

Policy Number	
Group Policy Number	
Application Date	
Processor	
Password	
Agency code	
Agent code	



PO Box 1058  
 Cape Gate  
 7562  
 Tel: 0861 632 123  
 Fax: 0865 327 661  
 info@meddb.co.za  
 www.meddb.co.za

Essmed Medical Cover CC - Trading as MDB Reg 2005/146525/23

**1: PERSONAL INFORMATION (Principal Applicant)**

Names			
Surname		Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address		Contact Details	
		H:	( )
	Postal Code	W:	( )
E-mail		C:	
ID Number		Fax:	( )

**1.1: MEDICAL INFORMATION**

Allergies	Major Medical Conditions	Chronic Medications
Blood Group	Organ Donor	Blood Donor
<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Religious / Special Request		

**1.2: VEHICLE INFORMATION**

Make		Color	
Registration Number		Model	

**2: PERSONAL INFORMATION: APPLICANT 2 Relationship to principal applicant**

Names			
E-mail		Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
ID Number			
Contact Number	H: ( )	W: ( )	C:

**2.1: MEDICAL INFORMATION**

Allergies	Major Medical Conditions	Chronic Medications
Blood Group	Organ Donor	Blood Donor
<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Religious / Special Request		

**2.2: VEHICLE INFORMATION**

Make		Color	
Registration Number		Model	

**3: PERSONAL INFORMATION: APPLICANT 3 Relationship to principal applicant**

Names			
ID Number		Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
		Cell:	

**3.1: MEDICAL INFORMATION**

Allergies	Major Medical Conditions	Chronic Medications
Blood Group	Organ Donor	Blood Donor
<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Religious / Special Request		

**4: PERSONAL INFORMATION: APPLICANT 4 Relationship to principal applicant**

Names			
ID Number		Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
		Cell:	

**4.1: MEDICAL INFORMATION**

Allergies	Major Medical Conditions	Chronic Medications
Blood Group	Organ Donor	Blood Donor
<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Religious / Special Request		

**5: PERSONAL INFORMATION: APPLICANT 5 Relationship to principal applicant**

Names

Gender Male  Female

ID Number

Cell:

**5.1: MEDICAL INFORMATION**

Allergies	Major Medical Conditions	Chronic Medications
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Blood Group  Organ Donor Yes  No  Blood Donor Yes  No

Religious / Special Request

**6: PERSONAL INFORMATION: APPLICANT 6 Relationship to principal applicant**

Names

Gender Male  Female

ID Number

Cell:

**6.1: MEDICAL INFORMATION**

Allergies	Major Medical Conditions	Chronic Medications
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Blood Group  Organ Donor Yes  No  Blood Donor Yes  No

Religious / Special Request

**7: IDENTIFICATION ITEMS(Please indicate which Identification Items each family member requires)**

Applicant	Wallet I'D Card	Window Sticker	Wristband
	Quantity	Quantity	Quantity
Principal Member	One Included		
Applicant 2			
Applicant 3			
Applicant 4			
Applicant 5			
Applicant 6			

I / We hereby request "instruct" and authorise you to draw / deduct from my / our account / salary with the below mentioned bank the amounts as indicated below. This being the amounts necessary for the settlement in respect of my / our purchases / agreement. These withdrawals from my / our bank account by you shall be treated as though it has been signed by me / us personally. I / We understand that the withdrawal hereby authorised will be processed by Netcash, and understand that the details of the withdrawal will be printed on my bank statement or on an accompanying voucher. I / We agree to pay any bank charges relating to this debit order instruction.

Total number of Items

Multiply by cost per item R 10 R 10 R 10

Totals  +  +  + R10 Postage = R

**7.1: NOMINATED BANK ACCOUNT**

Bank Name  Cheque  Transmission  Savings

Branch Name  Branch Code  Debit Order Action Date  25th  1st

Account No.

Name of account holder

Date  Signature

**8: FAMILY DOCTOR**

Name  W: (  )

**9: MEDICAL AID SCHEME / HOSPITAL PLAN**

Applicant	Medical Aid Scheme / Hospital Plan Name	Medical Aid Scheme / Hospital Plan Code	Medical Aid Scheme / Hospital Plan Tel:
Principal Member			
Applicant 2			
Applicant 3			
Applicant 4			
Applicant 5			
Applicant 6			

**10: PEOPLE TO CONTACT IN CASE OF EMERGENCY (Relationship to principal applicant)**

Parent 1 (Name)

H: (  ) C:  W: (  )

Parent 2 (Name)  Relationship

H: (  ) C:  W: (  )

Name 3  Relationship

H: (  ) C:  W: (  )

Name 4  Relationship

H: (  ) C:  W: (  )

**12: I CONFIRM THAT ALL THE INFORMATION CONTAINED IN THIS APPLICATION FORM IS TRUE AND CORRECT.**

Date

Initials and Surname  Signature