

Vitality Health Plan Application Form

1. Personal Details										
Title	Surname			Given Name						
Other Names:										
Nationo	al Identity Nur	mber				F	Passport	Number		
Date of Birth DD MM YYYYY Marita			al Status: Single Married Divorced Widowed							
Physica	l Address									
Postal Address										
Email:										
Home Telephone Cell Number										
2. H	ealth Plan									
No.	Health Plan	Option		Subscription				Choose Health plan by writing subscription on next to the option chosen		
		lity Health Standard		M100.00						
	Vitality Health Smart			M250.00						
	Vitality Heal	th Executive	;	M500.00						
3. D	ependent	s Details								
Full Names Surname Date		Date of	of Birth Relationship C		Gender	Physical Address	Telephone / bile phone	mo-		
	rincipal M o	ember's l		f Kin Relations	ship	Physical a Postal Ad		Email Address	Telephone, bile phone	/ mo-

Company/Business Name	Physical and Postal Address	Email Address	Telephone/ mobile phone	
6. Bank details for claim (information require		ent of benefits to pri	ncipal member)	
Account Name				
Account Number				
Bank Name				
Branch Name				
Account Type				
Please provide a letter from yo	ur bank confirming yo	ur bank details.		
I hereby authorise Vitality Hospital Management Services trading as Vitality Health to pay any scheme benefits that may be due to me into the abovementioned bank account. Should the banking details change, I will notify Vitality Health in writing.				
Account Holder's Signature	[Date		
7. BANK DETAILS FOR DI (Compulsory for individual				
Account Name				
Account Number				
Bank Name				
Branch Name				
Account Type				
I hereby authorize Vitality Helphaness by me to Vitality Health in term made during the term of my mapplicable subscriptions to the	(Bank Name), to dedunt of the rules of Vitality embership) from the abo	uct monthly contributions (cui Health Plan (including any ar ove-mentioned bank accoun	rrent and/or arrears) due mendments that may be	
Account Holder's Signatu	count: (at least two perso		ust sign this debit order)	
First Signature:	, Date:			
Second Signature:	, Date:			

NOTE: Please submit a letter from your bank confirming your banking details

8. Medical History Have you or your dependant(s) received any medical Indicate Name of Patient Condition Level Stage of treatment or care in the with an illness, condition, "X" in nature of Treatment, past 12 months or medical advice relating to any of **Medication dosage** the following conditions? the and hospitalization Nο Period Yes Date Congenital physical deviations e.g. bat-ears, valvular heart disease Abnormality of skin (including allergies) e.g. eczema, psoriasis Deviations and problems in skeleton, joints and muscles e.g. arthritis, back problems Sense organs: sight, hearing, speech, also state spectacles and/or contact lenses as well as visual strength reading if available Respiratory system e.g. asthma Cardio-vascular systems e.g. hypertension, cholesterol Digestive system e.g. hiatus hernia, stomach ulcer Bladder, kidney and sexual system Nervous system e.g. paralysis, epilepsy, parkinsonism Hormone system e.g. hormone replacement therapy Metabolic diseases e.g. obesity, diabetes, porphyria, thyroid problems Psychiatric or psychological treatment e.g. depression, anxiety Substance dependance e.g. alcohol, drugs Dental treatment A condition for which you and/or your dependant(s) receive a payment and/or medical treatment of whatever nature e.g. third party claim Pregnant or suspected pregnancy Previous abnormal pregnancies Contagious diseases e.g. HIV, Hepatitis B, Tuberculosis Operations undergone Are you and/or your dependant(s) currently being treated for a medical condition? Present medicine Any other medical condition not mentioned above, even though you or your dependant(s) did not receive treatment or advice or consult a doctor in the past 12 Do you and/or your dependant(s) participate in professional or dangerous amateur sport, like powerdriven vehicle sport, glider sport, scuba diving, bungee or parachute jumping? If so, provide details: 9. Family Doctor Details/Clinic Please provide full details of family doctor or clinic below.

Name of Person	Illness	Doctor's Name/ Clinic	Doctor's Name/ Clinic Address	Contact Details

10. P	rincipal Member Declaration					
l,	(Names of the Principal member as they appear in					
the na	tional identification) do hereby declare that:					
a)	I make an application to be admitted as a member of Vitality Health Plan. I agree to comply and abide by the rules of the scheme and their amendments.					
b)	All the information contained in this form is true to the best of my knowledge.					
c)	I am aware that any false statements and information provided by me in this application or the non-disclosure of material information will result in my membership being cancelled, and that any contributions paid towards the scheme shall be forfeited to the scheme.					
d)	I am aware that upon joining the scheme during the course of the calendar year, the maximum benefits to which I may be entitled shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular calendar year.					
e)	On signing this application form, I acknowledge and accept that I will be held personally responsible for all amounts (subscriptions and claims) due to Vitality Health Plan. Should Vitality Health need to take a legal action to recover bad debts, I accept responsibility for the legal fees on an attorney and client scale.					
f)	I agree that Vitality Health Plan has the right to the interest accumulated on outstanding amounts calculated at the maximum interest rate as levied in terms of the Usury Act, Act 73 of 1968.					
g)	For group membership only: I hereby authorize my employer to deduct from my salary and pay to the scheme all amounts that may be due by me.					
h)						
i)	, 3					
j)	I undertake to remain a member and to give one month's notice by registered mail, should I which to terminate my membership.					
	Signature (Principal Member) Date					
11. E	imployer's Declaration					
l/we decl	are that the above mentioned employee,(name of Employee),					
, 110 doc	indi ine above memenea employee,maine et employee,					
Occupat	ion, is a full-time (permanent) staff of					
	me of organization) and is entitled to membership from(state Month) and the monthly contributions of Mid from his/her salary to Vitality Health.					
Name of	authorized person:, Authorized Signature:					
Dosinatio	n of Authorized person:					
Desiriano	n of Authorized person:, Date:					
Stamp (of Employer:					
12. F	or Office Use:					
Memb	pership					
Joinin	g Date:Benefit Date:					
Memb	pership No:: Authorized Date:					
Acco	unts:					
	um:					
	orized Signature:, Date:					