Anglo Medical Scheme, reg. no. 1012 | Administered by Discovery Health (Pty) Ltd, reg. no. 1997/013480/07, an authorised financial services provider | PO Box 746 Rivonia 2128 | Call: 0860 222 633, WhatsApp 011 292 8797 | member@angloms.co.za; www.angloms.co.za

Applying to become a member of Anglo Medical Scheme 2025

This document is an application form for membership.

Important: Members join free of underwriting when they join within 30 days of joining the Scheme.

It also contains some terms and conditions. Please make sure you read and understand these terms.

How to complete this form

1. You can either ask your HR department to send you a link to complete this information in the secure member area on the Scheme website, **or**
2. Print this form and complete it clearly in black ink, or complete it electronically by typing into the fields below.
3. If you complete the form electronically, you will need to apply your signature with a digital certificate, through an approved digital signature provider. Learn more about the approved list of digital signature providers we accept.
4. Read and understand the Scheme Rules (available on the website **https://www.angloms.co.za/portal/ams/scheme-rules**) and the terms and conditions pertaining to your membership, as per below.
5. Please make sure the main applicant signs and dates any changes.
6. Once completed, submit the completed and signed application form to your employer representative.
7. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.
8. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.

Once you send us your application form, here is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- You will receive a counter offer letter confirming any impact on your contributions (if applicable) for you to consider, as well as any other information/documents to consider your membership on the Scheme. Please sign the counter offer letter if you accept the terms and email to **application@angloms.co.za**. The terms may change if you do not sign and send the letter back to us within 30 days.
- We will send you and your employer a welcome letter, SMS or an email to let you know when your application is considered to have been successful. This date may differ from the date on which you sign the application form.
- You will then get a welcome pack containing your membership cards, benefit booklet and certificate of membership. You will also receive a notification with a link to download your digital pack from the Anglo Medical Scheme website.
- If you do not hear from us seven days after sending us your application form, please contact us on **0860 222 633** or your employer representative.

When you sign this application, you confirm that you have read and understood the terms and conditions for membership and agree with them.

I consent to my spouse/partner, and/or adult dependant (who is part of this application), acting on my behalf and providing my personal information, including health information, to Anglo Medical Scheme for the purpose of my application to join the scheme ☐

1. About yourself (main member)

When do you want your membership to start? D D M M Y Y Y Y

Title _____ Initials _____

Surname _____

First name(s) (as per identity document) _____

ID or passport number _____ Tax number _____

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Telephone (H) _____ Telephone (W) _____

Cellphone _____

Email

Postal address (Post collected from post box, suite or private bag)

PO Box | Private Bag | Box number

Suite | Postnet Suite | Number

Suburb

City | Postal code

If your post is delivered to your street address, please complete these details under physical address.

Physical address:

Suite/Unit number | Complex name

Street number | Street name

Suburb | Postal code

2. About your spouse or partner (only complete if applying for membership)

Only complete this section if you are adding a spouse or partner.

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F | Date of birth D D M M Y Y Y Y

Race African | Coloured | Indian/Asian | White | Other | Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Telephone (H) | Telephone (W)

Cellphone

Email

3. About your dependant/s (only complete if applying for membership)

Dependant 1

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F | Date of birth D D M M Y Y Y Y

Race African | Coloured | Indian/Asian | White | Other | Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Cellphone

Email

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If your dependant is 23 years and older, are they:

Married? Yes No | Financially dependent on you? Yes No

Disabled? Yes No | A student? Yes No

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Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? **R**

Dependant 2

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Cellphone

Email

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If your dependant is 23 years and older, are they:

Married Yes ☐ No ☐ Financially dependent on you Yes ☐ No ☐

Disabled Yes ☐ No ☐ A student Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? **R**

Dependant 3

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Cellphone

Email

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If your dependant is 23 years and older, are they:

Married Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled Yes ☐ No ☐ A student Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? **R**

4. Please select your plan

Managed Care Plan ☐ Standard Care Plan ☐ Value Care Plan ☐

You have the right to ask for help in selecting a plan that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the plan you select.

5. About your employer (if applicable)

Please ask your employer to complete this section.

Name of employer

Employer billing number

Employee number

Date of employment D D M M Y Y Y Y

Branch name

Branch number

Date D D M M Y Y Y Y

Name

Designation

NB: Please note that the membership cannot be activated if the commencement date is not completed.

6. Banking details for claim refunds

If your contributions will be paid by your employer as a salary deduction, you only need to give us banking details for claim refunds. By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded.

Name of bank

Branch name

Branch code - -

Account number

Type of account Cheque Savings

Account holder

If we are paying a third party bank account, the main member must insert the ID number of the third party.

ID number

Account holder

Account holder contact details

Account holder email address

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit **www.angloms.co.za**.

Signature of main applicant

Please do not sign an incomplete application form

7. Your health questions

In the twelve months prior to your application, have you or any dependant in this application ever experienced, been investigated, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders.

Should you wish not to disclose any confidential information or chronic conditions (including HIV) on your application form via your employer, please note that you can email this information directly to the administrator to **application@angloms.co.za**. along with your ID number.

Please take note that if you have any disorder, symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 7.18 below. An indication of existing medical conditions on this application do not automatically enrol you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Scheme's Disease Management enrolment visit www.angloms.co.za. By disclosing this information, your application will not be prejudiced.

Please answer ALL questions by ticking "Yes" or "No". If you answered 'Yes', please provide full details in the sections provided.

Please refer to Annexure A should you need to disclose information that could not be completed in the health questions section below. Be sure to include the relevant question number.

7.1. Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast **Yes** ☐ **No** ☐

Example: disorders of the skin, skin lesions, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abscess, abnormal mammogram result, any autoimmune conditions, any congenital conditions or other skin conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.2. Heart and circulation conditions **Yes** ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, deep vein thrombosis, pulmonary embolus, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.3. Gynaecological and Obstetric conditions **Yes** ☐ **No** ☐

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed periods, ovarian cyst, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.4. Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or difficulty falling pregnant? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.5. Mental health conditions

Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling, any autoimmune conditions, any congenital conditions and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.6. Metabolic or endocrine conditions

Yes ☐ No ☐

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.7. Abdominal conditions

Yes ☐ No ☐

Example: hepatitis, cirrhosis, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.8. Brain and nerve conditions

Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, chronic headaches, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt used to drain fluid from the brain), intellectual disability, CVA, bleeding on the brain, down's syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.9. Breathing and respiratory conditions

Yes ☐ **No** ☐

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, ventilator, oxygen therapy, CPAP, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease, chronic cough > 3 months, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.10. Musculoskeletal (back, bone, injury and muscle pain)

Yes ☐ **No** ☐

Example: arthritis (any form), ongoing / intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis and internal insertion of surgical implants, sarcoidosis, polymyositis, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.11. Kidney or urinary conditions including current or past dialysis

Yes ☐ **No** ☐

Example: kidney failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.12. Blood conditions

Yes ☐ **No** ☐

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders / diseases, leukaemia, lymphoma, pulmonary embolus, haemochromatosis, other bleeding disorders, any autoimmune conditions, any congenital conditions, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.13. Eye conditions Yes ☐ No ☐

Example: cataract, keratoconus (cross linkage), corneal ulcer, intra-ocular pressure, visual disturbances, night blindness, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.14. Ear, nose and throat (ENT) and dentistry conditions Yes ☐ No ☐

Example: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.15. Male urogenital conditions Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), undescended testes, phimosis, urinary incontinence, urinary retention, infertility, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.16. Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

7.17. Have any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

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7.18. Have you or any of your dependants been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side effects not mentioned in the questions above, in the last 12 months before this application? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, please call us on **0860 222 633** within seven working days from the date we activate your Anglo Medical Scheme membership. We treat this information in the strictest confidence. It is in your interest to register on the HIV *Care* Programme. Anglo Medical Scheme may have waiting periods that apply in certain circumstances. These will not be reflected on any documents sent to you due to the sensitivity of the information and it is therefore important for you to phone to confirm funding.

8. Previous medical scheme details

Please give us the details of all registered South African medical schemes, that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. Please give us proof in the form of a membership certificate. We may also use the information on the membership certificate to determine if we can apply waiting periods.

Main applicant

Scheme name	Membership number	Start date	Are you still a member	End date if you have already resigned	Reason for leaving
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

If all dependants were on the same medical scheme/s as completed above, please tick here to confirm this ☐

If any of your dependants applying for membership belonged to different medical schemes, please complete below:

Spouse/Partner name

Scheme name	Membership number	Start date	Are you still a member	End date if you have already resigned	Reason for leaving
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

Dependant name

Scheme name	Membership number	Start date	Are you still a member	End date if you have already resigned	Reason for leaving
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

Dependant name

Scheme name	Membership number	Start date	Are you still a member	End date if you have already resigned	Reason for leaving
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

9. Addition of dependants over 23 years

This section must be completed if you are adding children over 23 years, aged parents and other special dependants.

1. Is the dependant entirely dependent on you for maintenance and support?

Yes ☐ Please provide reasons

No ☐ Please provide source of income and amount earned per month

2. Does the dependant reside with you?

Yes ☐ Please provide reasons

No ☐ Please provide reasons

3. Is the dependant a resident of an institution?

Yes ☐ The name of the institution must be furnished and it must be clearly stated whether the institution is responsible for medical expenses and the extent thereof

No ☐

4. Is the dependant a student?

Yes ☐ State whether full or part time, name of academic institution and expected period of studies

No ☐

5. Have any exclusions been imposed by the medical scheme on which the dependant has been registered?

Yes ☐ Please provide details

No ☐

10. Privacy Statement for Anglo Medical Scheme administered by Discovery Health (Pty) Ltd

When you engage with Anglo Medical Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse and dependants, where applicable. To view and read our Privacy Statement, please follow this link: **https://www.angloms.co.za/assets/medical-schemes/angloms/privacy-statement-for-anglo-medical-scheme.pdf**

Signature of main applicant

Date D D M M Y Y Y Y

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11. Terms and Conditions

In this document, “we” refers to Anglo Medical Scheme and/or Discovery Health (Pty) Ltd (“the Administrator”). “You” refers to the main member of Anglo Medical Scheme.

Your membership

Your membership with Anglo Medical Scheme is for yourself or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Anglo Medical Scheme Rules. You may be called the main member in our future communications to you.

Anglo Medical Scheme and the Administrator may get information from other approved sources

You agree that we can get information about you and your dependant/s from other relevant sources for the purpose of administration, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers or financial advisers). These include any entity that is part of the Administrator where you hold an independent contract, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give in respect of this application and any matter pertaining to or that arises during your membership of Anglo Medical Scheme, is true, correct and complete. You give permission that we may get any information that is relevant from your employer

Tell Anglo Medical Scheme or the Administrator about changes right away

If any of the information you provided changes, you must tell us in writing what the changes are. We need advance notice of administrative changes such as cancellation of membership due to termination, as we do not accept backdated changes.

When Anglo Medical Scheme may cancel your membership

Anglo Medical Scheme may cancel any membership immediately and keep any contributions paid, if you and\or your dependant/s give us any information that is not true, correct and complete.

About becoming a member

Anglo Medical Scheme might not pay for certain expenses immediately after you become a member

Anglo Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Anglo Medical Scheme starts paying for any general or specific medical conditions.

Resign from your current medical scheme when accepted as a member of the Anglo 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 scheme when you receive notice from Anglo Medical Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time

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

The Administrator and Anglo Medical Scheme may record telephone calls

We may record telephone conversations with you and your dependant/s. The recordings and all information we get during the recordings will be processed and kept as required by law.

Repaying money owed to the Scheme

The Scheme has the right, at any time, to collect from you any amount that you owe. We will notify you if there is any amount that you owe the Scheme.

You must repay any monies owed in your Medical Savings Account (MSA) if you leave Anglo Medical Scheme (Managed Care Plan)

When you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the ‘Medical Savings Account’. If you leave Anglo Medical Scheme before the year is up, you must repay the portion of the Medical Savings Account you have used that is more than you have paid back to the Anglo Medical Scheme over the year.

Contact us for more information

If you have any questions, please contact us on **0860 222 633** or email us at **member@angloms.co.za**

Signature of main applicant

Date D D M M Y Y Y Y

Please do not sign an incomplete application form.
I confirm that the information is accurate and complete.
The main applicant must sign and date any changes

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Annexure A

Question number	Patient name	Date first Diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Date of last treatment	Symptoms/ Medical diagnosis	Medicine used for this condition and dosage