MEDICAL SCHEME NEEDS ANALYSIS & RECORD OF ADVICE

CONSULTANT	
TELEPHONE	
FAX	
EMAIL	

1. PERSONAL DETAILS (Prof Dr Mr Mrs Ms)

Name of Member:			Current membership number:	
Employer:				
Salary Band:			ID / Passport Number:	
Contact Tel no:			Contact Fax no:	
Contact Cell no:			Email Address:	
No. of Dependants	Spouse/Life Partner	Adult Dependants (e.g. Parents)	Child Dependants (>21)	Child Dependants (<21)
Current Medical Scheme:			Current option:	

Period of Membership	From	To
Previous Membership	From	To
Employer's subsidy (if applicable)	%	

Current Contribution	Risk (Major Medical Expenses)	Savings (Day-to-Day) *if applicable	Other (Life Style Programmes)	Total
	R	R	R	R

2. COVER REQUIRED BY THE MEMBER

HOSPITAL COVER

Network	Associated	Freedom of choice

CHRONIC COVER

Do you suffer from any existing chronic condition?	
Do these conditions form part of the 26 Prescribed Minimum Benefits?	
Cost in Rand per month?	
From which provider do you obtain your medication?	
Are you prepared to change your medication provider?	

DAY-TO-DAY

What do you estimate your annual non-chronic, out of hospital expenditure to be?	

What services do you currently require?

Oncology		Specialised Dentistry	
Radiology		Optical	
Pathology		General Practitioners	
Physiotherapy		Specialists	
Prosthesis		Medication (non-chronic)	

Other – Specify eg Diabetes/Advanced Dentistry

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3. ADDITIONAL INFORMATION

Any particular reasons why you want to join or change your medical scheme?

Any other information which could influence this advice?

4. RECORD OF ADVICE

Based on the information supplied by the above member I recommend the following:

To remain on the current benefit plan

Recommended medical scheme:	To change the benefit plan
Medical aid products (benefit options) considered	Recommended benefit plan:

Reasons for recommendations (accessibility, cost constraints, cover, affordability, etc)

Additional information *if any

GAP COVER: Discussed Y/N

Advise given:

Will be there by a late joiner penalty? Y/N

(If yes, what will be the penalty)

Total Contribution including employer's subsidy *if applicable

Total Contribution including employer's subsidy *if applicable	Risk (Major medical expenses)	Savings (Day-to-Day) *if applicable	Other (Life Style Programmes)	Total
	R	R	R	R

Acknowledgement

I confirm that the following information has been explained to me and I fully accept my responsibilities as follows:

1.	Although I have joined ______________________________ medical scheme, payment of all medical accounts remains my responsibility. Should an account remain unpaid by my medical scheme, I have a responsibility to follow up with the provider and the medical aid to ensure that it is paid. If the claim submission period expires (four months) I am responsible for paying the provider.	Initial
2.	I confirm that I am responsible to disclose all medical information to the medical scheme for underwriting. I understand that in the event of it being found that any particulars are knowingly inaccurate or incomplete, benefits may be declined and membership terminated.	Initial
3.	I confirm that I am responsible for the payment of the premium on the first day of the month and that it is my responsibility to ensure that the debit order has taken place successfully.	Initial
4.	I acknowledge that the chronic benefits have been fully discussed.	Initial
5.	I acknowledge that waiting periods have been fully explained to me.	Initial
6.	I acknowledge that the late joining penalties have been fully explained to me.	Initial
7.	I am aware of and understand the exclusions as contained in the member booklet	Initial
8.	I understand that medical aid is an insurance against future illnesses and ailments and that the past is for guidance only and cannot be a predicator of future claims.	Initial
9.	I acknowledge receipt of the member booklet and hereby confirm that it is my responsibility to read the contents of the booklet as this provides the detail of the scheme and related benefits.	Initial
10.	I confirm that Gap Cover products have been discussed and I accept/decline such products	Initial

Accept ☐ Decline ☐

I understand that should I decline Gap Cover I am at risk of shortfalls that the medical scheme might not cover for in-hospital procedures.

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ACKNOWLEDGEMENT

I, ____ hereby acknowledge that the above needs analysis form has been completed during our discussion and that the recommendations mentioned herein have been discussed with me and they are limited to the information provided above. I therefore confirm my acceptance of advice given to me on the basis of the said recommendations. Should there be any other material information which has not been disclosed by me at the time of performance of this need analysis, I acknowledge that there may be limitations on the appropriateness of the advice provided.

I agree that if I elect to choose a benefit option different to what has been advised above, I acknowledge that there may be risks associated with my decision/election and that I should take particular care on my own to consider whether my decision/election is appropriate in light of my objectives, financial circumstance and my medical need analysis.

______________________________	______________________________
Client Signature	**Date**
______________________________	______________________________
Consultant Signature	**Date**
______________________________	______________________________
Supervised by :	**Signature**

The above mentioned registered consultant(s) is employed by …
Full details of relevant disclosure documents have been made and/or are available on request.