

ADDITIONAL DEPENDANTS APPLICATION FORM

PLEASE PRINT IN CAPITAL LETTERS. USE A BLACK PEN ONLY. PLEASE MARK APPROPRIATE CHOICE USING A CROSS (x).
 THIS FORM SHOULD BE COMPLETED IN RESPECT OF SUBSEQUENT ADDITIONS TO THE FAMILY UNIT

Membership no.	
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SECTION A: MEMBER DETAILS

Title: Mr / Mrs / Miss	Initials	First name
Surname		
Name of employer	Employer code	
Email		
Tel. no. (h)	(w)	(Cell)
Physical address		Postal code
Postal address		Postal code

SECTION B: PARTICULARS OF DEPENDANTS

Name of dependant	Date of birth / Identity no.	Relationship to member (spouse, partner, daughter etc.)	Date of admission to Hosmed

Is or was the dependant previously registered with a medical scheme?	Yes	No	(If yes, please complete the following):
Name of previous medical aid(s) for past 2 years			
Membership no.			
Period of membership	From	To	KINDLY ATTACH CERTIFICATE/S OF MEMBERSHIP Full details over last two years must be given
Give details of any illnesses, treatments or conditions for which the dependant was excluded from benefits by the above named medical aid scheme (if space is insufficient attach separate schedule) attach separate schedule)			

Kindly complete health questionnaire on reverse side hereof in full detail. PLEASE NOTE: Failure to complete or submit all information required will delay processing of membership of dependant. Failure to disclose medical information or the provision of incorrect information can result in the immediate cancellation of your membership.

Date of marriage where dependant is spouse	
Member: date	Signature
Employer: date	Signature

SECTION C: EMPLOYER DETAILS

Company	
Region	Date of employment

Signature _____ Designation _____ Date _____

