The Building & Construction Industry Medical Aid Fund

Reference no. 1590. Registered in terms of the Medical Schemes Act no. 131 of 1998

MEMBER AND DEPENDANT APPLICATION FORM

NEW APPLICATION [ ] **ADD DEPENDANT/S** [ ] **CONTINUATION MEMBER** [ ]

Surname:

Full names:

ID no.: | | | | | | | | | | | | | | Date of Birth: D D M M Y Y Y Y

Postal address:

Code:

Physical address:

Code:

E-mail:

Tel no.: Home: (   ) Work: (   )

Cell: (   ) Gender: M F

Race: African | Coloured | Indian/Asian | White Tax Reference no.:

Union: Y N Union Name:

SECTION 1: EMPLOYER DETAILS

Name of Employer: Ref. no.:

Contact person: Tel no.:

Employee hourly wage: R Employee no.:

Occupation: **Date Employed:**

1st Medical Aid Contribution will be deducted for **week-ending** ________/________/ 20 ____________ OR

for the month of: ______________________ 20 ________.

I declare that I have disclosed all relevant particulars and that I am aware that any false statement or non-disclosure of information will relieve the Fund from liability and subject my membership to cancellation.

____
Signature of applicant

Date: D D M M Y Y Y Y

____
Employer's signature and/or company stamp

Date: D D M M Y Y Y Y

SECTION 2: DEPENDANT DETAILS (INCLUDING SPOUSE/PARTNER)

Full names & surname	Race	ID no.													Relationship

Do you, your spouse or children currently suffer from any medical condition / illness? Y N

If yes, please state below:

Name of beneficiary	Medical Conditions

SECTION 3: MEDICAL DETAILS

Please complete all questions in full as non-disclosure of material information could prejudice future claims made by you and/or any of your dependants.

	Principal Member	Spouse/ Partner	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Height (cm)						
Weight (kg)						
Smoker/ Non smoker						

Please give the name of your General Practitioner and / or specialist, you or any of your dependants have consulted recently.

Name of General Practitioner / Specialist	Telephone number	Number of years consulted
	Code ( )	
	Code ( )	
	Code ( )	
	Code ( )	

SECTION 4: MEDICAL HISTORY

It is most important that the following questions be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit.

Please advise whether you or any of your dependants suffer from, or have suffered from, or received treatment/consultation for any of the following conditions. Please ensure that you tick and complete the appropriate block/s.

SECTION 4: MEDICAL HISTORY (Continued)

			Yes	No	Name of member / dependant
1.	**Heart & Vascular System**	High blood pressure; high cholesterol; angina; heart attack; angiogram; previous coronary artery bypass; rheumatic fever; heart murmurs; valve problems / replacement; arrhythmias – insertion of pacemakers; heart failure; stroke; varicose veins; DVTs (deep vein thrombosis); pulmonary emboli.			
2.	**Lungs**	Asthma; emphysema; chronic bronchitis; TB; chronic infections - bronchitis & pneumonia.			
3.	**Digestive System, Gallbladder; Liver**	Dyspeptic disease (heartburn; hiatus hernia; peptic ulcers; reflux); irritable bowel syndrome (spastic colon; inflammatory bowel disease e.g. CHRON'S & ulcerative colitis; chronic diarrhoea / constipation); gallstones & jaundice; hepatitis; pancreatitis; haemorrhoids; incontinence; bowel prolapse.			
4.	**Nervous System**	Persistent headaches; epilepsy; paralysis; degenerative diseases – Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).			
5.	**Bone; Muscle & Joints**	Arthritis; rheumatism; gout; back, knee or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease; osteoporosis; previous amputations / artificial limbs; birth defects; joint replacements.			
6.	**Urinary Tract**	Infections; stones; albumin / blood in urine; urinary incontinence; prolapsed bladder.			
7.	**Gynaecological System**	Menopause; female hormone replacement; irregular menses; infertility; breast tumours (benign / malignant); ovarian tumours; cysts; prolapsed uterus / rectum / bladder; miscarriage; caesarean section.			
8.	**Male Genital System**	Prostate problems (hypertrophy / cancer or infections); infertility; hernias – groin; scrotal swellings; testicular tumours; abnormalities of the penis.			
9.	**Gland / Hormonal**	Over / under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.			
10.	**Blood**	Anaemia; bleeding disorders (haemophilia); leukaemia; Hodgkin's disease.			
11.	**Ear, Nose & Throat**	Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness – hearing aids.			
12.	**Eyes**	Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus); allergies – pterygiums; anticipated / previous laser surgery; artificial eyes.			
13.	**Emotional (psychological, psychosomatic problems)**	Depression; bipolar disorder; anxiety; stress; previous treatment for post-traumatic stress syndrome; eating disorders – bulimia & anorexia; mental retardation; alcoholism; drug abuse.			
14.	**Infections / Tropical Diseases**	Sexually transmitted diseases; genital warts; HIV / AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzias; cholera; typhoid.			
15.	**Skin Disorders**	Acne; eczema; psoriases; lesions (keloid hypertrophic scars); skin rashes; shingles; Kaposi sarcoma – tumours.			
16.	**Connective Tissue Disorders**	Systemic lupus erythromatosis; scleroderma.			
17.	**Teeth & Gums**	Impacted molars (wisdoms); previous / current orthodontic treatment; braces; crowns; recurrent infections - gums.			
18.	**Cancer**	Cysts; growths; tumours of any kind.			
19.	**Allergies**	Are you or any of your dependants allergic to any specific type of medication (e.g. penicillin, aspirin, sulphas, morphine, NSAIDS); pollen dust; animals; specific food types (e.g. nuts).			
20.	**Immuno-Suppressive Treatment**	Have you or any of your dependants ever had or expecting to undergo an organ treatment transplant? Have you or any of your dependants ever suffered from any condition requiring Immunosuppressive treatment?			
21.	Have you or any of your dependants ever received any form of physiotherapy, occupational therapy or chiropractic treatment?				
22.	Are you or any of your dependants pregnant? If **yes** - how many weeks? Please give expected date of delivery.				
23.	Have you or any of your dependants had any previous or pending claims for which any other party may be liable e.g. MVA (Motor Vehicle Accident) claims? If **yes**, please give details.				
24.	Are you or any of your dependants expecting to undergo any medical treatment, e.g. hospitalisation, operation, specialised dentistry etc, within the next twelve months?				
25.	Do you or any of your dependants have a chronic condition requiring ongoing medication? If **yes**, please give the name and dosage of all the medication you or any of your dependants are currently taking.				
26.	Have you or any of your dependants ever received any medical attention of any nature, e.g., hospitalisation, operation, specialised dentistry etc, not mentioned above?				
27.	Have you or any of your dependants ever appeared before a medical board in view of early retirement and declared medically unfit?				

If any of the questions above have been answered yes, please supply full details below. If there is not enough space, please attach an additional page.

No	Member / Dep	Full details of the disorder, consulting Doctor, type of medication & dosage used	Date of treatment	Degree of recovery

SECTION 5: PREVIOUS MEDICAL AID MEMBERSHIP

Please attach Certificates of Membership (from previous Medical Scheme/s) to this Application. If no certificate/s is attached, interchangeability could be forfeited.

Name of Previous Medical Scheme/s	Membership Number	Date Joined	Date Terminated

SECTION 6: BANKING DETAILS – NEW APPLICATION

Name of account holder:

Bank:

Branch name: Branch code:

Account no.:

Account type: Cheque/Current Savings Transmission

PLEASE REMEMBER TO ATTACH PROOF OF BANK DETAILS WHEN SUBMITTING THIS FORM. (CANCELLED CHEQUE, BANK LETTER, OR BANK STATEMENT)

Authorised signature

Date: D D M M Y Y Y Y

DISCLAIMER: It is the member's responsibility to advise the administrator in writing of any change in banking details. Neither the Fund nor its Administrators will be held liable should an incorrect amount be credited under any circumstances.

BCIMA Claims Dept. Date: D D M M Y Y Y Y

SECTION 7: METHOD OF PAYMENT FOR CONTRIBUTIONS

Please select method of payment (please tick)

Debit Order

Direct Payment via Cheque / EFT Transmission

If paying by Debit Order, please fill in the following:

I / We hereby authorize the Fund to debit my / our account (wherever it may be), the amount necessary for any contributions and changes in relation to this agreement, incorporating the contribution rate changes.

Name of account holder:

Name of Bank:

Branch name: Branch code:

Account no.:

Account type: Cheque/Current Savings Transmission

Date: D D M M Y Y Y Y

Authorised signature

SECTION 8: THE BUILDING & CONSTRUCTION INDUSTRY MEDICAL AID FUND DECLARATION

1. The Building & Construction Industry Medical Aid Fund, hereafter referred to as "the Fund", confirms that your and your dependants' personal details and medical information shall be kept confidential and the Fund shall take all reasonable steps to comply with the provisions of any legislation applicable to the protection of your and your dependants' personal information.
2. The Fund confirms that your and your dependants' identifiable information (personal and health information) will neither be used for purposes of related company business nor sold for commercial purposes.
3. The Fund confirms that it has data security measures in place, including restricted access to your and your dependants' data, data back-up systems and data recovery systems.
4. The Fund shall take all reasonable steps to ensure that all staff within the Fund and all third parties who have access to beneficiary information for the purpose of data transfer and management, Fund administration, managed care agreements and compliance with applicable legislation, keep the personal information of beneficiaries confidential and comply with applicable legislation.
5. The Fund confirms it has granted access to certain persons within the Fund and its contracted third parties to your and your dependants' personal and health information. The use of relevant personal information and/or personal health information provided is for the following purposes: verifying your identity; processing your application for membership; administration of your medical Fund membership; membership verification and eligibility checking; assessment, processing and reimbursement of claims for medical expenses; determining your entitlement to benefits; underwriting or risk assessments; providing relevant information to a healthcare provider who requires this information to provide a healthcare service to you or any of your dependants; providing managed care services to you or any of your dependants; sharing your information with service providers, including electronic switching houses, for the purpose of processing it and rendering services to you such as electronic submission of claims to us; risk management practices; fraud prevention and detection, audit and record keeping purposes; compliance with applicable legal and regulatory requirements; population of the beneficiary registry as required by the Council for Medical Schemes and the Department of Health; collection of monies owed by you or healthcare providers to us; statistical analysis (this will always be on an anonymous basis, which means that data about you that is relevant to the analysis is used but it is not linked to your name or membership number).
6. In the event of a breach of confidentiality, the Fund shall assume responsibility if the Fund is at fault and will manage the breach according to its internal protocols and disciplinary procedures.
7. The Fund will ensure that underwriting is applied to all members in a consistent and equitable manner.

SECTION 9: MEMBER ACKNOWLEDGEMENT AND DECLARATION

Please read the declarations below carefully. These contain acknowledgements of fact that may impact on your rights. These declarations must be read in conjunction with the rules of The Building & Construction Industry Medical Aid Fund (hereafter referred to as "the Fund"), and the Medical Schemes Act No. 131 of 1998 (hereafter referred to as "the MSA"), and all these provisions shall be binding on you and your dependants. Please tick the boxes to acknowledge that you have read each declaration:

1. I, the undersigned hereby apply for membership of The Building & Construction Industry Medical Aid Fund 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 The Building & Construction Industry Medical Aid Fund 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 Fund as amended from time to time and grant my employer the right to deduct from my remuneration any amounts (including members portions) outstanding by myself to The Building & Construction Industry Medical Aid Fund. I further grant my employer the right to pay such monies over the Fund. ☐
4. I understand that the Fund 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 Fund within 30 days in the event that any alternation 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. I (the member) acknowledge that it is my sole responsibility as a member to ensure that the monthly premium is received by the Fund. Furthermore, I understand that I will be liable for any legal costs incurred in the recovery of any amount owing to the Fund on the attorney and own client scale. ☐
7. I declare that neither the applicant nor any of his / her dependant/s are beneficiaries of another registered medical Fund, on the date of registration with The Building & Construction Industry Medical Aid Fund. ☐
8. I understand that once I am enrolled as a member I may not terminate my membership voluntarily and that membership may only be terminated once I leave my current employment, or I am eligible to become a member of another medical Fund of which my spouse is a principal member. ☐
9. I hereby give the fund permission to communicate to me by SMS or Email. ☐
10. 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 Fund from liability and subject my membership to cancellation. I warrant that I am authorised to sign on behalf of my dependant/s. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me. ☐
11. I also authorise any doctor or other person, who may be in possession of or hereafter acquire information about my health or the health of my dependants, to disclose the information to the Fund and its contracted third parties, provided such information shall be treated as confidential at all times. I confirm that I have the required consent of my dependants to share information of such dependants with the Fund and its contracted third parties. ☐
12. I understand that my confidential health and personal information will only be used for the purposes as outlined by the Fund on the application form and any deviation from this constitutes a breach of confidentiality. ☐
13. In the event that the Fund wishes to use my (or my dependants') confidential information for purposes other than those outlined in the application form, the rules of the Fund and the MSA, the Fund is required to obtain further consent from me (or my dependants). ☐
14. I agree to inform the Fund of any changes in my or my dependants' personal status, as required by the Fund rules, within 30 days of the change in circumstances. ☐
15. I shall ensure that the Fund is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of my application for membership, the administration of my membership, payment of claims and communication by the Fund with me. ☐
16. I acknowledge that my dependants and I may have access to our personal information held by the Fund and request the Fund to correct any inaccurate information as prescribed by applicable legislation. ☐
17. I further acknowledge that the personal information of my dependants and I shall be retained as part of the records of the Fund for as long as it is required by the Fund for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of applicable law. ☐
18. If any of my dependants or I have any concern about the processing of our personal information, we can raise the matter with the Fund by contacting the Principal Officer. ☐
19. I agree that contribution late joiner penalties may apply to my adult dependants 35 years and older if they have not been a member or a dependant of any previous medical Fund(s) or existing dependant at time of registration. ☐
20. I consent to all conversations between myself and the Fund or its contracted third parties being recorded. ☐
21. I confirm that I have received a copy of the current Member Benefit Guide and understand the contents therein. ☐
22. I confirm that I am familiar with the terms of this agreement, being the conditions, limits and benefits of the Fund. ☐
23. I hereby guarantee that as the main member of the Fund, to the extent that it may be required by law, that I have received the necessary consent from my dependants to access and view their healthcare claims made on my membership and deal with all matters relating to their claims on my membership as set out in this section. ☐
24. I confirm that I am aware that my contribution will be calculated on my gross monthly/hourly income, including all allowances, but excluding overtime. ☐

____
Signature of applicant

Date: | D | D | M | M | Y | Y | Y | Y |

SECTION 10: BROKER DECLARATION AND DETAILS

WHERE A BROKER HAS BEEN USED, THE BROKER MUST COMPLETE THE FOLLOWING BROKER DECLARATION SECTION:

1. I hereby confirm that I have been appointed by the member applicant, and acknowledge that the member applicant may terminate my services at any time.
2. I confirm that I am fully accredited in terms of relevant legislation, on date of my signature, of this document.
3. Financial Services Board: Accreditation number ______ Council for Medical Schemes: Accreditation number ______
4. I confirm that I have provided the member applicant with my full name, physical and postal address and telephone number.
5. The commission payable upon completion of the transaction by the: Member applicant R ______ Fund R ______
6. I confirm that I have a valid contract with the Fund.
7. I confirm that the information provided by me, to the member applicant and the Fund is true and correct to the best of my knowledge.
8. I confirm that where I have completed this application form on behalf of the applicant member, the applicant member is familiar with the information requested and responses provided.
9. The advice and assistance provided to the applicant member was impartial and in his / her best interests.
10. In the event of a material misrepresentation being made by me or engagement in unlawful conduct I undertake to refund all monies paid by the applicant member and / or the Fund in consequence of such misrepresentation or conduct.
11. I confirm that the member applicant has personally signed the form.

DISCLAIMER: The Fund shall not be held responsible for any misrepresentation made by any of its agents / representatives / consultants.

SECTION 11: BROKER DETAILS

Brokerage Name: ______ Broker code: ______

Broker's Name: ______

Broker's Cell: ______ Tel no.: Code ( ) ______

Approval of Broker Appointment

Signature of Broker

D	D	M	M	Y	Y	Y	Y

Signature of Member

D	D	M	M	Y	Y	Y	Y

SECTION 12: DOCUMENTS TO ACCOMPANY APPLICATION (Please tick appropriate box)

Copy of Identity Documents for Principle Member / Spouse / Partner / Dependant/s ☐

Copy of Marriage Certificate / Tribunal Union Certificate ☐

Copy/s of Unabridged Birth Certificate/s for Dependant/s ☐

Children older than 18 years old:
Proof of Dependency (POD) - Letter from School, College, University ☐

Membership Certificate from previous Medical Aid ☐

Copy of Principle Member's latest Payslip ☐

March 2021

Ms P Makatini (CEO), Trustees: Mr M Mphomela (Chairman), Mr E Koji (Vice Chairman), Mr J Mpe, Mr C Schmidt, Mr C Froneman, Mr S Mlangeni, Ms R Maseko

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