EMPLOYER APPLICATION FORM

(TO BE COMPLETED IN BLACK INK)

spectramed

• 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 •

Spectramed Reg No: 1141

1. USE BY INTERMEDIARY/DIRECT MARKETING AGENT ORDER TO APPLICANT (FOR OFFICE USE ONLY)

INTERMEDIARY HOUSE		DIRECT MARKETING AGENT NAME	
INTERMEDIARY HOUSE ACCREDITATION NO.		DIRECT MARKETING AGENT SURNAME	
INTERMEDIARY CODE		DIRECT MARKETING AGENT CODE	
SIGNATURE		**SIGNATURE**	
DATE OF SIGNATURE (YEAR/MONTH/DAY)	YYYY MM DD	DATE OF SIGNATURE (YEAR/MONTH/DAY)	YYYY MM DD
DATE OF COMMENCEMENT (YEAR/MONTH/DAY)	YYYY MM DD	DATE OF COMMENCEMENT (YEAR/MONTH/DAY)	YYYY MM DD

2. EMPLOYER'S DETAILS

COMPANY NAME

CONTACT PERSON

POSTAL ADDRESS

CODE

PHYSICAL ADDRESS

CODE

TELEPHONE NO. FAX NO.

EMAIL ADDRESS

DESCRIBE THE NATURE OF THE BUSINESS

3. MEMBERSHIP DETAILS

DATE OF COMMENCEMENT (YEAR/MONTH/DAY) YYYY MM DD

PREVIOUS MEDICAL SCHEME INFORMATION

EMPLOYER	SCHEME NAME	DATE FROM (YEAR/MONTH/DAY)	DATE TO (YEAR/MONTH/DAY)
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD
		YYYY/MM/DD	YYYY/MM/DD

INITIAL

RELEVANT MEMBERSHIP DETAILS

TOTAL NO. OF EMPLOYEES WITHIN THE COMPANY

HOW MANY PRINCIPAL MEMBERS ARE TO BE COVERED BY SPECTRAMED?

WILL MEMBERSHIP OF SPECTRAMED BE VOLUNTARY FOR STAFF MEMBERS? YES NO

IF ANSWER IS 'NO', PLEASE SPECIFY FOR WHOM MEMBERSHIP IS COMPULSORY: ALL EMPLOYEES YES NO

IS THIS APPLICABLE TO A SPECIFIED CATEGORY ONLY? YES NO SPECIFY

WILL MEMBERSHIP BE COMPULSORY FOR FUTURE EMPLOYEES? YES NO

IS THIS APPLICABLE TO A SPECIFIED CATEGORY ONLY? YES NO SPECIFY

Kindly ensure that a membership application form has been completed by each member and all relevant membership certificates of previous cover are supplied. *Please note that Spectramed reserves the right to individually underwrite current employees and pensioners.*
Membership of Spectramed is only available to current employees and employees who have retired from active service with the company as of the date of application.

4. OPTION SELECTION

ARE OPTIONS SELECTED BY EACH EMPLOYEE? YES NO **OR**

ARE SPECIFIC OPTIONS SELECTED FOR EACH EMPLOYEE CATEGORY?

1ST CATEGORY OF STAFF OPTION

2ND CATEGORY OF STAFF OPTION

5. BILLING METHOD

PLEASE INDICATE BELOW THE PREFERRED BILLING METHOD:

ONE ACCOUNT FOR THE ENTIRE GROUP ONE ACCOUNT PER BRANCH

PLEASE PROVIDE ADDRESS DETAILS FOR THE SUBMISSION OF THE ACCOUNTS PAYABLE:

CONTACT PERSON ADDRESS

BRANCH CODE

CONTACT PERSON ADDRESS

BRANCH CODE

CONTACT PERSON ADDRESS

BRANCH CODE

CONTACT PERSON ADDRESS

BRANCH CODE

6. PAYMENT DETAILS

PLEASE NOTE THAT A GROUP DEBIT ORDER PAYMENT IS COMPULSORY FOR AN EMPLOYER GROUP OF MORE THAN 10 PRINCIPAL MEMBERS

PLEASE NOTE: Billing of contributions is done in advance or in arrears on the 1st calender day of every month.

Contributions will be paid no later than the 4th day of the same month.

DEBIT ORDER

BANK NAME

ACCOUNT NUMBER

ACCOUNT TYPE

NAME OF BRANCH

BRANCH CODE

NAME OF ACCOUNT HOLDER

AUTHORISED SIGNATURE DESIGNATION

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

INITIAL

7. DECLARATION

All information disclosed in this form is subject to the provisions of sections 16(b), 29(2) and 66 of the Medical Schemes Act No. 131 of 1998, as amended (or its successor-in-law) and the rules of Spectramed as amended from time to time. Kindly note that the "employer" for the purposes of this form is the "duly authorised" person who signs the declaration of this form.

1. I, the undersigned, hereby make application to join Spectramed, on behalf of our employees and pensioners.
2. I, the undersigned, confirm that we understand that it is illegal to belong to more than one registered medical scheme at a time and that on behalf of my employees and pensioners, I will terminate our current medical membership with our current medical scheme ("the current medical scheme") with effect from __/__/__
3. If membership of the employees and pensioners is granted on a group basis, we accept that the acceptance of membership is subject to alteration should membership profiles change and should the group's claims experience be adverse or should membership criteria differ from that indicated in Section 3 hereof.
4. I, the undersigned, acknowledge that if membership is voluntary, all new applicants to Spectramed will be subject to individual underwriting at the time of membership application.
5. I, the undersigned, acknowledge any changes whatsoever to the health of any one of my employees or pensioners will be notified in writing to Spectramed if these changes occur prior to the end of the membership of the current medical scheme, or on receipt of a Spectramed Membership Card, or on receipt by Spectramed of contributions, whichever is the latest.
6. I, the undersigned, declare that the contents of this application are true, correct and complete in every aspect.
7. I, the undersigned, declare that any false or misleading statement and/or non-disclosure of all and any material information to Spectramed shall result in the termination of any membership granted to an employee or pensioner, and any contributions paid shall be forfeited.
8. I, the undersigned, acknowledge that membership of Spectramed is not valid unless confirmed in writing by Spectramed. I understand that certain waiting periods and/or exclusions may apply as defined in the Medical Schemes Act or in the Rules of Spectramed or both.
9. I irrevocably authorise:
   - 9.1 Spectramed to obtain from any person any information that Spectramed requires to assess the information contained in his/her application and/or to assess claims in respect of benefits to which his/her application relates and/or to obtain a second opinion; and
   - 9.2 Spectramed and/or its administrator to provide me with any relevant information by means of email and/or cellular phone and/or ordinary post and to pass that information on to any 3rd party in order to allow Spectramed to fulfil its functions, duties, obligations and realize its rights in terms of any law.
   - 9.3 Spectramed or its contracted 3rd party service providers, or both of them, shall keep confidential, subject to the provisions of South African law, all information received by either one or both of them from a member, subject to any obligation on either Spectramed or its contracted 3rd party service providers, or both of them, to utilise such information in order to fulfil their respective obligations pursuant to the registered rules of Spectramed from time to time, and the applicable legislation.
10. I, the undersigned, acknowledge that it is my sole responsibility to ensure that my contributions are paid to Spectramed, on behalf of employees and pensioners
11. I, the undersigned, acknowledge that it is my sole responsibility to ensure the contributions are paid by myself on behalf of the organisation's employees by no later than the 4th day of each month, as per billing statement.
12. I, the undersigned, hereby agree to advise Spectramed, in writing, of any changes to the banking details and acknowledge that failure to do so will result in the employer being liable for any subsequent banking charges incurred by Spectramed.
13. I, the undersigned, understand that according to the Rules, I may terminate our membership of Spectramed on giving one month's calendar written notice and that all rights to benefits cease after the last day of our membership.
14. I, the undersigned, understand that certain benefits in the first year of membership, once membership has been confirmed by Spectramed, are pro-rated and that an employee or pensioner will not be entitled to a full year's cover if they join or change their existing option after 31 December of each year.
15. I consent to the processing of the information herein for purposes of marketing of value-added or similar products and services.

SIGNED AT

DULY AUTHORISED SIGNATURE

FULL NAME (Please print in block letters)

WITNESS SIGNATURE

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

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GROUP UNDERWRITING REQUEST

(TO BE COMPLETED IN BLACK INK)

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DATE REQUESTED (YEAR/MONTH/DAY) YYYY MM DD

DATE DUE (YEAR/MONTH/DAY) YYYY MM DD

1. UNDERWRITING DETAILS (INTERNAL USE)

TOTAL NUMBER OF EMPLOYEES

TOTAL NUMBER OF APPLICANTS

MEMBERSHIP: COMPULSORY

VOLUNTARY

DESIGNATED EMPLOYEES

TOTAL NUMBER OF APPLICANTS WHOSE AGES ARE:

BETWEEN 0 & 30 / %

BETWEEN 31 & 40 / %

BETWEEN 41 & 50 / %

BETWEEN 51 & 60 / %

BETWEEN 61 & 65 / %

OVER THE AGE OF 65 / %

	TOTAL	RATIO	DESCRIPTION
*PENSIONER RATIO		%	
*AVERAGE AGE			
*CHRONIC RATIO		%	
AVERAGE DEPENDANT RATIO		:1	
*NO. OF MEMBERS WITH CHRONIC DISEASE		%	
*NO. OF MEMBERS REQUIRING SPECIALISED DENTISTRY		%	
*NO. DEPENDANTS WITH SCHEDULED HOSPITALISATION		%	
*NO. OF PREGNANCIES		%	

2. QUOTATION DETAILS (INTERNAL USE)

*OPTION/S TO QUOTE

COMPANY CONTRIBUTION

AMOUNT R

OR COMPANY SPLIT % / %

MANAGER RECOMMENDATION: SUPPORTED

NOT SUPPORTED

SUPPORTED AS AMENDED

UNDERWRITING DECISION

SCHEME SIGNATURE

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

INITIAL