Application to partake in VIVAMED's prepaid basic subsidized health care service

VIVAMED for the people

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

About yourself (main applicant)

ID or passport number N N N N N N N N N N N N N

Title ______ Initials ______ Surname ______

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

Preferred name ______ Gender ○ M ○ F Date of birth Y Y Y Y M M D D

Previous or maiden name ______ Marital status ______

Occupation ______

Telephone (H) ______ Telephone (W) ______

Cellphone ______ Fax ______

Preferred time to be contacted ______

Email ______

Physical address in South Africa

Suite/Unit number ______ Complex name ______

Street number ______ Street name ______

Suburb ______ Post code ______

About your dependants

ID or passport number N N N N N N N N N N N N N

Title ______ Initials ______ Surname ______ Gender ○ M ○ F Date of birth Y Y Y Y M M D D

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

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)

Title ______ Initials ______ Surname ______ Gender ○ M ○ F Date of birth Y Y Y Y M M D D

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

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)

Title ______ Initials ______ Surname ______ Gender ○ M ○ F Date of birth Y Y Y Y M M D D

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

Relationship to main member ______

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

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)

Your banking details

Your contributions

Please note: We cannot accept credit card account details and only South African banking details are accepted. If we are debiting a third party account, the main member must sign next to the account holder.

Bank name ______

Branch name ______ code ______

Account number ______ Type of account ○ Cheque ◉ Savings

Account holder ______

Upon acceptance of this application form, which then forms the basis of the contract inter partes, I, the applicant herein, instruct VIVAMED to collect my payments by debit order using the bank information above, "on a monthly basis at R100 per month for a rolling twelve month period automatically renewed annually" unless cancelled in terms of this contract, "or a once-off payment of R1000" (delete whichever is not applicable). I also irrevocably authorize VIVAMED to adjust any incorrect or missed transactions and or correct any electronic transfer of funds errors without prior notice.

Signature of main applicant ______ Date Y Y Y Y M M D D

If the account holder's details differ from the applicant, we require a letter from the account holder instructing and authorizing VIVAMED to collect contributions/payments from their bank account. We will also require a copy of the account holder's identity document and a bank statement or letter from the bank confirming the account holder's details.

Acknowledgement and Declaration

1. I, the undersigned, apply to partake in the VIVAMED private subsidized prepaid basic health care contract service rendered by a closed group of medical practitioners as listed herein below.
2. I understand and accept that I am entitled to ten subsidized basic medical consultations per annum for a monthly fee of R100 per month (R1200 per annum), or a once-off payment of R1000 per annum. At the sole discretion of the medical practitioner, basic medication may be dispensed at no extra cost.
3. I declare that the information in this application form is true and correct. I also declare that I have permission from my dependants to disclose personal information about them to VIVAMED.
4. I declare that any false information in this application or material non-disclosure may result in this contract being declared null and void at the sole discretion of VIVAMED.
5. I accept that VIVAMED has the right to claim damages in respect of any loss or damages it may suffer due to either non-payment, non-disclosure, misrepresentation of fraudulent behaviour.
6. I understand that should a period of three months or more lapse since monthly contributions were not paid to VIVAMED, that this contract will automatically terminate and that the contract will not be re-instated for the current rotating year. In that event, I understand that I will have to re-apply for the following rotating year. (A rotating year is the twelve month period from the commencement of the annual contract herein).
7. I understand and accept that any basic medical consultations, it being subsidized, not utilized during a contract year period lapses at the end of the year.
8. I authorize my and my dependant's healthcare providers to disclose information to VIVAMED and its contracted medical practitioners and partners, provided that the information is and remains confidential.
9. I allow VIVAMED to take all reasonable steps to verify information provided by me in this application. I confirm the content of this application form, and declare that the information provided by me herein is true and correct.
10. I understand that should I want to terminate this contract at the end of the twelve month period, I must give VIVAMED at least three months' written notice of such termination. In the absence thereof, this contract will automatically renew for another twelve month at the expiration of the said twelve month contract period.

Protection of Information

1. VIVAMED undertakes to keep your and your dependant's information confidential. We have adequate data security measures in place.
2. We will only use your information for the following purposes:
    - 2.1. The rendering of contracted services;
    - 2.2. Assessing and processing this application and payments;
    - 2.3. Audit and record keeping;
    - 2.4. Verifying your identity and banking details;
    - 2.5. Certain in house marketing and related activities which may become applicable or relevant from time to time, subject to any rights you may have;
3. We may share your information with the service provider medical practitioners to the extent necessary.
4. You may, at any time, with prior notice, access your personal information we hold and request us to correct any errors.

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

The main applicant must sign and date any changes.

⚠ **Please only sign if you have read and understand all of the above.**

Bank: **First National Bank**
Account Name: **Vivamed**
Account Number: 62887950676
Broker Code: 261050
Email proof of payment to
info@vivamed.africa