APPLICATION
FOR MEMBERSHIP

A Member of AfroCentric Group
medscheme
ESWATINI

Please complete both sides of this application form to avoid a delay in registration.

Call +268 2409 8700
Visit www.medscheme-eswatini.com
Email membership@medscheme-eswatini.com
Walk-in Shop J6, Swazi Plaza, Mbabane

PHOTO

The contents of this form will be kept in strict confidence and provide the basis upon which Medscheme Eswatini will consider membership. Please complete in black ink sections 1, 2, 3 and 5 of this form.

SECTION 1: General

I hereby apply to be admitted as a member of Medscheme Eswatini and agree to abide by and be bound by its rules and regulations.

I certify that all the information given is true and correct and agree that any false statements in this application shall render my membership null and void.

I, _____ hereby authorise my employer _____ to deduct from my salary/wage any such amount as I may lawfully owe to Medscheme Eswatini and to remit such amounts to Medscheme Eswatini. Furthermore, I understand I shall be held liable for any legal costs incurred in the recovery of any amounts owing to Medscheme Eswatini.

I hereby authorise any doctor or other persons, who may be in possession of or hereafter acquire information concerning my health or the health of any of my dependants, to disclose this information to the Fund.

I understand that all hospitalization is subject to pre-authorization by Medscheme Eswatini.

_____
Applicant's signature

Date D D M M Y Y Y Y

SECTION 2: Membership of other medical aid schemes

Please give details of membership of any other medical aid scheme(s) prior to this application.

NAME OF SCHEME	MEMBER NUMBER	MEMBERSHIP					
		FROM			TO		
		DATE	MONTH	YEAR	DATE	MONTH	YEAR

NOTE: Please attach a certificate of membership as proof of membership of previous scheme(s), covering at least two years immediately prior to the date of this application.

SECTION 3: Personal details

Title (eg. Prof, Dr, Mr, Mrs) Initials Gender M F

Full names

Surname

Date of birth D D M M Y Y Y Y Marital Status Single Married Divorced

ID number

Home address

Postal address

Home tel. no.

Work tel. no.

Cellular no.

Email address

Preferred method of communication Email Post SMS

BANKING DETAILS (To be used for member refunds)

Name of bank

Account no.

Account type (current / savings) Branch code

Attach proof of banking details (bank confirmation letter or 3 months bank statement - both must not be older than 3 months from date of submission)

DEPENDANT DETAILS (Please read note under Dependant Codes)

Full first names (as they appear on ID or birth certificate)	Date of birth								*Dependant code			Gender M/F
	DAY		MONTH		YEAR				AD	CD	P	
	D	D	M	M	Y	Y	Y	Y				
	D	D	M	M	Y	Y	Y	Y				
	D	D	M	M	Y	Y	Y	Y				
	D	D	M	M	Y	Y	Y	Y				
	D	D	M	M	Y	Y	Y	Y				
	D	D	M	M	Y	Y	Y	Y				
	D	D	M	M	Y	Y	Y	Y				
	D	D	M	M	Y	Y	Y	Y				

*** DEPENDANT CODES:** **AD** - Adult dependant **CD** - Child dependant **P** - Parent

Required documents for dependants:
AD (Spouse) – Certified copies of marriage certificate and spouse ID
CD – Certified copy of birth certificate
P – Certified copies of member/spouse birth certificate and Parent ID Copy
All dependants to provide passport size photos (in colour)

SECTION 4: Employer (Please complete sign and stamp this section)

Date Fund joined	Date of benefit	No. of Deps
D D M M Y Y Y Y	D D M M Y Y Y Y	

Member's share of contribution	Employer's share of contribution	Total monthly contribution

OPTION

- ◯ **Comprehensive Plan**
- ◯ **Flexible Plan**
  - ◯ Level 0
  - ◯ Level 1
  - ◯ Level 2
  - ◯ Level 3
  - ◯ Level 4
  - ◯ Level 5
- ◯ **Primary Care Plan**
- ◯ **Tertiary Care Plan**
- ◯ **Hospital Cash Plan**
- ◯ **Achiever Plan**

We confirm that the applicant is employed by us and commenced employment on D D M M Y Y Y Y and that contributions are being deducted in accordance with the applicant's income and the number of eligible dependants and in terms of the appropriate contribution table.

Date D D M M Y Y Y Y

Company name

Signature

Stamp

Contact Person

Address

Telephone no.

Email address

FOR STATISTICAL PURPOSES

Make a cross (**X**) in the appropriate box

Gender — Male ☐ Female ☐

Marital status — Single ☐ Married ☐ Divorced ☐ Widowed ☐

FOR MEDSCHEME Eswatini USE ONLY

Member number

Paypoint — Dependant Code

Interchangeability

SECTION 5: Medical history — State YES or NO

Have you or your dependants ever been subject to any of the following conditions?
If **"YES"**, state full details of each in the schedule below.

1. Any disorder of the heart? For example: rheumatic fever, heart murmer, coronary artery disease, chest pain, shortness of breath or palpitations.	
2. High blood pressure or disease of the blood vessels or circulatory disorder? For example cramps during exercise, stroke, high cholesterol, hardening of arteries, etc.	
3. Any respiratory or lung disease? For example asthma, bronchitis, persistent cough or tuberculosis.	
4. Any disorder of the digestive system, gall bladder, pancreas, or liver? For example actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, anal bleeding, haemorrhoids or jaundice.	
5. Disease or disorder of kidneys, bladder, or reproductive organs? For example albumin in urine, kidney stones, prostalitis, veneral disease, infertility or impotence.	
6. Any nervous or mental complaint? For example epilepsy, blackouts, anxiety state or depression.	
7. Any type of nerve ailment? For example loss of sensation, numbness, or paralysis etc.	
8. Ear, eye, nose or throat disorder? For example ear discharge, defective vision.	
9. Disorder or disease of skin, muscles, bones, joints, limbs, spine? For example psoriasis, arthritis, gout, slipped disc or other back trouble etc.	
10. Diabetes, hormonal imbalance, glandular or metabolic disease, thyroid or blood disorder?	
11. Cancer, growth of tumor or any kind?	
12. Any other illness, disorder, operation, disability or accident? For example fractured nose, breathing disorders, mammary hypertrophy (enlarged breasts with associated side effects) etc.	
13. Are you or your dependants currently undergoing or expecting to undergo any medical, dental or surgical treatment?	
14. Are you (if female) or any of your female dependants pregnant? If "YES" state the expected date of confinement _____20_____	
15. Have any exclusions been imposed by any medical scheme on which you or your dependants have been registered? If "Yes" please state details.	

SCHEDULE

Question Number	Name of Patient	Nature and duration of complaint and full details of treatment being or expected to be received	Name and telephone number of attending Doctor or Hospital	When did you or your dependants last have symptoms or received treatment?

IMPORTANT: Failure to dislose all relevant and/or correct information may adversely affect the benefits available to you and your family.