

# DEPENDANT ADD APPLICATION



Pharos Medical Plan™ (Pharos) will only process this dependant add application if it has been completed in full and the supporting documentation requested, has been submitted with this application. Please complete with black ink and print clearly.

## Section 1: Personal Details

When do you want cover to start for your dependant/s?

### 1. Principal Member Details

Title	Initials	Surname
Member Number		

### 2. Adding a Spouse or Life Partner (Please submit marriage certificate or affidavit of co-habitation)

Title	Initials	Surname
First name(s)		
Maiden Name		Gender <input type="text" value="F"/> <input type="text" value="M"/>
ID Number	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/>	Please provide date of birth if using passport number
Or Passport Number		Please submit copy of ID/passport

### 3. Adding Other Dependants (Please submit birth certificates, appointment of court or adoption certificates)

First name (s)	1.	
Surname (if different from principal)		
ID Number	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/>	Gender <input type="text" value="F"/> <input type="text" value="M"/>
Relationship to principal		
Adult over 21 years	<input type="text" value="YES"/> <input type="text" value="NO"/>	(If Yes, please complete Section 2)
First name (s)	2.	
Surname (if different from principal)		
ID Number	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/>	Gender <input type="text" value="F"/> <input type="text" value="M"/>
Relationship to principal		
Adult over 21 years	<input type="text" value="YES"/> <input type="text" value="NO"/>	(If Yes, please complete Section 2)
First name (s)	3.	
Surname (if different from principal)		
ID Number	<input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="D"/> <input type="text" value="D"/>	Gender <input type="text" value="F"/> <input type="text" value="M"/>
Relationship to principal		
Adult over 21 years	<input type="text" value="YES"/> <input type="text" value="NO"/>	(If Yes, please complete Section 2)

If adding more than 3 dependants please attach additional pages.

## Section 2: Adult Dependiant Details

Excluding your spouse or life partner, are the adult dependants financially dependent on you?	<input type="text" value="YES"/>	<input type="text" value="NO"/>
Do these adult dependants receive any income? e.g. pension, salary, wages, grant	<input type="text" value="YES"/>	<input type="text" value="NO"/>
If Yes, please declare gross monthly income?	Dependant 1. <input type="text" value="R"/>	
	Dependant 2. <input type="text" value="R"/>	

## Section 3: Previous Medical Schemes' Details

Please list previous medical schemes' details for adult dependants. If no previous cover, please declare so.

Name of Beneficiary	Name of Scheme	Date Joined	End Date
Have your dependants ever had a waiting period, exclusion or late joiner penalty imposed?			<input type="text" value="YES"/> <input type="text" value="NO"/>
Have your dependants ever been refused cover by a life assurance company?			<input type="text" value="YES"/> <input type="text" value="NO"/>
Have your dependants ever had membership terminated by a medical scheme?			<input type="text" value="YES"/> <input type="text" value="NO"/>
If you have answered Yes to any of the above questions, please provide details below.			

**Section 4. Employer Verification (If applicable)**

I/We are not aware of any fact other than those stated which should be made known to the Scheme and do hereby certify the applicant to be a permanent staff member and that Pharos may add the dependent contributions to the billing.

<b>Signature:</b>	<b>Date:</b>
<b>Designation:</b>	<b>Contact Number:</b>

**Section 5: Health Questionnaire**

**Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in immediate termination of your membership.**

If the nature of any condition of yours or your dependants is of such a sensitive nature that confidentiality is required, you may use a sealed envelope enclosing all relevant documentation that will give the administrators insight and full understanding of the condition. This sealed envelope may be attached to this application form or may be submitted directly to Pharos.

Have your dependants ever had any of the following:

(If yes to any of the questions, please provide full details. You may also attach any relevant documentation and additional pages if you need more space)

Any disorder of the heart, blood vessels or circulatory system? (e.g. blood pressure, chest pain, heart murmurs, palpitations, thrombosis, shortness of breath, stroke, raised cholesterol, calf cramps during light or moderate pace walking)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Respiratory or lung trouble? (e.g. asthma, bronchitis, persistent cough, tuberculosis, or coughing of blood)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Disease or disorder of the kidneys, bladder or reproductive organs? (e.g. stones, protein in urine, prostatitis or trouble passing urine)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Any nervous, mental, neurological complaint or psychiatric conditions? (e.g. fits, epilepsy, blackouts, persistent headaches, paralysis, anxiety or depression)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>

Disorder of the digestive system, abdomen or liver? (e.g. hernia's, gastric/duodenal ulcer, recurrent indigestion/heartburn, rectal bleeding, hepatitis, jaundice, cirrhosis,			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Ear, eyes, throat or nose disorder? (e.g. defective vision, deafness and recurrent tonsillitis) Do your dependants wear glasses or contact lenses?			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Disease or disorder of muscles, bones, joints, limbs or spine e.g. rheumatism, arthritis, gout, pain			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Skin disorders? (e.g. psoriasis, dermatitis or eczema)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Any hereditary or congenital conditions?(e.g. Down's syndrome, porphyria, congenital abnormality)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Diabetes or sugar in the urine?			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Leukemia, anaemia, blood, spleen or bleeding disorders?			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Any endocrine, glandular disorders? (e.g. thyroid, Addison's or Cushing's syndrome)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>

Growth tumour or cancer of any kind, whether benign or malignant?			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Congenital mental insufficiency, brain dysfunction, birth syndromes			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Ever treated for HIV/AIDS, TB, infectious diseases, hepatitis or sexually transmitted diseases?			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Any connective tissue, autoimmune disorders? (e.g. leprosy, sarcoid, multiple sclerosis, lupus)			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Are any of your dependants currently undergoing, or planning to undergo, any specialist dentistry treatment? e.g. wisdom teeth removal, orthodontics, braces, maxillofacial procedures			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Are any of your dependants pregnant or planning a pregnancy in the next 12 months?			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>If pregnant how many weeks?</b>	<b>If planning write yes below</b>	<b>Doctor's Name</b>	
Are there any other conditions, symptoms, health concerns whether diagnosed or not that you have not already detailed for which medical advice, diagnosis, treatment or care has been recommended, received or could potentially result in a claim within the next 6 months?			<b>YES</b>	<b>NO</b>
<b>Which Dependant?</b>	<b>Condition &amp; Date Diagnosed</b>	<b>Treatment</b>	<b>Still on treatment?</b>	<b>Doctor's Name</b>
Have any of your dependants immediate family suffered or died from diabetes, heart disease, HIV/Aids, TB, high blood pressure, raised cholesterol, mental or any hereditary disease? If "yes" please state age of relative and type of disease			<b>YES</b>	<b>NO</b>
<b>Which Relative</b>	<b>Age of Relative</b>	<b>Condition</b>		

## Section 6: Conditions, Undertakings and Warranties

1. I hereby apply for my dependants to join Pharos Medical Plan™ (Pharos), administered by Private Health Administrators™ (the Administrator)
2. I acknowledge that any breach of any warranty or non-disclosure of any information by me or my dependants that is relevant to the assessment of this application will make any contracts to which this application relates null and void. I will also forfeit all contributions that I paid to Pharos. In such an event Pharos will have the right to reclaim any amounts that Pharos may have paid to me or any person on behalf of me or my dependants under such contracts.
3. I will notify Pharos if any alteration takes place in any circumstances on which Pharos based its assessment of its risk after the date of this application and before the date of Pharos's acceptance of the risk. I acknowledge that failure to do so will make any contracts to which this application relates null and void. In such an event Pharos will have the right to reclaim any amounts that Pharos may have paid to me or any person on my or my dependant's behalf under such contracts.
4. I am aware that Pharos's Rules will bind my dependants and I understand that the registered rules are decisive in the case of a dispute.
5. I authorize access to any medical or other information required by Pharos or the Administrator during the process of assessment as well as any further claim's procedures. I furthermore authorise my service provider to provide ICD10 codes on all my accounts.
6. I shall notify Pharos, through pre-authorization, should any of my dependants require hospitalisation for a non-emergency event and acknowledge that failure to do so will result in a penalty being applied or a reduction in benefits provided by Pharos for any procedure undertaken.
7. No benefit will be payable by Pharos unless they are satisfied as to the validity of a claim and have received all the information which they may require from my dependants.
8. I consent to Pharos addressing any request for information, tests or examinations directly to any dependant of mine over the age of 21 (twenty one), with the same legal consequences as if the request had been addressed to me in my capacity as a principal member.
9. I undertake to obtain the necessary consents from any of my dependants to whom these conditions may apply and indemnify Pharos against any claim which may arise as a result of my failure to do so.
10. I understand the following underwriting may apply to my adult dependants:
  - A three month general waiting period
  - A twelve-month exclusion on a pre-existing condition
  - Late-joiner contribution penalty.
11. I acknowledge that should this application be submitted via the Internet or facsimile, it is solely for the purposes of convenience and neither I nor the Administrator (subject to its sole discretion) nor Pharos will rely on the information herein contained without my first providing Pharos with a signed hard copy of this application.
12. I warrant that the contents of this application are true, correct, and complete.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

Signature of Principal Applicant. \_\_\_\_\_