CompCare
Medical Scheme

UMBONO PLUS
APPLICATION FORM

Universal House, 15 Tambach Road, Sunninghill Park, Sandton
PO Box 1411 Rivonia 2128
Tel: +27 86 122 2777
Email: student@universal.co.za
Website: www.studentplan.co.za

Administrated by Universal Administrators (Pty) Ltd

ON-CAMPUS USE

Name & Surname | Signatory | d d m m y y y y

1. Quality Check Yes No
2. Card printed Yes No
3. Membership Certificate printed Yes No

OFFICE USE - MEMBERSHIP DEPARTMENT

1. *Capturer*	Name & Surname	Signatory	d d m m y y y y
2. *Quality Check*	Name & Surname	Signatory	d d m m y y y y
3. *Card printed*	Name & Surname	Signatory	d d m m y y y y
4. *Membership Certificate printed*	Name & Surname	Signatory	d d m m y y y y

APPLICANT STATUS

New Applicant ☐ **Renewal** ☐ **Existing Membership Number** _____

Period of membership _____ (months)

Start date d d m m y y y y

Confirmation/Correspondence to be sent via SMS ☐ Email ☐

Method of Payment EFT ☐ Credit card ☐

End date d d m m y y y y

PERSONAL DETAILS *(To be completed in full)*

Surname _____

First name/s _____ Gender Male ☐ Female ☐

Title _____ Marital status _____ Nationality _____ Present age _____

Date of birth d d m m y y y y Passport No. _____

South African postal address _____ Postal code _____

South African physical address _____

Email address _____

Telephone (H) c o d e _____ Telephone (W) c o d e _____

Study Institution _____ Cell c o d e _____

Country of Origin _____ Student No. _____

Basic Salary R _____ Embassy _____

As per SARS this information is required.
Does the member have a registered disability? Yes ☐ No ☐ *If yes please also complete the Disability declaration form and submit together with the application.*

PLEASE NOTE: A copy of the Institution acceptance letter, study visa, passport and proof of payment must be attached to this application form

MEDICAL DETAILS

Kindly circle the correct answer e.g. if you circle YES, it means you have received OR intend to receive treatment, and NO means you have not OR do not intend to receive treatment.

Please indicate and provide details of any medical treatment received*

Have you received treatment for Chronic and/or Acute conditions in the past twelve months?		Yes	No
Do you anticipate receiving any treatment for Chronic and/or Acute conditions in the next twelve months?		Yes	No
Have you been admitted to hospital in the 12 months prior to completing this application form?		Yes	No
Do you anticipate being admitted to hospital in the next 12 months?		Yes	No
Are you pregnant or suspect that you may be pregnant?	N/A	Yes	No

If you answered **"Yes"** to any of the above questions, please provide details below:

Name	Details of condition	Date of treatment	Degree of recovery

Explanation of *: *Please ensure that when completing this form, you provide complete, up to date and accurate information at all times. Any non-disclosure of material information or any other fraudulent act, may result in the cancellation or suspension of your membership. You may be guilty of an offence as provided for in the Medical Schemes Act No 131 of 1998 and liable on conviction to a fine or imprisonment or both.

In the event that I am hospitalised and the Scheme will need to communicate with someone on my behalf, I hereby nominate the following person and warrant that I have obtained their consent to share their personal details with the Scheme for this purpose:

Name and Surname _____ Relationship _____

Telephone details Tel: Code ( ) _____ Cell: _____

BANKING DETAILS

Account holder:	CompCare Medical Scheme	Account holder:	CompCare Medical Scheme	Account holder:	CompCare Medical Scheme
Bank:	Nedbank	Bank:	Standard Bank	Bank:	ABSA
Branch code:	194405	Branch code:	Rivonia 1255	Branch code:	632005
Acc number:	1944105972	Acc number:	422070912	Acc number:	4077182095
Swift no:	NEDSZAJJXXX	Swift no:	SBZAZAJJ	Swift no:	ABSAZAJJ

BANKING DETAILS FOR CLAIMS REIMBURSEMENT

CREDIT CARD AND FOREIGN BANK ACCOUNTS ARE NOT ACCEPTED

Name of account holder _____

Name of bank _____ Branch code ___ - ___ - ___

Account number _____

Type of account (please tick) Current ☐ Savings ☐ Transmission ☐

DISCLAIMER
It is the member's responsibility to advise the Scheme's Administrator in writing of any change in banking details. Neither the Scheme nor its Administrator shall be held liable under any circumstances should an incorrect account be credited.

Signature of applicant _____ Authorised Signature of account holder required *(if different from applicant)* _____

DECLARATION

1. I, the undersigned, hereby apply for membership of CompCare Medical Scheme and agree that all answers and information contained in this application completed by me or by any other person/s will be the basis of the proposed agreement.
2. I warrant that the contents of this application are true, correct and complete. No cover will be granted unless CompCare Medical Scheme specifically notifies me in writing of their acceptance of the risk, or on receipt of a valid membership card. Failure to comply with any of the terms and conditions of the agreement shall render the agreement null and void.
3. I agree to abide by and undertake to familiarise myself with the rules of the Scheme as amended from time to time.
4. I understand that the Scheme will not be liable for reimbursement in respect of health services obtained for any pre-existing conditions, unless the details are fully disclosed, which may be subject to waiting periods and condition-specific exclusions in accordance with the Medical Schemes Act (No. 131 of 1998).
5. I agree to notify the Scheme within 30 days in the event that any alteration in the circumstances on which the assessment of their risk is based, occurs between the date of this application and the date of their acceptance of the risk.
6. The following will apply in respect of exchange of confidential information and medically confidential information concerning members and their dependants:
   - 6.1. For the purpose of considering application/s for membership, as well as any claims for benefits, CompCare Medical Scheme and any medical personnel authorised by CompCare Medical Scheme have the right to obtain or forward any medically relevant information, including the HIV/AIDS status, which it may deem necessary from or to any medical practitioner or institution or nominee that possesses or needs such information, and that party may disclose such information to CompCare Medical Scheme and any party duly authorised by CompCare Medical Scheme.
   - 6.2. The information may be requested and supplied at any time, including after the death of the member or dependants, and will include accounts from service providers, indicating diagnoses, and medical or clinical reports when indicated. Such information will, however, be treated as confidential at all times by the party to whom it is supplied.
   - 6.3. By agreeing to sign the application form/s the applicant/member and dependants thereby waives his/her right to privacy in terms of the abovementioned clauses.
   - 6.4 For the relevant institution to confirm my status of registration with CompCare for any particular year for which I have provided proof of membership.
   - 6.5 For CompCare to confirm my status of registration with the relevant institution for any particular year for which I have provided proof of registration.
7. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the Scheme.
8. I confirm that neither the applicant nor any of his/her dependant/s will be/are beneficiaries of another registered medical scheme, on the date of registration with CompCare Medical Scheme.
9. I hereby indemnify and hold harmless the Scheme and Administrator against any claims that may result due to the use of preferred providers.
10. I hereby give the Scheme permission to communicate to me by SMS ☐ Email ☐
11. I hereby appoint the below-mentioned broker as my Healthcare intermediary.
12. If you have appointed a broker to provide a healthcare administrative service to you or your registered dependants, you hereby consent for the Scheme and the Administrator to share your personal information with your chosen broker as needed.
13. If the broker requests any information from the Scheme or Administrator to provide a healthcare administrative service to you or your registered dependants, you confirm that the necessary consent for this disclosure to your broker is in place.
14. It remains your responsibility to inform the Scheme and Administrator of any changes to your appointed broker. Should you withdraw the consent to disclose information to the appointed broker, if you change brokers, or if you terminate the services of the appointed broker and fail to inform us, the Scheme and Administrator will not accept responsibility for disclosing any information to the said broker.

I declare that I have disclosed all particulars relevant to this application and that I am aware that any false statement or non-disclosure of information will relieve the Scheme of liability and subject my membership to cancellation. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

Applicant signature _____ If the applicant is a minor, the Parent(s)/Legal Guardian(s) need to complete a CONSENT LETTER	**Date**

Employer/University/Embassy Signature		Date	
Brokerage name or broker name		Broker code	
Broker signature		Date	
Broker consultant name		BC code	

CompCare Medical Scheme is administered by Universal Healthcare Administrators (Pty) Ltd

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Administered by

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