

MEMBER APPLICATION



Pharos Medical Plan™ (Pharos) will only process this application form 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 you and your dependants? | | | | | | | | | | 2 | | 0 | | Y | | Y | | M | | M | | D | | D | | | |
| 1. Principal Applicant | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title | | Initials | | | | Surname | | | | | | | | | | | | | | | | | | | | | |
| First name(s) | | | | | | | | | | | | Marital Status | | | | | | | | | | | | | | | |
| Maiden Name | | | | | | | | | | | | Gender | | F | | M | | | | | | | | | | | |
| ID Number | | Y | | Y | | M | | M | | D | | D | | Please provide date of birth if using passport number | | | | | | | | | | | | | |
| Or Passport Number | | | | | | | | | | | | Please provide copy of ID or Passport | | | | | | | | | | | | | | | |
| Telephone H | | | | | | | | | | W | | Cellular | | | | | | | | | | | | | | | |
| Fax | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Language | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physical Address (Domicilium citandi et executandi) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Code | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postal Address (if different from above) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Code | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Company Name | | | | | | | | | | | | Employment Date | | | | Y | | Y | | M | | M | | D | | D | |
| Employee Number | | | | | | | | | | | | Occupation | | | | | | | | | | | | | | | |
| Tax Number | | | | | | | | | | | | (For Tax Certificate where applicable) | | | | | | | | | | | | | | | |

2. Spouse or Life Partner (Please submit marriage certificate or affidavit of co-habitation with application)

| | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------|--|----------|--|---|--|---------|--|---|--|---|--|-----------------------------------|--|---|--|---|--|--|--|--|--|--|--|
| Title | | Initials | | | | Surname | | | | | | | | | | | | | | | | | |
| First name(s) | | | | | | | | | | | | Marital Status | | | | | | | | | | | |
| Maiden Name | | | | | | | | | | | | Gender | | F | | M | | | | | | | |
| ID Number | | Y | | Y | | M | | M | | D | | D | | Please provide date of birth if using passport number | | | | | | | | | |
| Or Passport Number | | | | | | | | | | | | Please submit copy of ID/passport | | | | | | | | | | | |

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

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------------------------|--|---|--|---|--|---|--|---|--|---|--|-----|--|--------|--|-------------------------------------|--|---|--|--|--|--|--|--|--|
| First name (s) | | | | | | | | | | | | 1. | | | | | | | | | | | | | |
| Surname (if different from principal) | | | | | | | | | | | | | | | | | | | | | | | | | |
| ID Number | | Y | | Y | | M | | M | | D | | D | | Gender | | F | | M | | | | | | | |
| Relationship to principal | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult over 21 years | | | | | | | | | | | | YES | | NO | | (If Yes, please complete Section 2) | | | | | | | | | |
| First name (s) | | | | | | | | | | | | 2. | | | | | | | | | | | | | |
| Surname (if different from principal) | | | | | | | | | | | | | | | | | | | | | | | | | |
| ID Number | | Y | | Y | | M | | M | | D | | D | | Gender | | F | | M | | | | | | | |
| Relationship to principal | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult over 21 years | | | | | | | | | | | | YES | | NO | | (If Yes, please complete Section 2) | | | | | | | | | |
| First name (s) | | | | | | | | | | | | 3. | | | | | | | | | | | | | |
| Surname (if different from principal) | | | | | | | | | | | | | | | | | | | | | | | | | |
| ID Number | | Y | | Y | | M | | M | | D | | D | | Gender | | F | | M | | | | | | | |
| Relationship to principal | | | | | | | | | | | | | | | | | | | | | | | | | |
| Adult over 21 years | | | | | | | | | | | | YES | | NO | | (If Yes, please complete Section 2) | | | | | | | | | |

If more than 4 dependants please attach additional pages. If dependants are over 21 years of age, please submit proof of dependency or a supporting affidavit detailing financial dependency to Principal applicant

Section 2: Banking

| | | | | | | | | | |
|--|--------|--------|--------------|---------|---|--------|--------|--------------|---------|
| <input type="checkbox"/> USE THIS ACCOUNT FOR ALL TRANSACTIONS <input type="checkbox"/> USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS ONLY (Please submit original proof of banking details for debit order. If employer is responsible for paying contributions, the employer must also complete section 4.) | | | | | <input type="checkbox"/> USE THIS ACCOUNT FOR CLAIMS AND SAVINGS REFUNDS ONLY (Reimbursement will only be via direct deposit into the nominated bank account, no cheque payments can be made. Claims cannot be reimbursed if details are incorrect or not provided) | | | | |
| Bank name | | | | | Bank name | | | | |
| Branch name / Code | | | | | Branch name / Code | | | | |
| Type of Account | Credit | Cheque | Transmission | Savings | Type of Account | Credit | Cheque | Transmission | Savings |
| Name of account holder | | | | | Name of account holder | | | | |
| Bank Account number | | | | | Bank Account number | | | | |
| 1. I authorise Pharos Medical Plan™ (the Scheme) to debit this account with the amount due under contract in accordance with the Scheme's debit order system, and/or 2. I understand that by providing these details I authorise the Scheme to pay claim reimbursements directly into this bank account, and 3. I will not hold the Scheme responsible for incorrect details provided and agree to inform the Scheme in writing of any changes to details. | | | | | | | | | |
| Signature of Account Holder | | | | | Signature of Account Holder | | | | |
| Date : | | | | | Date : | | | | |

Section 3: Benefit Option Selection

1. I would like to become a member of: **Option**

2. I understand that I may only change my benefit option within the month of commencement of my membership or in January of every year.
 3. The benefits of the option selected have been explained to me and I understand them.

| | |
|------------------------------------|--------|
| 4. Principal Applicant's Signature | Date : |
|------------------------------------|--------|

Section 4: Employer Warranty.

| | | |
|--|-----|----|
| 1. I warrant that the principal applicant detailed in Section 1 is an employee of our organization. | YES | NO |
| 2. Pharos may bill our organisation for the amount due in respect of this member. | YES | NO |
| 3. Pharadigm may bill our organisation for the amount due in respect of this member. | YES | NO |
| 4. This application has been scrutinized and we are not aware of any facts, other than those stated, which should be made known to Pharos. | | |
| 5. The following broker/brokerage is legally appointed to our organisation: | | |

| | | | | | | | | | |
|----------------------|------|---|---|---|---|---|---|---|---|
| Authorised Signatory | Date | 2 | 0 | Y | Y | M | M | D | D |
| Name | | | | | | | | | |
| Designation | | | | | | | | | |
| Company Stamp | | | | | | | | | |

Section 5: Broker Details and Declaration

| | |
|--|-----------------|
| 1. Name | |
| 2. ORG/ BR Number | |
| 3. FSB Number | |
| 4. Pharos Consultant | |
| 5. Declaration: | |
| 1. The applicant has been advised that membership of Pharos Medical Plan is not subject to a broker being appointed. 2. The applicant has appointed me as broker and the applicant is entitled to cancel my services at any time. 3. I have confirmed my accreditation details and confirm that I am accredited at the date of my signature. 4. I am licensed by the FSB in terms of the FAIS Act. 5. I have provided the applicant with my name, physical and postal address and telephone number. 6. I have confirmed the commission payable by member/Scheme on this transaction. 7. I have a valid contract with the Scheme. 8. There has been no material misrepresentation of any fact by me. | |
| Broker's Signature | |
| Date | 2 0 Y Y M M D D |

Section 6: Health Questionnaire

Please detail any chronic conditions, illnesses, hospital admissions, symptom of illness, whether diagnosed or not and the treatments undertaken including any medications. Additional pages may be attached if needed.

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

Have you or any of 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)

| | | |
|--|-----|----|
| 1. 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) | YES | NO |
| 2. Respiratory or lung trouble? (e.g. asthma, bronchitis, persistent cough, tuberculosis, or coughing of blood) | YES | NO |
| 3. Disease or disorder of the kidneys, bladder or reproductive organs? (e.g. stones, protein in urine, prostatitis or trouble passing urine) | YES | NO |
| 4. Any nervous, mental, neurological complaint or psychiatric conditions? (e.g. fits, epilepsy, blackouts, persistent headaches, paralysis, anxiety or depression) | YES | NO |
| 5. Disorder of the digestive system, abdomen or liver? (e.g. hernia's, gastric/duodenal ulcer, recurrent indigestion/heartburn, rectal bleeding, hepatitis, jaundice, cirrhosis, | YES | NO |
| 6. Ear, eyes, throat or nose disorder? (e.g. defective vision, deafness and recurrent tonsillitis) Do your dependants wear glasses or contact lenses? | YES | NO |
| 7. Disease or disorder of muscles, bones, joints, limbs or spine e.g. rheumatism, arthritis, gout, pain | YES | NO |
| 8. Skin disorders? (e.g. psoriasis, dermatitis or eczema) | YES | NO |
| 9. Any hereditary or congenital conditions?(e.g. Down's syndrome, porphyria, congenital abnormality) | YES | NO |
| 10. Diabetes or sugar in the urine? | YES | NO |
| 11. Leukemia, anaemia, blood, spleen or bleeding disorders? | YES | NO |
| 12. Any endocrine, glandular disorders? (e.g. thyroid, Addison's or Cushing's syndrome) | YES | NO |
| 13. Growth tumour or cancer of any kind, whether benign or malignant? | YES | NO |
| 14. Congenital mental insufficiency, brain dysfunction, birth syndromes | YES | NO |
| 15. Ever treated for HIV/AIDS, TB, infectious diseases, hepatitis or sexually transmitted diseases? | YES | NO |
| 16. Any connective tissue, autoimmune disorders? (e.g. leprosy, sarcoid, multiple sclerosis, lupus) | YES | NO |
| 17. Are you or any of your dependants currently undergoing, or planning to undergo, any specialist dentistry treatment? e.g. wisdom teeth removal, orthodontics, braces, maxillofacial procedures | YES | NO |
| 18. Are you or any of your dependants pregnant or planning a pregnancy in the next 12 months? | YES | NO |
| 19. 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? | YES | NO |
| 20. Have you or 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 | YES | NO |

| Ques. No. | Which Beneficiary? | Condition & Date | Treatment | Still on treatment? | Doctor's Name |
|-----------|--------------------|------------------|-----------|---------------------|---------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Section 7: Previous Medical Schemes' Details

Please list previous medical schemes' details. If no previous cover, please declare so. Details must be provided for spouse and adult dependants if different from principal member. Previous and current membership certificates must be submitted with this application. **Failure to complete this accurately and in full will affect underwriting outcome.**

| Name of Beneficiary | Name of Scheme | Date Joined | End Date |
|---------------------|----------------|-------------|----------|
| | | | |
| | | | |
| | | | |
| | | | |

Section 8: Medical Scheme Declaration

Pharos Medical Plan Declares that:

1. A member's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential.
2. Member information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes.
3. The medical scheme has data security measures in place.
4. The medical scheme has granted access, to certain persons within the organisation and its contracted third parties, to a beneficiaries' personal and health information.
5. All staff within the medical scheme and its contracted third parties are bound by internal confidentiality agreements.
6. The medical scheme and its contracted third parties will use the medical/health/diagnosis/procedure information provided for the following purposes: processing the application for membership; re-imburement of claims, determining member entitlement to benefits and risk management practice.
7. The medical scheme has ensured that confidentiality agreements have been entered into with all contracted third parties who have access to beneficiary information for the purposes of data transfer and management, scheme administration and managed care arrangements.
8. In the event of a breach of confidentiality, the medical scheme assumes responsibility and the breach will be managed according to the scheme's internal protocols.

Section 9: Conditions, Undertakings and Warranties

1. I hereby apply for my dependants and myself 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 my or my dependants behalf 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' 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 me when my membership commences. I understand that the registered rules are decisive in the case of a dispute. I am aware that I had the opportunity to read the Pharos Medical Plan™ Rules before signing this application and that, even if I have not taken up the offer, I will be deemed to have read the Rules.
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 and any dependants' 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. On termination of my membership with Pharos, I shall repay any amount by which claims paid out of my Private Fund exceed contributions paid into such account, on demand.
10. I hereby authorize the deduction of my monthly contribution and any other indebtedness due to Pharos and understand it is my sole responsibility as a member of Pharos, to ensure that the monthly contribution is received by Pharos. I accept that non-receipt of a single contribution will result in immediate suspension of benefits. This suspension will last until I have paid all contributions in arrears. I accept that non-receipt of two consecutive month's contributions will result in the termination of my membership.
11. I understand that this application for membership must reach the administrator on or before the 15th of the month before the start month of membership and that the first debit order deduction to secure this start date will be on the first banking day of the start month. In the event that this application reaches the administrator after the 15th of the month, I understand that the start month of membership will become the month thereafter unless I submit proof of payment to secure the earlier start date.
12. 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.
13. I accept that in the case of new Pharos Medical Plan™ members, the following may apply:
14. • A three month general waiting period • A twelve-month exclusion on a pre-existing condition • Late-joiner contribution penalty.
15. I acknowledge that I may withdraw this application for membership within 14 (fourteen) days of the active start date on condition that the withdrawal is made in writing and that no benefits have been claimed. If the written withdrawal is received within 14 (fourteen) days of the active start date by Pharos and no benefits have been claimed, then Pharos will reverse that month's contribution.
16. 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.
17. I agree that this application submitted to the Administrator will constitute an offer on my part for membership with Pharos.
18. Pharos shall be entitled to obtain credit and related information concerning myself at any time and lodge, exchange and disclose such information with any credit bureau without any further notice to me. Pharos shall be entitled to verify such information and to make any queries it deems necessary. I understand that in the event of a negative credit record, Pharos will not advance Private Fund benefits for non-essential healthcare without my lodging of a bank guarantee with Pharos.
19. I consent to all conversations between myself and Pharos being recorded and regard all information obtained through these conversations as part of Pharos's records. I further consent to all of these recordings remaining the sole property of Pharos
20. I warrant that the contents of this application are true, correct, and complete.

Signed at _____ this _____ day of _____ 20_____.

Signature of Principal Applicant. _____

To avoid a delay in the processing of your application; please utilize the following checklist and ensure all important sections of your application are completed and all relevant documentation is attached.

| Important Sections – Completed | | Important Documents – Attached | |
|--|--|--|--|
| ➤ Start Date | | ➤ Copy of I.D document | |
| ➤ Personal Details | | ➤ Birth Certificates / Affidavits (where dependants surnames differ) | |
| ➤ Identity Number (age) | | ➤ Individual Members – Original proof of bank details | |
| ➤ Employment Date | | ➤ Previous M/A membership certificates | |
| ➤ Contact Details | | ➤ Proof of Income (Footprint Comprehensive Option – Below R7000) | |
| ➤ Signed Debit order details | | | |
| ➤ Signature on Option Selection | | | |
| ➤ Company Members – Employer Signature and Stamp | | | |
| ➤ Completed Statement of Health | | | |
| ➤ Signed Section 10 – Rules | | | |

Banking Details for Pharos

| | | | |
|-----------------------------------|-------------------------|-----------------------------------|------------------------|
| Name : Pharos Medical Plan | | Account Number : 252523504 | |
| Standard Bank | Westville Branch | Code : 045426 | Current Account |

Pharos is proudly administered by Private Health Administrators™
P O Box 343, Westville, 3630 Tel: 031 267 5000 Fax: 031 267 5169
Client Services: 0860 227 464 E-Mail: pharos@pha.co.za

18/11/2009