APPLICATION FOR MEMBERSHIP

RHODES UNIVERSITY MEDICAL SCHEME

7 LUTMAN STREET RICHMOND HILL PORT ELIZABETH 6000
P.O.BOX 1672 PORT ELIZABETH 6001
CALL CENTRE: 041 395 4476
EMAIL: rumed@providence.co.za
WEBSITE: www.rumed.co.za

ADMINISTERED BY PROVIDENCE HEALTHCARE RISK MANAGERS

SECTION 1 | PERSONAL DETAILS

Title | Initials | Surname

First Names

Date of Birth (Y Y Y Y M M D D)

Identity Number

Postal Address (code)

Physical Address (code)

ID Type RSA Passport Other

Passport Country

Date of Employment (Y Y Y Y M M D D)

Occupation/Designation

Telephone Number (Work) (code)

Telephone Number (Home) (code)

Cellular Number

E-mail Address

Please select one option by placing an "X" in the appropriate box

Gender M F

Marital Status Single Widowed Married Divorced

SECTION 2 | PREVIOUS MEDICAL SCHEMES

Please provide full details of previous membership of registered Medical Aid schemes (starting with most recent) and provide proof by attaching your Certificates of Membership. (Your previous Medical Aid membership card will not be accepted)

Scheme Name
Membership Number
Date from (Y Y Y Y M M D D)
Date to (Y Y Y Y M M D D)
Certificate Attached Yes No
Years/Months on Medical Aid (Y Y M M)

Scheme Name
Membership Number
Date from (Y Y Y Y M M D D)
Date to (Y Y Y Y M M D D)
Certificate Attached Yes No
Years/Months on Medical Aid (Y Y M M)

Scheme Name
Membership Number
Date from (Y Y Y Y M M D D)
Date to (Y Y Y Y M M D D)
Certificate Attached Yes No
Years/Months on Medical Aid (Y Y M M)

SECTION 3 | YOUR DEPENDANTS' DETAILS

B. SPOUSE DETAILS

Title | Initials | Surname

First Names | Date of Birth (Y Y Y Y M M D D)

Identity Number

Marital Status | Single | Married | Widowed | Gender | M | F

Postal Address (code)

Physical Address (code)

Telephone (Work) (code)

Cellular Number

Telephone (Home) (code)

E-mail

B. OTHER DEPENDANTS

NOTE: A separate form must be completed for each of the following dependants: Common Law Partner / Adopted Child / Foster Child. Acceptance of dependants will be decided in accordance with the Scheme Rules.

D1 Name | Surname | ID Number | Date of Birth (Y Y Y Y M M D D) | Gender (Female / Male) | Relationship

D2 Name | Surname | ID Number | Date of Birth (Y Y Y Y M M D D) | Gender (Female / Male) | Relationship

D3 Name | Surname | ID Number | Date of Birth (Y Y Y Y M M D D) | Gender (Female / Male) | Relationship

D4 Name | Surname | ID Number | Date of Birth (Y Y Y Y M M D D) | Gender (Female / Male) | Relationship

D5 Name | Surname | ID Number | Date of Birth (Y Y Y Y M M D D) | Gender (Female / Male) | Relationship

D6 Name | Surname | ID Number | Date of Birth (Y Y Y Y M M D D) | Gender (Female / Male) | Relationship

SECTION 4 | MEMBER BANKING DETAILS

APPLICATION FOR ELECTRONIC TRANSFER OF FUNDS

I hereby instruct Rhodes University Medical Scheme to electronically collect contributions or to deposit refunds into my bank account. I understand that credit card accounts may not be used for these transactions. I also irrevocably authorise Rhodes University Medical Scheme to reverse any erroneous transaction and/or to rectify any incorrect electronic transfer of funds without prior notice.

Signature (Member) _____ **Date** Y Y Y Y M M D D

BANK DATE STAMP REQUIRED

BANK NAME

BRANCH NAME

ACCOUNT HOLDER NAME

BANK ACCOUNT NUMBER

BRANCH CODE - - -

ACCOUNT TYPE CURRENT CHEQUE SAVINGS TRANSMISSION

NOTE : For a cheque account, please attach an original cancelled cheque

SECTION 5 | MEDICAL HISTORY (SEE QUESTIONNAIRE)

DECLARATION

By signing below I hereby give permission for, warrant, acknowledge and/or agree to the following:

- That the information in this application, whether in my own handwriting or not, is complete and accurate.
- To undergo a medical examination, at my own expense, should this be required.
- To submit proof of good health for me and my dependants and that the Scheme benefits may be limited or excluded in respect of any particular admission to RUMed, or RUMed may decline to accept me or any of my dependants in accordance with the Scheme Rules.
- That I am required at all times, if accepted as a member, to give RUMed all such information and evidence as RUMed may require. To this end I hereby authorise the medical practitioner, or any provider who has attended to me and/or my dependants in the past or the future, to provide RUMed with such information. I hereby waive the provision of any law or regulation restricting access to such information.
- My doctor, or the doctor of a patient who is a dependant of mine, may provide personal and/or clinical information on this application form.
- Any information concerning this application will remain confidential at all times.

Signature (Member) _____ **Date** Y Y Y Y M M D D

MEDICAL HISTORY

Height

Weight K G

Do you Smoke Yes No

Are you Pregnant Yes No

If yes, How many weeks

How often do you consume alcohol ? Please mark

Never Yes No

Occasionally (2-4 times a month or less) Yes No

Moderately (2-3 times a week) Yes No

Frequently (More than 4 times a week) Yes No

Has your weight changed by more than 5kg in the last year? Yes No

Do you use Chronic Medication? Yes No

Are you aware of any medical condition(s) which could require medical treatment or surgery? Yes No

If Yes, please supply details on Page 5.

Identity Number

CONDITION INFORMATION

Have you or any of your dependants ever experienced or been treated for, or are currently suffering from any of the following conditions?

If Yes, Please tick the appropriate block or specify the conditions, and complete page 5

1. Cardiovascular and or Blood disorders

- ☐ Chest Pain (Angina)
- ☐ Valve defect
- ☐ Rheumatic heart disease
- ☐ Heart attack
- ☐ Murmurs
- ☐ Hypertension (Blood pressure)
- ☐ Arrhythmia
- ☐ Hypercholestrolaemia
- ☐ Anemia
- ☐ Leukemia

Other, Specify

2. Respiratory problems (Lungs or breathing)

- ☐ Difficulty in breathing
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Asthma
- ☐ Croup
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Coughing up blood

Other, Specify

3. Ear, Nose & Throat

- ☐ Hearing/speech impairment
- ☐ Ear Infections
- ☐ Sinus problems
- ☐ Allergic rhinitis

Other, Specify

4. Kidney / Urinary System

- ☐ Blood in urine
- ☐ Kidney infections
- ☐ Prostate conditions
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Congenital urinary conditions
- ☐ Recurrent urinary tract infections

Other, Specify

5. Gynaecological

- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Abnormal pap smears
- ☐ Fibroid
- ☐ Enlarged uterus
- ☐ Menstrual disorders
- ☐ Pregnant at present

Other, Specify

6. Glandular/ Endocrine

- ☐ Diabetes Mellitus
- ☐ Addison's disease
- ☐ Cushing's syndrome
- ☐ Growth disorders
- ☐ Disorders of the pituitary gland
- ☐ Hypo/hyperactive thyroid gland

Other, Specify

7. Neurological (Nervous system)

- ☐ Paralysis
- ☐ Stroke
- ☐ Epilepsy
- ☐ Migraine
- ☐ Brain or spinal cord disorder
- ☐ Multiple sclerosis

Other, Specify

8. Gastrointestinal

- ☐ Malena Stools (Bleeding)
- ☐ Ulcers
- ☐ Jaundice
- ☐ Change in bowel habits
- ☐ Pancreatic disorders
- ☐ Colitis
- ☐ Gall Stones/Cholecystitis
- ☐ Pancreatic disorders
- ☐ Irritable bowel syndrome

Other, Specify

9. Musculoskeletal

- ☐ Joint or spine condition, including Rheumatoid/Osteo-arthritis
- ☐ Neck or Back problems
- ☐ Recurrent back pain
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis

Other,Specify

10. LumpsorGrowths

- ☐ Benign tumours
- ☐ Malignant tumours
- ☐ Lymph cancer
- ☐ Melanoma

Other, Specify

11. Emotional / Psychological

- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Attention deficit disorder
- ☐ Anorexia
- ☐ Anorexia or any other eating disorders
- ☐ Alzheimers disease
- ☐ Bi-polar disorders

Other, Specify

12. Eyes

- ☐ Glaucoma
- ☐ Blindness
- ☐ Impaired vision
- ☐ Retinitis
- ☐ Conjuntivitis
- ☐ Macular degeneration
- ☐ Cataract

Other, Specify

Have you ever had, or are you currently undergoing or anticipating any specialised dentist treatment? (e.g. Orthodontic treatment or impacted wisdom teeth) Yes / No

Do you have any congenital, hereditary or physical disability? Yes / No

Do you participate in any hazardous sports or pursuits e.g. mountain climbing, paragliding? Yes / No

Are you aware of any other conditions which may not have been specified on this form? Yes / No

If you answered "yes" to any of the previous questions on page 4, please provide full details by completing this schedule

Question Number	Beneficiary	Diagnosis and Date of Onset	Condition resolved Yes or No?	Name of current medication	Further treatment expected	Date of last treatment or symptoms	Prognosis	Name and contact number of treating GP, dentist or specialist

SECTION 6 | EMPLOYER TO COMPLETE AND SIGN

Paypoint

Scheme Join Date (Y Y Y Y M M D D)

Clock/Payroll Number

Date of Employment (Y Y Y Y M M D D)

Date of Benefit (Y Y Y Y M M D D)

Basic Salary

R

Number of Subsidised Dependants

Spouse

Child

Adult Dependants

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the selected RUMed Scheme Rules.
All sections of the application form have been completed and signed.

Employer's Telephone (c o d e)

Employer's Fax (c o d e)

Employer's E-mail

Name of Medical Scheme/Salary Administrator

Designation

COMPANY STAMP REQUIRED

Signature: _____ (Y Y Y Y M M D D)

SECTION 7 | DECLARATION BY MEMBER

IMPORTANT Failure to disclose all relevant information accurately may adversely affect the benefits available to you and your dependants.

- I hereby apply to Rhodes University Medical Scheme (RUMed) for membership for myself and my listed dependants, and agree to abide by the Rules of the Scheme.
- I understand that false information could result in my application for membership being rejected or my membership being cancelled. Should this occur, I agree to refund to RUMed all relevant payments which RUMed made on my behalf.
- I accept any penalties that may be applied in accordance with the Medical Schemes Act of 1998. I understand that these penalties include a 3 month general waiting period, a 12 month waiting period for pre-existing conditions and, if applicable, a late-joiner penalty fee.
- Contributions due to RUMed by me or my dependants will be paid MONTHLY. Failure to do so will result in my membership being suspended or terminated as per the RUMed Scheme Rules.
- I acknowledge and understand that RUMed is entitled access to my medical scheme history in terms of the Medical Scheme Act.
- I agree that PROVIDENCE, as the appointed administrator or RUMed, is permitted access to this information in order to render services to RUMed.
- I understand that RUMed may provide written notification, to my postal address, of its Rules. Any notice sent to my postal address, shall be considered received by me on the 7th day after the date of posting.

- By signing below I give permission for, warrant, acknowledge and/or agree to the following:
  - that the information in this application, whether in my own handwriting or not, is complete and accurate.
  - to undergo a medical examination, at my own expense should this be required.
  - to submit proof of good health for me and my dependants and that the scheme benefits may be limited or excluded in respect of any paticular admission to RUMed, or RUMed may decline to accept me or any of my dependants in accordance with the Scheme Rules.
  - that I am required at all times, if accepted as a member, to give RUMed all such information and evidence as RUMed may require. To this end I hereby authorise the medical practitioner, or any provider who has attended to me and/or my dependants in the past or the future, to provide RUMed with such information. I hereby waive the provision of any law or regulation restricting access to such information.
  - my doctor, or the doctor of the patient who is a dependant or mine, may provide personal and/or clinical information on this application form.
  - any information concerning this application will remain confidential at all times.

I CONFIRM THAT THE FOLLOWING DOCUMENTATION (WHERE APPLICABLE) IS ATTACHED TO THE APPLICATION FORM:

- Copy of my ID document and my dependants ID documents/Birth Certificates
- Certificates of previous membership of registered medical schemes
- Marriage certificate / Affidavit

Signed _____ (Member's signature) on this _____ day of _____ 20____

CHRONIC MEDICATION BENEFIT APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for chronic medication.
2. Allow **5 working** days for the processing of your application.
3. The original prescription must be given to the provider who dispenses your medication.
4. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
5. The information required is for the clinical assessment of this application as well as for Risk Equalisation Fund (FEF) purposes.
6. You may contact the Pharmacy Benefit Management (PBM) Team at **(041) 395 4482** or email **pbm@providence.co.za**
7. Send completed forms via fax **086 680 8855**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **pbm@providence.co.za.**

B. MEMBER DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

Postal Address | Code

C. PATIENT DETAILS (Beneficiary who requires Chronic Medication)

Surname | First Names

Title | Date of Birth | ID Number

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

The outcome of this application must be communicated to me via my email address: Yes ☐ No ☐ **OR** fax number Yes ☐ No ☐

D. PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the PBM Team;
- Any information concerning this application will remail confidential at all times;
- It may be a pre-condition to the approval of the Chronic Medication Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
- My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns, irrespective of the outcome of his application.
- This funding authorisation is at all times subject to the Scheme rules even if a member's circumstances change after the authorisation is provided. This authorisation is not a guarantee of payment.
- This funding authorisation is based on the most appropriate clinical criteria in terms of the Scheme rules and protocols. All treatment decisions remain the responsibility of the beneficiary's health care provider irrespective of the funding decision made in terms of the Scheme rules, clinical critera and protocols.
- PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.

Patient Signature (or member if patient is a minor) _____ Date Y Y Y Y M M D D

E. PATIENT HEALTH INFORMATIOB (to be completed by doctor)

Weight kg | Height m | Hip/Waist ratio | Smoker? Y N | Ave per day

Exercise: Frequency X per week | Intensity (Please tick) Low ☐ Medium ☐ High ☐

Current blood pressure mmHg | Fasting Blood Glucose (If available) mmol/L

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Version 6 (March 2012)

Patient name

Membership number

F. CLINICAL CRITERIA

The following information is required when applying for a new chronic condition

Certain conditions which do not appear on the form below may be considered for approval on the Chronic Benefit, although not all long-term conditions, which a doctor may define as chronic, will fulfill the criteria for approval.

** Chronic conditions only available on the Extended Chronic Benefit .*

Condition	Requirements		
Addison's Disease	1. Serum Cortisol Test.	2. ACTH Stimulation Test.	3. Initial Specialist Application.
ADHD *	1. Initial Specialist Application .	2. Motivation if > 12 years.	
Alzheimer's Disease*	1. Folstein's Mini Mental Examination State (MMSE) result.		2. Initial Specialist Application.
Ankylosing Spondylitis	1. Initial Specialist Application .		
Asthma	1. Lung function test (8 yrs and older).		
Benign Prostatic Hypertrophy*	1. Motivation for 2nd line agents (E.g. Avodart®, Flomax® and Xatral®).		
Bipolar Mood Disorder	1. Specialist to complete Section J.		
Bronchiectasis	1. Attach relevant radiology report.	2. Initial Specialist Application.	
Cardiac failure	1. Please classify according to NYHA or ACC-AHA Classification.	2. Details of diagnosing specialist to be supplied.	
Cardiomyopathy	1. Details of diagnosing specialist to be supplied.		
Chronic Obstructive Pulmonary Disease	1. Lung function test including FEV1/FVC and FEV1 post bronchodilator.		
Chronic Renal Disease	1. Serum Creatinine Clearance.	2. Initial Specialist (Nephrologist) Application.	
Coronary Artery Disease	1. Stress ECG confirming diagnosis.	2. Attach history of previous cardiovascular disease event(s).	
Crohn's Disease	1. Details of diagnosing specialist to be supplied.		
Cystic Fibrosis	1. Details of diagnosing specialist to be supplied.		
Depression*	1. Funding for first line therapy will be allowed for 6 months only. Further funding will only be considered on motivation from a psychologist and/or prescription from a psychiatrist.		
	2. Prescriber to complete Section J.		
Diabetes Insipidus	1. Water deprivation test results.	2. Initial Specialist Application.	
Diabetes Mellitus	1. Attach initial diagnostic report.		
Dysrhythmias	1. Prescriber to clearly indicate ICD-10 code.		
Epilepsy	1. EEG report confirming diagnosis.	2. Attach detailed seizure history .	
Generalised Anxiety Disorder*	1. Specialist motivation required for treatment exceeding a 6 month period.		
Glaucoma	1. Supply initial diagnostic intra-ocular pressure.		
GORD*	1. Diagnostic Gastroscopy or Barium Meal Swallow report.		
Haemophilia	1. Haemophilia A (Factor VIII as % of Normal).	2. Haemophilia B (Factor IX as % of Normal).	
Hyperlipidaemia	1. Prescriber to complete Section G and I.	2. Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.	
Hypertension	1. Prescriber to complete Section G and H.	2. Initial Specialist Application if younger than 30 years.	
Hyperthyroidism	1. Attach report showing T3, T4 and TSH levels.		
Hypothyroidism	1. Attach initial diagnostic report.		
Menopause*	1. Motivation required for early-onset menopause (< 40yrs) and the prescription of Livifem ®.		
Multiple Sclerosis	1. Extended Disability Status Score (EDSS).	2. Comprehensive disease history.	3. Initial Specialist Application.
Osteoporosis*	1. DEXA bone mineral density (BMD) scan and report on any additional risk factors.		
Parkinson's Disease	1. Initial Specialist Application.		
Rheumatoid Arthritis (RA)	1. Initial diagnostic test results confirming RA may be required where a "stepped therapy" approach has not been implemented.	2. Initial Specialist Application and motivation For Enbrel® and Revellex®.	
Schizophrenia	1. Psychiatrist to complete Section J.		
Systemic Lupus Erythematosus	1. Initial Specialist Application.		
Ulcerative Colitis	1. Details of diagnosing specialist to be supplied.		

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Version 6 (March 2012)

Patient name

Membership number

G. CARDIOVASCULAR (to be compleded by doctor when applying for hypertension, hyperlipidaemia or diabetes mellitus)

Is the patient (if female) post-menopausal? Y N

Is Microalbuminuria present? Y N

Is GFR less than 60ml/min? Y N

Please indicate which of the following co-morbidities/risk factors apply to this patient?

- Peripheral arterial disease
- Nephropathy
- Retinopathy
- Heart Failure
- Left ventricular hypertrophy
- Chronic renal disease
- Cardiomyopathy
- Prior stroke/TIA
- Prior myocardial infarction
- Prior Coronary Artery Bypass Graft (CABG)
- Prior Stent
- Angina

If Heart failure is present, please indicate classification below:

NYHA/ACC-AHA Classification A B/I(Mild) C/II(Mild)-III(Moderate) D/IV(Severe)

Ref: De Marco T, Delgado RM III, Agocha A. et al. J Cardiac Fail. 2004;10

H. HYPERTENSION (to be completed by doctor when applying for hypertension)

Please supply Two blood pressure readings, performed at least two weeks apart before initiating drug therapy, for newly diagnosed patient

1) Y Y Y Y M M D D ____ mmHg 2) Y Y Y Y M M D D ____ mmHg

I. HYPERLIPIDAEMIA (to be completed by doctor when applying for hyperlipidaemia)

Please attach the diagnosing lipogram. The application cannot be reviewed if this is not submitted.

Is there a family history of early-onset arteriosclerotic disease? Y N

If yes, please provide details below:

Does the patient suffer from familial hyperlipidaemia? Y N

If yes, please indicate the signs below?

- Family history of disorder/ heart attack at early age
- High LDL levels (Treatment resistant)
- Tendon Xanthoma

Other

Please risk your patient as per the Framingham coronary prediction algorithm %

J. PSYCHIATRIC CONDITIONS (to be completed by when applying for psychiatric disorders)

Please indicate DSM IV Diagnosis

Please indicate number of relapses

K. ADDITIONAL NOTES

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Patient name

Membership number

L. MEDICAL PRACTITIONER DETAILS

Surname

Initials

Practice number

Speciality

Telephone number

Cellular

Fax number (Confidential)

Email address (Confidential)

The outcome of this application must be communicated to me via my email address: Yes No **OR** fax number Yes No

M. CONDITION AND MEDICATION DETAILS (to be completed by doctor)

CD-10 Code	Medication prescribed (Name, strength & dosage)	Date Medication initiated & prescriber details	Repeats

Signature of Medical Practitioner _____ Date Y Y Y Y M M D D

N. HOW THE CHRONIC BENEFIT WORKS

The Chronic Benefit includes cover for medication from a specified list of chronic conditions which is in accordance with the scheme option.

These conditions have been selected according to clinical and actuarial criteria.

Chronic Disease List -

The Prescribed Minimum Benefit regulations require that medical schemes cover the diagnosis, medical management and medication for a specified list of 27 chronic conditions known as the Chronic Disease List.

All such ailments meeting approval criteria will be authorised under the PMB Chronic Medication benefit.

Extended Chronic Disease List -

Certain medical scheme options provide cover for an Extended Disease List which includes some 46 additional chronic conditions. All approved medication will be paid up to the benefit limit on the respective plan.

All such ailments meeting approval criteria will be authorised under the Extended Chronic Medication benefit.

The PROVIDENCE PBM (Pharmacy Benefit Management) team will authorise an amount for all approved chronic conditions.

The approved amount (PCV – PROVIDENCE Chronic Value) is determined based on the treatment protocols for all levels of treatment for each condition. The PCV is the maximum Rand amount that will be approved for the class/category of each drug that is authorised.

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