GETMED HEALTH PROTECTION PLAN

ADD / REMOVE DEPENDANTS

68 OAK Avenue, Highveld Techno Park, Centurion, 0046
PO Box 10999, Centurion, 0046
Tel: 0800 002 505 Fax: 086 6410 0139

MEMBERSHIP NUMBER:					
Title		Surname		Option	
Full First Names					
Identity Number/ Passport Number				Gender	M / F
Telephone	Cell:		Work:		
Reply by	Fax	E-mail		Employee Number	
Employer					

ADD / REMOVE DEPENDANTS														
Name								Date of Birth						
	Add	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D
	Add	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D
	Add	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D
	Add	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D
	Add	Remove	SPOUSE	CHILD	M	F	Y	Y	Y	Y	M	M	D	D

Member Signature		Date of Signature	

Please Note:

1. Please provide GetMed with a copy of the dependants ID.
2. No money will be refunded if you removed a dependant.
3. Your request is subject to a 30 day notice period.

Disclaimer:
Information contained in this form is confidential and contain privileged or copyright information. You must not present this message to another party without gaining permission from the sender. If you are not the intended recipient you must not copy, distribute or use this information.

If you have received this information in error, please notify the sender immediately, and delete this email from your system.

Please complete the request information on the form and on the Health Questionnaire and fax/e-mail it back to:

Fax: 012 682 8023
e-mail: members@getmed.co.za

HEALTH QUESTIONNAIRE

A. MEDICAL HISTORY OF THE APPLICANT AND THE DEPENDANTS		
Have you or any of your dependants ever experienced any of the following conditions, if you have answered "YES" to any of the questions, please provide us with full details for that person in the space provided. If you or any of your dependants suffer from a chronic condition, please provide us with the medical report from your treating doctor stating particulars of the condition and the duration and the estimated cost of treatment per annum.		
1. In the last 12 months, have you or any of your dependants had medical problems or received treatment relating to:		
1.1. Physical disability since birth.	YES	NO
1.2. Disorders of the heart and blood vessels. *(e.g. hypertension, heart attack, heart failure, vascular disease)*	YES	NO
1.3. Disorders of the skin. *(e.g. psoriasis, acne, cancer, eczema, allergies.)*	YES	NO
1.4. Disorders of the muscles, joints, and spine. *(e.g. rheumatism, osteo or rheumatoid arthritis, muscular dystrophy)*	YES	NO
1.5. Disorders of the special senses: vision, touch, hearing, taste and smell. *(e.g. blindness, cataracts, glaucoma, and deafness.)*	YES	NO
1.6. Disorders of the respiratory tract or lungs. *(e.g. asthma, bronchitis, tuberculosis, persistent cough, emphysema.)*	YES	NO
1.7. Disorders of the digestive system, gallbladder or liver. *(e.g. gastric, duodenal ulcers, recurrent heartburn, gallstones, liver cirrhosis, hepatitis B, spastic colon, Crohns disease, pancreatitis, Irritable Brown syndrome.)*	YES	NO
1.8. Disorders of the bladder, kidney and reproductive system. *(e.g. kidney stones, infertility, recurrent bladder infections, ovarian cysts, endometriosis, erectile dysfunction, prostatitis)*	YES	NO
1.9. Disorders of the hormonal and endocrine system. *(e.g. post menopausal syndrome on HRT, diabetes, hypo and hyperthyroidism.)*	YES	NO
1.10. Disorders of the nervous system or mental illness. *(e.g. epilepsy, paralysis, speech disorder, depression, anxiety, bipolar mood disorder, schizophrenia, Alzheimer's, Parkinson's disease, chronic headaches or migraines)*	YES	NO
1.11. Disorders of the immune system. *(e.g. scleroderma, psoriasis, HIV/AIDS, systemic Lupus Erythematosus)*	YES	NO
1.12. Disorders of the ear nose and throat. *(e.g. hay fever, allergic sinusitis, tonsillitis, ear infections)*	YES	NO
1.13. Substance dependence. *(e.g. alcohol, drugs, sleeping tablets, painkillers)*	YES	NO
1.14. Special dental treatment. *(e.g. root canal treatment, crowns, orthodontics.)*	YES	NO
1.15. Metabolic disorders. *(e.g. obesity, porphyria, gout)*	YES	NO
1.16. A disease or medical condition for which you or any of your dependants are receiving a payment and / or guaranteed medical treatment of whatever nature. *(e.g. disability pensions, hospital plans)*	YES	NO
1.17. In the last 12 months, have you or any of your dependants been hospitalized for any reason. *(e.g. surgery, accident, medical investigations.)*	YES	NO
1.18. Are you or any of your dependants currently receiving ongoing treatment for any disorder? *(e.g. depression, epilepsy, diabetes, asthma, hypertension, cancer.)*	YES	NO
1.19. For female applicants and female dependants. Do you suspect that you are pregnant, if so how many months? ____	YES	NO

If you have answered “YES” to any of the questions, please give full details.				
Full Name	**Disease / Condition**	**Date**	**Doctor / Hospital information**	**Medication / Treatment.**

______________________________ ____________________

Signature (Principal Member) **Date**

GetMed

BETTER HEALTHCARE FOR YOU

FOR OFFICE USE ONLY: UNDERWRITING DATE:										
Underwriter	Signature	**Date**	d	d	m	m	y	y	y	y

Underwriting decisions:

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Approved: Yes…… No ………