spectramed

Spectramed Reg No: 1141

DISCLOSURE FORM

(TO BE COMPLETED IN BLACK INK)

• CUSTOMER SERVICE CENTRE: 0861 497 497 • NATIONAL FAX LINE: 0861 492 492 • DEDICATED FAX LINE: 086 506 0226 •
• NATIONAL POSTAL ADDRESS: Private Bag X1, Gardenview, 2047 •

REASON FOR DECLARATION: (Tick appropriate box) | CO-HABITATION | FINANCIAL DEPENDENCY | CERTIFICATE OF MEMBERSHIP

I, _____ (Full names of principal member - as on Identity Document) I.D. NUMBER _____

RESIDING AT _____

HOME TEL. NO. _____ CELLULAR NO. _____

WORK TEL. NO. _____

DECLARE THE FOLLOWING: CO-HABITATION

- Customary or traditional union / Live-in partners
- If the surname/s of the applicant and adult/child dependant are different
- Application for Adult dependant

DEPENDANT _____ (Full names - as on Identity Document)

I.D. NUMBER _____ RELATION _____ (Fiancée,Parent)

RESIDE AT THE SAME PHYSICAL ADDRESS AS THE APPLICANT AND HAVE FOR A PERIOD OF _____ MONTHS/YEARS

FINANCIAL DEPENDANCY

- Dependant over the age of 21 not studying for whom membership is applied for
- Application for adult/child dependant

THAT THE ADULT DEPENDANT _____ (Full names - as on Identity Document)

I.D. NUMBER _____ IS UNEMPLOYED AND FINANCIALLY DEPENDENT ON THE APPLICANT

☐ I HAVE SUBMITTED 3 MONTHS' BANK STATEMENTS ☐ I HAVE NO BANK ACCOUNT

OTHER _____

CERTIFICATE OF MEMBERSHIP

- I am not able to provide a Certificate of Membership to validate previous cover at a medical scheme/s for the following reason/s:

_____

_____

- All information regarding previous membership is true and correct;
- All medical scheme details reflected on my Spectramed Application Form are true and correct.

SM18/DF/V1 INITIAL _____

Kindly note that the "Applicant" for the purposes of this form is the person who signs the declaration of this form.

I, (Full names of principal member - as on Identity Document) I.D. NUMBER

1) I declare that the contents of the disclosure form is true, correct and complete in every aspect

2) I declare that the contents of this disclosure form is binding on my conscience

3) I declare that any false or misleading statements and/or non-disclosure of all and any material information to Spectramed shall result in the termination of any membership granted to me and any contributions paid by me or on my behalf shall be forfeited

SIGNED AT

SIGNATURE OF APPLICANT DATE OF SIGNATURE (YEAR/MONTH/DAY) YYYY MM DD

SIGNATURE OF WITNESS DATE OF SIGNATURE (YEAR/MONTH/DAY) YYYY MM DD

NOTES

 INITIAL

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www.spectramed.co.za

SM18/DF/V1