Application Form

Wemas
Wella Medical Aid Society

Wella Medical Aid Society Ltd
European Business Center,
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SECTION 1: OPTION

Choose ONE Product option by placing "x" in the appropriate box

FAMILY SCHEME			PENSIONERS SCHEME			SPECIAL PRODUCT
☐ MTENDE	☐ MOYO	☐ THANZI PLUS	☐ PREMIER	☐ STANDARD	☐ BRONZE	☐ MEDICAL SAVINGS PLAN

I Wish to join the scheme from (dd mm yy) D D M M Y Y Y Y **Membership number (administrative use only)**

SECTION 2: DETAILS OF PRINCIPAL MEMBER

Surname **Maiden name** (if applicable)

Title **First name/s** **Initials**

Gender M F **D.O.B** D D M M Y Y Y Y **National ID/ number**

Telephone (Home) **Telephone (Work)**

Cell phone number **Fax**

E-mail address

Postal address

Physical address

Passport size photo

Primary doctor
G.P | Paediatrician | OB/GYN

Are you changing your medical scheme due to a change in your employment? Yes No

Have you had previous medical aid cover? Yes No *If yes, please provide details below*

Name of previous medical scheme	Membership number	Date joined	Date left

Marital status
FOR STATISTICAL PURPOSES ONLY
Single ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐

SECTION3: SPOUSE DETAILS (Only if spouse is to be covered)

Passport Size photo

Title **Initials** **Gender** M F **First name/s**

Surname **Maiden name** (if applicable)

Primary doctor
G.P | Paediatrician | OB/GYN

Cell phone number **E-mail address**

National ID/ number **D.O.B** D D M M Y Y Y Y

SECTION 4: DEPENDANTS YOU WISH TO REGISTER

1

Passport Size photo

Adult ☐ Child ☐

Gender M F

Title ☐ Initials ☐ Relationship to member ☐

Surname

First name/s

Date of birth D D M M Y Y Y Y Marital status ☐

Primary doctor
G.P | Paediatrician | OB/GYN

National ID number

Cell phone number

E-mail address

2

Passport Size photo

Adult ☐ Child ☐

Gender M F

Title ☐ Initials ☐ Relationship to member ☐

Surname

First name/s

Date of birth D D M M Y Y Y Y Marital status ☐

Primary doctor
G.P | Paediatrician | OB/GYN

National ID number

Cell phone number

E-mail address

3

Passport Size photo

Adult ☐ Child ☐

Gender M F

Title ☐ Initials ☐ Relationship to member ☐

Surname

First name/s

Date of birth D D M M Y Y Y Y Marital status ☐

Primary doctor
G.P | Paediatrician | OB/GYN

National ID number

Cell phone number

E-mail address

4

Passport Size photo

Adult ☐ Child ☐

Gender M F

Title ☐ Initials ☐ Relationship to member ☐

Surname

First name/s

Date of birth D D M M Y Y Y Y Marital status ☐

Primary doctor
G.P | Paediatrician | OB/GYN

National ID number

Cell phone number

E-mail address

SECTION 5: MEDICAL HISTORY OF MAIN MEMBER AND DEPENDANTS

Any previous or current treatment for a disorder or condition must be marked as Yes . Answer all questions by selecting YES or NO. Where the answer is Yes, please give full details. A doctor's report may be requested in some cases.

Please circle the specific condition.

EXAMPLE

Condition	Yes	No
Birth defects & inherited disorders - spina Bifida, Injurie Heart Disorder or other.		

Condition	Yes	No
01 **Birth Defects & Inherited Disorders -** Spina Befida, Injuries, Heart Disorder or other	Y	N
02 **Dermatological -** Acne, Eczema, Pemphigus, Psoriasis, Fungal infections or other	Y	N
03 **Musculo-Skeletal -** Osteo-arthritis, Rheumatoid Arthritis Osteo-sarcoma, Gout, Osteoporosis, Lupus Erythematosus or other.	Y	N
04 **Ear, Nose and Throat -** Deafness/Hearing impairment, Allergic Rhinitus, Recurrent Throat Infections, Vertigo, Chronic Sinusitis, Meniere's Disease or other.	Y	N
05 **Respiratory Disorders -** Asthma, Emphysema, Chronic Obstructive Pulmornary Disease, Cystic Fibrosis, Bronchiectasis or other.	Y	N
06 **Gastro-Intestinal -** Hiatus Hernia, Chronic Peptic Ulcer, Crohn's disease, Esophageal Reflux, Spastic Colon, Ulcerative Colitis, Malbsorbtion Syndrome or Other.	Y	N
07 **Urological Disorders -** Chronic Renal Failure, Kidney Stones, Chroniic Pyelonephritis or Prostatic Hypertrophy, Neurogenic bladder, Urinary Incontinence, Urinary retention or other.	Y	N
08 **Neurological-** Cerebro Vascular Accident, Neuropathy, Epilepsy, Multiple Sclerosis, Neuralgia, Migraine, Parkinson's Disease, Myasthenia Gravis, Stroke, Alzheimer's, Narcolepsy or other.	Y	N
09 **Psychiatric-** Anxiety, Depression, Bipolar Mood Disorder, Schizophrenia, Sleep Disorders, Attention Deficit Hyperactivity Disorder, Neurosis, Obsessive- Compulsive Disorder or other.	Y	N

Condition	Yes	No
10. **Metabolic Disorder-** Lipid Disorders Porphyria or other	Y	N
11. **Cardiovascular-** Hypertension, Hypotension, Dysrrhythmias, Cardiac Failure, Hypercholesterolaemia, Aneurysm, Angina, Ischaemic Heart Disease, Peripheral Vassular or other.	Y	N
12. **Liver and pancreas Disorders -** Hepatitis, Cirrhosis, Gall-stones, Pancreatitis, Chronic Cholecystitis or other.	Y	N
13. **Blood Disorder -** Anaemia, Leukemia, Haemophilia, Clotting Disorder, Thrombocytopenia or other.	Y	N
14. **Endocrine Disorders-** Diabetes Insipidus, Hyperthyroidism, Addison's Disease Cushing's Syndrome, Diabetes Mellitus, Hypoglycemia or other.	Y	N
15. **Infections -** HIV, Hepatitis or any sexually transmitted disease	Y	N
16. **Cancer** - any form	Y	N
17. **Gynaecological system** - infertility, Endometriosis, Overian Cysts, Menopause, Menstrual Disorder, Mastalgia or other	Y	N
18. **Eye Disorder-** Impaired Vision, Glaucoma, Retinopathy, other	Y	N
19. **Have/are you being compensated for any disability?**	Y	N
20. **Are you pregnant or do you suspect you are?**	Y	N
21. **Any previous surgery?**	Y	N
22. **Any exclusions on previous medical aid?**	Y	N

Any other conditions *(Please use a separate page if more than two conditions)*

If YES to any of the previous questions complete the section below, and fill in the applicable condition number:
(Please use a separate page if more information applies to relevant questions)

Condition No. **Patient** **Doctor**

Treatment **Last date of treatment** (dd mm yyy) D D M M Y Y Y Y

Condition No. **Patient** **Doctor**

Treatment **Last date of treatment** (dd mm yyy) D D M M Y Y Y Y

Condition No. **Patient** **Doctor**

Treatment **Last date of treatment** (dd mm yyy) D D M M Y Y Y Y

SECTION 6: CURRENT CHRONIC MEDICATION *(Please use a separate page if more than three chronic medications are used)*

Initials **Registered first name**

Surname **Medicine**

Duration of use **From (dd mm yyy)** D D M M Y Y Y Y **To (dd mm yyy)** D D M M Y Y Y Y

Initials **Registered first name**

Surname **Medicine**

Duration of use **From (dd mm yyy)** D D M M Y Y Y Y **To (dd mm yyy)** D D M M Y Y Y Y

Initials **Registered first name**

Surname **Medicine**

Duration of use **From (dd mm yyy)** D D M M Y Y Y Y **To (dd mm yyy)** D D M M Y Y Y Y

SECTION 7: STATEMENT BY MAIN MEMBER

I, _____ hereby state that:

(a) Should I be enrolled as a member of the Scheme, I will subject myself to the rules of WEMAS. The information herein is completed true to the best of my knowledge and conviction. No relevant information has been omitted. If after my admission to WEMAS, it is found that my statement or information furnished by me was knowingly and willfully inadequate or untrue, I agree to refund in full to WEMAS all payments which WEMAS has made on my behalf and to relinquish any claim to any benefits on the part of WEMAS

(b) Should there be any deterioration or change in my state of health or in that of any of my dependants before the date of event to be set by WEMAS for the commencement of membership or the date of acceptance of this application by WEMAS; or the date of receipt of the first contribution(Whichever date is the latest) WEMAS will be entitled to reconsider the application and approve new terms of admission or declare the membership null and void.

(c) Any monies paid to WEMAS in terms of this membership before WEMAS is informed of the changes shall be forfeited and benefits paid by WEMAS shall immediatery be refunded to WEMAS.

(d) I am bound now and in future, if we (myself and my dependants) are accepted as members, to give WEMAS all such information and evidence to WEMAS as they require from time to time. I authorize the attending medical practitioner or any provider, to provide WEMAS with such information as it may require, hereby waiving the provision of any law or regulation restricting such information.

(e) I undertake to pay any other amount due to WEMAS , or on default. I hereby authorise my employer to deduct the due amount from my salary or any other monies due by me.

(f) In the event of voluntary resignation from WEMAS, I agree to give WEMAS **one** calendar month notice which must be received by WEMAS in writing by not later than the 15th of the month following the month of cancellation.

(g) I agree to call WEMAS Client Service with regards to any queries and pre-authorise any treatment as requested by WEMAS.

(I) I agree to pay over and above my benefits if I exceed them.

Signature of Applicant _____ Date (dd mm yy) _____

SECTION 8: FOR OFFICIAL USE ONLY

	NAME	DATE	SIGNATURE
Received by		D D M M Y Y Y Y	
Checked by		D D M M Y Y Y Y	
Approved by		D D M M Y Y Y Y	