PROFMED

APPLICATION TO CHANGE PRINCIPAL MEMBER

EMAIL THE COMPLETED FORM TO CONTRIBUTIONS@PROFMED.CO.ZA.

The purpose of the form is to change the principal member on an existing Profmed membership.

1 ELIGIBILITY*

**Eligibility criteria apply.*

Please note: Should the new principal member not qualify for membership in their own right, the previous principal member may not resign from the membership. In the case of the death of the previous principal member, please attach a certified copy of the death certificate.

A) PROFESSION CATEGORY

Medical ☐ Humanities ☐ Student ☐ Legal ☐ Sciences ☐

Financial ☐ Built Environment ☐ Other ☐

B) PROFESSION DETAIL, E.G. ADVOCATE, ENGINEER

Profession

C) CURRENT OCCUPATION/ EMPLOYMENT

D) QUALIFICATIONS

DEGREE/QUALIFICATION	ACADEMIC INSTITUTION	MINIMUM DURATION OF DEGREE/QUALIFICATION

(Please attach copy of degree(s)/qualification(s). Attach additional information if space is insufficient.)

E) ARE YOU A MEMBER OF PPS? Yes ☐ No ☐ PPS member no.

2 ABOUT THE NEW PRINCIPAL MEMBER

Membership number | Effective date of new principal member D D M M Y Y Y Y

Title | First names

Surname | Maiden name | Gender: Male ☐ Female ☐

Race: Black ☐ Coloured ☐ Indian ☐ White ☐ I do not wish to disclose this information ☐

This information is used to establish the race demographics of Profmed in terms of the Broad-Based Black Economic Empowerment Act (BBBEE)

ID/Passport no. | Date of birth D D M M Y Y Y Y

Street address | Postal address

SUBURB | SUBURB

CITY/TOWN | Post code | CITY/TOWN | Post code

Telephone: Work Home

Cell Fax

Email address

Gross monthly income from all sources R p.m.

3 DETAILS OF PREVIOUS PRINCIPAL MEMBER

In the case of the death of the previous principal member, please attach a certified copy of the death certificate.

Title First names

Surname Maiden name Gender: Male Female

Race: Black Coloured Indian White I do not wish to disclose this information

This information is used to establish the race demographics of Profmed in terms of the Broad-Based Black Economic Empowerment Act (BBBEE)

ID/Passport no. Date of birth D D M M Y Y Y Y

Street address Postal address

SUBURB SUBURB

CITY/TOWN Post code CITY/TOWN Post code

Telephone: Work Home

Cell Fax

Email address

Gross monthly income from all sources R p.m.

4 BANK DETAILS

A) CONTRIBUTIONS

Debit Order EFT Persal (for Government employees)

If Debit Order, please complete Annexure A, Authority and Mandate for Debit Order Instruction, attached.

B) REFUNDS

If refunds are to be paid into the same account as your contributions, as detailed in Annexure A, Authority and Mandate for Debit Order Instruction, attached, please tick here

If different bank account than for contributions, please complete this section

I authorise Profmed to deposit any credits due to me into my bank account:

Name of account holder

Name of bank Branch name Branch code

Account number Type of account Cheque Transmission Savings

Signature of account holder D D M M Y Y Y Y

Please note: If your membership date is confirmed after the monthly contribution debit orders have been generated, a double contribution will be deducted the following month.

Are your contributions paid by Government? Yes No If yes, please attach a copy of your latest salary advice.

5 CONSENT TO RECEIVE MARKETING MATERIAL

Profmed's Administrator (PPS Healthcare Administrators) may use my information for the purpose of marketing (including direct marketing) of life and non-life insurance products (including sickness benefits), investments, retirement benefits, and any other financial or non-financial services offered by PPS Insurance Company Limited and its subsidiaries. You may withdraw your consent at any time.

Yes ☐ No ☐

6 DETAILS OF BROKER

Surname _____ Initials _____

Profmed broker no. _____

FSP no. _____ Business/company name _____

Signature of Profmed broker _____ Date D D M M Y Y Y Y

7 YOUR PERSONAL INFORMATION

READ THIS SECTION CAREFULLY. EVERY TERM IS MATERIAL

1. The privacy and security of your personal information (which includes the personal information of your dependants) are important to Profmed. Profmed will only process personal information, which includes collect, use, store and share such information, in accordance with its Privacy Policy (available at www.profmed.co.za) and if the processing is permitted by law, for a legitimate interest or otherwise with your consent. Profmed will share your personal information with its contracted outsourced providers (such as its administrator and managed healthcare organisations) who assist it to administer your membership and provide you and your dependants with membership benefits.
2. All information required on this form is mandatory. Should any information be incorrect or incomplete, your application for membership might not be approved, your membership might be terminated subject to payment of a reasonable cancellation fee, or it might prevent Profmed from providing you and your dependants with benefits and services, including payment of claims. Profmed may require additional information about you and your dependants to assess your eligibility for Scheme membership, apply waiting periods and/or late joiner penalties, subject to the provisions of the Medical Schemes Act and the Scheme Rules, and for Profmed to exercise its rights and discharge its obligations in terms of the agreement with members.

8 DECLARATION AND CONSENT BY THE APPLICANT

A) DECLARATION

1. I had adequate opportunity to read and understand the contents of this document and all my questions have been answered satisfactorily. The contents of this document have been explained to me in a language that I understand and all my questions have been answered satisfactorily.
2. I am applying for membership of Profmed and warrant that all the information supplied and statements made on this application form and any accompanying information, whether completed by me or on my behalf are, to the best of my knowledge and belief, correct and complete in every respect. I will advise Profmed as soon as any of the information changes.
3. I understand that acceptance of my membership by Profmed is subject to the Rules of Profmed and is conditional upon there having been no deterioration in the state of my health or that of my dependants between the date of completion of this application and the date of membership. I undertake to advise Profmed immediately of any deterioration occurring.
4. I understand that the information supplied on this application form, together with the supporting information, forms the basis of my membership of Profmed and that my membership is subject to the condition(s), exclusions and limitations of benefits in accordance with the Medical Schemes Act and the Rules of the Scheme.
5. I understand that Profmed will inform me whether my application for membership has been successful and whether any underwriting condition(s) will be imposed.
6. I have read the Privacy Policy (available at www.profmed.co.za) of Profmed and I fully understand how Profmed will process my/our personal information, with whom it will be shared and our rights in respect of such information.
7. I guarantee that, to the extent that it may be required by law, I have the necessary authority or permission from my dependants to provide the consent, permissions and personal information on their behalf as set out in this document and as may be required from time to time by Profmed, and should I not have such authority or permission, I indemnify Profmed against any claim of whatsoever kind (including any action for damages) asserted or action taken against Profmed by any of my dependants.

B) CONSENT

1. I expressly authorise any healthcare service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to Profmed, or its contracted outsourced providers, on request, for any purpose directly related to our membership or which is authorised in terms of the Medical Schemes Act, the Scheme Rules or any other legislation, also after the death or termination of membership of any of us.
2. I authorise Profmed to deal with my dependants and me electronically and treat electronic communication (such as email, telephone, Profmed's digital App) as being the same as written authority and confirmation. I agree further that, where we choose to use electronic methods to transact with Profmed, we will carry the risk of such use.
3. I provide the consent of my own free will without any undue influence from any person whatsoever.

Signature of applicant _____ Date D D M M Y Y Y Y

FSP. No.: 43918

ANNEXURE A

AUTHORITY AND MANDATE FOR DEBIT PAYMENT INSTRUCTIONS

Written authority and mandate is not necessary if the employer pays your TOTAL membership contribution, or if you pay your contributions by EFT.

A DEBIT ORDER DETAILS

Name of bank account holder

Physical address *(Please provide again even if provided elsewhere on this form)*

Name of bank | Branch name | Branch code

Account number | Type of account: Cheque / Transmission / Savings

Amount: **AS PER THE MEMBERSHIP CERTIFICATE TO BE ISSUED** (This amount will differ depending on whether a late joiner penalty is applied and subject to the family structure i.e. number of dependants etc.)

Commencement date of debit order mandate: **1ST DATE OF THE DATE OF COMMENCEMENT OF MEMBERSHIP**

Debit order deduction date: **1ST DAY OF EACH MONTH**

Name of recipient: **PROFMED** | Description of name of the recipient as registered with the bank to be reflected on your bank statement: **PROFMED0001**

Profmed's registered address: **PROFMED PLACE, 15 ETON ROAD, PARKTOWN, 2193, JOHANNESBURG**

This signed Authority and Mandate refers to the application form dated: D D M M Y Y Y Y

I/We hereby authorise Profmed to issue and deliver payment instructions to First National Bank for collection against the above-mentioned account at the above-mentioned bank (or any other bank or branch to which I/we may transfer my/our account, of which I/we will inform Profmed accordingly) and continuing until this Authority and Mandate is terminated by me/us by giving you notice in writing of not less than 20 ordinary working days, and submitted to Profmed at contributions@profmed.co.za.

The individual payment instructions so authorised to be issued must be issued and delivered monthly.

The payment date is the 1st day of the month. If the 1st falls on a weekend or recognised South African public holiday, the payment will take place on the first working day thereafter. Furthermore, if there are insufficient funds in my account to meet the obligation, I understand that it is my responsibility to ensure that the outstanding amount is paid to Profmed within seven days of default.

I/We understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African banks. I also understand that details of each withdrawal will be printed on my bank statement. Such must contain a number, which must be included in the said payment instruction and if provided to me should enable me to identify the withdrawal. This number is displayed on this form in Section D.

B MANDATE

I/We acknowledge that all payment instructions issued by Profmed shall be treated by my/our above-mentioned bank as if the instructions have been issued by me/us personally.

C CANCELLATION

I/We agree that, although this Authority and Mandate may be cancelled by me/us, such cancellation will not cancel my membership of Profmed. I/We shall not be entitled to any refund of amounts which you have withdrawn while this Authority was in force if such amounts were legally owing to Profmed.

D WITHDRAWAL TRANSACTION REFERENCE NUMBER

This reference number is: **PROFMED0001**

Signature of account holder _____ Date D D M M Y Y Y Y