

7. Banking details for reimbursement of your claim

If we do not have banking details, we will send you a cheque. Claims can only be paid into a South African bank account.

Bank name Branch name
 Account type Cheque Transmission Savings Branch code - - -
 Name of account holder
 Account number

Signature of bank accountholder

By signing above, you acknowledge that once claims have been refunded into the account above, the Scheme will not be liable in any way for the amounts refunded.

8. Your family's previous medical scheme details

MAIN APPLICANT (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme Membership number
 Date of joining: to or currently a member

2. Name of previous medical scheme Membership number
 Date of joining: to

3. Name of previous medical scheme Membership number
 Date of joining: to

SPOUSE/PARTNER/ADULT DEPENDANT (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme Membership number
 Date of joining: to or currently a member

2. Name of previous medical scheme Membership number
 Date of joining: to

3. Name of previous medical scheme Membership number
 Date of joining: to

DEPENDANT 1 (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme Membership number
 Date of joining: to or currently a member

2. Name of previous medical scheme Membership number
 Date of joining: to

3. Name of previous medical scheme Membership number
 Date of joining: to

DEPENDANT 2 (please complete ALL fields below if applying for cover)

1. Name of previous medical scheme Membership number
 Date of joining: to or currently a member

2. Name of previous medical scheme Membership number
 Date of joining: to

3. Name of previous medical scheme Membership number
 Date of joining: to

Note: If you have more dependants, please attach their previous medical scheme information in the same format as above.

9. Your medical questionnaire (continued)

2. Brain and nerve disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example stroke <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> epilepsy <input type="checkbox"/> migraine <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> quadriplegia <input type="checkbox"/> paraplegia <input type="checkbox"/> cerebral palsy <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. Cancer Yes <input type="checkbox"/> No <input type="checkbox"/> example any form of cancer <input type="checkbox"/> or pre-cancerous growth/s <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
4. Heart and circulation disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example angina/chest pain <input type="checkbox"/> heart failure <input type="checkbox"/> heart murmurs <input type="checkbox"/> rheumatic fever <input type="checkbox"/> high blood pressure <input type="checkbox"/> heart attack <input type="checkbox"/> raised cholesterol <input type="checkbox"/> previous heart surgery <input type="checkbox"/> rhythm disturbance (palpitations) <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
5. Connective tissue disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example systemic lupus erythematosus <input type="checkbox"/> scleroderma <input type="checkbox"/> dermatomyositis/polymyositis <input type="checkbox"/> mixed connective tissue disorder <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
6. Dental disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example over/underbite problems <input type="checkbox"/> missing/skew teeth <input type="checkbox"/> ongoing or planned dental treatment <input type="checkbox"/> ongoing or planned orthodontic treatment <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
7. Eye, ear and speech disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> tinnitus <input type="checkbox"/> hearing/visual impairment <input type="checkbox"/> disorders of the cornea <input type="checkbox"/> blindness <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
8. Gynaecological disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example ovarian cysts endometriosis <input type="checkbox"/> fibroid disorders of the cervix <input type="checkbox"/> menstrual disorders <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
9. Kidney/urinary tract disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example kidney failure <input type="checkbox"/> kidney stones <input type="checkbox"/> recurrent infections <input type="checkbox"/> nephritis <input type="checkbox"/> prostate problems <input type="checkbox"/> blood/protein in urine <input type="checkbox"/> polycystic kidneys <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

9. Your medical questionnaire (continued)

10. Liver/pancreatic disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example hepatitis <input type="checkbox"/> cirrhosis <input type="checkbox"/> liver failure <input type="checkbox"/> gallstones <input type="checkbox"/> pancreatitis <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
11. Mental health/psychiatric disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example depression <input type="checkbox"/> anxiety <input type="checkbox"/> schizophrenia <input type="checkbox"/> eating disorders <input type="checkbox"/> Bipolar <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
12. Metabolic/endocrine disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example diabetes <input type="checkbox"/> thyroid abnormalities <input type="checkbox"/> growth disorders <input type="checkbox"/> Cushing's disease <input type="checkbox"/> Addison's disease <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
13. Musculoskeletal disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example rheumatoid arthritis <input type="checkbox"/> osteo-arthritis <input type="checkbox"/> myasthenia gravis <input type="checkbox"/> gout <input type="checkbox"/> osteoporosis <input type="checkbox"/> loss of limb <input type="checkbox"/> back problems/operations <input type="checkbox"/> slipped disk <input type="checkbox"/> backache <input type="checkbox"/> other <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
14. Respiratory disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example cystic fibrosis <input type="checkbox"/> emphysema <input type="checkbox"/> chronic bronchitis <input type="checkbox"/> shortness of breath <input type="checkbox"/> persistent cough <input type="checkbox"/> asthma <input type="checkbox"/> chronic obstructive airways disease <input type="checkbox"/> any lung surgery <input type="checkbox"/> coughing up blood <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
15. Gastro-intestinal disorders Yes <input type="checkbox"/> No <input type="checkbox"/> example Crohn's disease <input type="checkbox"/> ulcerative colitis <input type="checkbox"/> bleeding ulcers <input type="checkbox"/>					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
16. Are you or any of your dependants suffering from any symptoms not yet diagnosed by a medical professional Yes <input type="checkbox"/> No <input type="checkbox"/> example heartburn <input type="checkbox"/> reflux <input type="checkbox"/> etc.					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
17. If you or any of your dependants have any condition or symptom/s which is not directly covered by these questions, please provide FULL medical details.					
Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

9. Your medical questionnaire (continued)

18. Are you or any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months? Yes No

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

19. Have you or any of your dependants had an operation or been admitted to hospital in the past 12 months? Yes No

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

20. Please detail whether any person included in this application form is pregnant.

Name

22. Have you or any of your dependants ever had or are currently suffering from alcohol or drug problems ? Yes No

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

23. HIV AND AIDS

If you or any of your dependants are living with HIV and AIDS and would prefer not to disclose the HIV and AIDS status on this form in the interest of confidentiality then you must call us on 0860 100 417 within 7 (seven) working days from the date we activate your LA Health membership. If you or any of your dependants are aware that you or they are HIV-positive, it would be in your interest to register on the HIVCare Programme. Should you or they only find out at a later stage that you or they are HIV-positive, please let us know as soon as possible.

Name	Medical diagnosis	Date first diagnosed	Currently on treatment for this condition?	Date of last symptoms <input type="checkbox"/> , consultation <input type="checkbox"/> or hospitalisation <input type="checkbox"/>	Medicines used for this condition and date last taken
			Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Yes <input type="checkbox"/> No <input type="checkbox"/>		

10. Rules for membership

Rules for membership are the rights and responsibilities for your membership of the scheme. They may change from time to time but you may ask us for a copy of these rules at any time.

When you sign this application, you confirm that you agree that you and those you apply for will be bound by the rules of the scheme.

Please speak to your broker or us if there is anything you do not understand.

1. Acting for others

You confirm that you have the right to act for others

By signing this document, you confirm that:

- You have the right to apply for membership and to act for those that you apply for in any matter relating to this application.
- You have received permission from your spouse and any dependants over 21 to act for them in any matter relating to this application.

2. Giving Information

You must give us true, correct and complete information

To consider your application for membership, the scheme must learn more about you and those you apply for. The information must be true, correct and complete. This includes the details you give us in this application form and in future dealings with us.

We may ask those you apply for who are 21 and older for information and it will be treated as if we had asked you in your role as main member.

We may get the information from other relevant sources

To consider an application for membership or a claim for medical expenses, you agree that the scheme can get information about you and those you apply for from other relevant sources, including medical practitioners and brokers.

Tell us about changes right away

If any of the information you gave to us changes between the day you sign this document and the day your membership starts, you must tell us in writing what the changes are. This includes information about your health and the health of those you apply for.

10. Rules for membership (continued)

When the scheme may cancel

The scheme may cancel any memberships immediately and keep any contributions paid, if you and those you apply for:

- do not give us information that later turns out to be relevant for this application
- give us any information that is not true, correct and complete
- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

3. Sharing information and confidentiality

When we may share your information

The scheme will keep your information and the information about those you apply for confidential.

The scheme may share this information with other relevant parties only if the following two conditions are met:

- The information is needed only to administer the scheme and any claims
- The parties the scheme shares the information with agree to keep the information confidential.

If we want to share your information for any other reason, we will do so only with your permission.

The scheme may record calls

The scheme may record telephone conversations with you and those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

4. About becoming a member

Resign from your current medical scheme

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the scheme by letter, email or SMS telling you that you and those you apply for have been accepted as members of LA Health.

You must ensure contributions are paid on time

As the main member of the scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month.

5. You must repay any medical savings or other debt owing when you leave the scheme

When you become a member, depending on the benefit option you chose, you may have money available in advance through the Medical Savings Account to use for medical expenses during the year. If you leave the scheme before the year is up, you must repay the proportion of medical savings you have used in advance.

Any other debt must also be paid to the scheme.

Signed at on

Y	Y	Y	Y	M	M	D	D
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Signature of applicant

11. Your broker details

Broker Code Principal

Broker house Code

Broker's contact details:

Tel (W) Cellular

Signature of intermediary(ies)

Commissioner of oath stamp