actively at work.

1. DETAILS OF THE GROUP (To be completed in all instances)

Will membership of the scheme be available to all employees employed by your company? YES NO

State the total number of employees actively employed by your company

State the total number of pensioners

State the total number of active employees eligible to be covered under the Scheme

State the total number of active employees that will participate under the Scheme

State the total number of pensioners eligible to be covered under the Scheme

State the total number of pensioners that will participate under the Scheme

State the number of branches

Member correspondence to group HR? YES NO

C. EXISTING MEDICAL SCHEME DETAILS

Please provide details of your group's medical scheme membership over the past 3 years.

1 Name of scheme

From To

2 Name of scheme

From To

Has your company ever been declined, loaded, or had exclusions applied by a medical scheme? YES NO

(If "Yes" please provide details) _____

D. BILLING METHOD (Please indicate with an "X" where applicable)

Advance
 Arrear

Schedule
 10th
 15th
 20th
 25th

Payment of additional products
 Group
OR
 Members

Contact person for schedule

Name

Designation

Telephone No. Email

Preferred option for all group members YES NO of which option:

ACTIVE MEMBERS
 One bill for the entire group
OR
 One bill per branch

PENSIONER MEMBERS Employer **OR** Member
OR Specify

E. MEMBERSHIP CARDS

Posted to each member's postal address Delivered to Company

F. COMMUNICATION

May we communicate directly with the RHMS members? **YES** **NO**

If "Yes" please indicate communication type Email Internet Printed Media SMS

Other _____

Name of Contact Person

Contact No.

 Email

G. PAYMENT DETAILS

Payment Method Debit Order Electronic Transfer Cheque

Name of Bank

 Branch

Account Type

 Branch Code

Name of Account Holder

Account No.

Resolution Health Medical Scheme ("the Scheme") is hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted, and similarly I/We authorise my/our bank debit my/our account with amounts drawn against it by the Scheme, or to credit my/our account with amounts due to me by the Scheme.

I understand that the withdrawals hereby authorised will be processed by computer through a system known as the ABSA Link Direct Service/Debit order/Multidata and I also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher.

I/We agree to pay any bank charges relating to this debit order instruction.

This authority may be cancelled by me/us by giving the Scheme thirty (30) days notice in writing, sent by prepaid registered post, but I/we understand that I/we shall not be entitled to any refund of amounts which the Scheme has withdrawn while this authority was in force is such amounts were legally owing to the Scheme. Receipt of this instruction by the Scheme shall be regarded as receipt thereof by my/our bank.

I/We further agree to advise the Scheme in writing of any changes which may occur.

Authorised Signatory(ies)	SIGNATURE	SIGNATURE
Designation	<table border="1" style="width: 100%; height: 15px;"></table>	<table border="1" style="width: 100%; height: 15px;"></table>

H. INTERMEDIARY DETAILS

Full name of Broker

 Individual Broker Reference No.

Name of Brokerage

 Resolution Health Brokerage Code

Telephone No.

 Email Address

Fax No.

SIGNATURE

Signature of Intermediary

SIGNATURE

Signature of Consultant

I. DECLARATION

General

1. As a participating employer we hereby apply for membership for our employees of the Resolution Health Medical Scheme (“the Scheme”).
2. On our employees’ behalf, we accept:
 - 2.1 The benefits provided for in terms of the Rules of the Scheme.
 - 2.2 The Rules of the Scheme together with any amendments from time to time.
3. We warrant the correctness of the statements and information contained in this application and acknowledge that the correctness thereof and of all other documents submitted now or in the future by any officer, members or intermediary of or on behalf of the employer shall constitute a condition precedent to the payment of the benefits provided for in terms of the Rules of the Scheme.
4. We consent to our employees and their listed dependants participating in the contracts to which this proposal relates being called upon to submit to such medical examinations and tests as the Scheme deems necessary, during the currency of the said contracts and of the Scheme addressing such requests directly to our employees or their dependants, with the same legal consequences as if such requests had been addressed to us.
5. We acknowledge and accept that the Scheme reserves the right to cancel membership of the Scheme if any contribution is not paid on due date.
6. We understand that the Scheme assumes no liability for any employee until such time as a notice of acceptance of the risk is given by the Scheme and payment of the first contribution has been received.
7. We undertake to give the Scheme immediate notice should any changes material to the assessment of this application occur prior to the date upon which the Scheme grants written acceptance. This enable the Scheme to reconsider the terms of acceptance.

Signed at _____ on this _____ day of _____ / _____

Authorised Signatory(ies)	SIGNATURE	SIGNATURE																														
Designation	<table border="1" style="width: 100%; height: 15px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>																<table border="1" style="width: 100%; height: 15px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>															

NB. Any misrepresentation or non-disclosure of material medical or factual information will render all benefits granted by the Scheme null and void. In addition any payment made due to such actions will be recovered from the member by the Scheme.

OFFICE USE ONLY

CATEGORY	A	B	C	
COPY <input type="checkbox"/>		ORIGINAL	<input type="checkbox"/>	
NO WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 MONTHS WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TWELVE MONTHS WAITING PERIOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PMB PAYMENT YES <input type="checkbox"/>		NO	<input type="checkbox"/>	
LATE JOINER PENALTY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MEMBERSHIP PACK TO UNDERWRITING				
<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 100%;"></td> </tr> </table> Signature				