

**MEMBERSHIP APPLICATION FORM**

ALL QUESTIONS TO BE ANSWERED IN FULL (Please print)

**1. Applicant's Details**

Title: Mr  Mrs  Miss  Ms  Marital status: Single  Married  Widow(er)  Divorced

Applicant's Surname:	First Name(s)
Date of birth:	National I.D. number: (This will be included on your membership card)
Occupation:	
Have you ever been a member of a Fund administered by Sovereign Health? Yes <input type="checkbox"/> No <input type="checkbox"/>	If you answered yes, please provide your previous membership number:

**2. Details of Immediate Family Members To Be Covered On Medical Aid**

Please list children in order of age, oldest first, under 18 years only.

Surname	First Name(s)	Sex	Date of Birth	National I.D. Number	Relationship

**3. Contact Details**

Postal address			
Home address			
Telephone Numbers	Work:	Home:	
Cell phone Number	E-mail address:		

**4. AACMAS MEDICAL SAVINGS ACCOUNT CONTRIBUTION OPTION (Please tick desired option)**

MSA Contribution	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Super High
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**5. Banking Details**

AACMAS claim refunds are deposited direct into members bank accounts using Electronic Fund Transfer (E.F.T.).

Please provide your bank details to enable us to deposit your refunds direct into your bank account

Name of Account Holder	Name of Bank	Branch	Branch Sort Code	Account Number

**6. Previous medical aid membership**

Name of medical aid	Membership number	Joining date	Termination date	Name of Employer

Please attach certificates of membership (not membership cards) which are required to avoid late joiner penalties, waiting periods and condition specific exclusions.

PLEASE TURN OVER

**7. THIS SECTION TO BE COMPLETED BY ALL DEPENDANTS APPLYING TO JOIN  
PLEASE PLACE AN "X" IN THE APPLICABLE BLOCK**

a) Are you or any of your dependants pregnant, if so how many months? N.B. Waiting periods may apply	YES	NO	NO. OF MONTHS	NAME OF PERSON
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- b) Have you or any of your dependants ever had any of the following?  
Please provide name of dependant and complete a separate form for each dependant.

**NAME**

	YES	NO
1. Any disorder of the heart e.g., rheumatic fever, heart murmur, heart attack, coronary artery disease, chest pains, shortness of breath or palpitations, ankle swelling?		
2. High blood pressure or disease of the blood vessels?		
3. Any respiratory or lung trouble e.g. asthma, bronchitis, persistent cough, tuberculosis?		
4. Any disorder of the digestive system, gall bladder or liver, e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, pancreatitis?		
5. Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis or venereal disease?		
6. Any nervous or mental complaint e.g. epilepsy, blackouts, paralysis, anxiety state or depression?		
7. Ear, eye, nose or throat disorder, e.g. ear discharge, recurrent tonsillitis?		
8. Any disorders of the eyes, e.g. defective vision, cataracts, glaucoma?		
9. Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?		
10. Diabetes, sugar in urine, thyroid or other glandular or blood disorder?		
11. Cancer, growth or tumour of any kind?		
12. Any tropical disease, e.g. bilharzias, malaria?		
13. Any other illness, disorder, disability or accident which required hospitalisation, specialist, radiological, surgical or pathological investigations during the past 5 years?		
14. Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause?		
15. Do you or any of your dependants suffer from any ailment or disease at present?		
16. Are there, in respect of you or any of your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire, relating to past or present diseases, accidents, operations or other conditions including pregnancy for which advice has been sought or treatment has been received or recommended during the past 5 years?		
17. Are you or your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months?		
18. Have you or any of your dependants had any surgical procedure in the past?		
19. Have you received advice to quit smoking?		
20. Have you received counselling for or treatment of any treatment of any substance abuse? e.g. alcohol or drugs		

**If you have answered YES to any of the above the following details are to be provided by your General Practitioner or Specialist:**

a) Diagnosis	
b) Cause	
c) Date of onset	
d) Treatment	
e) Prognosis	
f) Further treatment expected	
g) Name of Practitioner(s) involved	
OTHER	

**N.B.:** Failure to disclose pre-existing conditions could result in benefits being limited, excluded and/or membership being terminated.

**8. Waiting Periods**

8.1 Subject to the Fund Rules, applicants who are transferring direct from a National Association of Medical Aid Societies (NAMAS) affiliated medical aid society may be admitted without waiting periods. Proof of previous medical aid membership has to be submitted with this application.

8.2 Applicants joining medical aid for the first time will be subject to specified waiting periods.

**9. SEPARATE APPLICATION SHOULD BE MADE IN RESPECT OF:**

All Dependants other than spouse/partner over the age of 18 provided such dependant is reliant on the member for family care and support. Consideration will be given on Application to AACMAS. Separate contracts will be issued.

**10. ACKNOWLEDGEMENTS**

10.1. I acknowledge that I am aware of the provisions of your Rules dealing with undesirable business practises, the submission of fraudulent claims to the Fund, the commission of fraudulent acts and the non-disclosure of material information to the Fund. In particular, I am aware that I am not permitted to allow any person other than my registered dependants to use my membership card.

10.2. I am aware that, if I am accepted for membership, your Rules will be binding on me.

10.3. I hereby authorise and instruct my Employer to deduct from my remuneration and any other sums due to me any amounts which may be due by me to AACMAS from time to time and to pay the same to AACMAS. Likewise, I hereby authorise and instruct any person (such as my Employer or a pension fund or provident fund) who holds funds for my benefit after I cease employment to pay, and continue to pay, the amounts referred to in the first sentence hereof to AACMAS as and when they fall due.

10.4. I am aware that proof of identification may be requested at any stage.

10.5. All sums due by me to AACMAS shall be forthwith due and payable by me to AACMAS immediately upon my ceasing to be a member.

**11. DECLARATION**

11.1. The answers given herein are full, complete and true and, if I am accepted as a Member of AACMAS, will constitute the basis of my membership.

11.2. I realise that I must submit evidence of the good health of myself and my Dependants and that Benefits may be limited or excluded in respect of any particular ailment, disease, disorder, condition or disability which existed on my admission date.

11.3. I acknowledge that I have been given the opportunity of perusing the Rules of AACMAS prior to signing this Application and that, even if I have not availed myself of such offer, I shall be deemed to have read the Rules.

11.4. Words used in this Application shall bear the meaning ascribed to them in the Rules.

**12. Effective date of A.A.C.M.A.S. Membership:** \_\_\_\_\_

**APPLICANTS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Signed by me as Applicant declaring that I have carefully read this application form and accepting that the fact that I have applied does not necessarily mean that I will be accepted as a member.**

