

Your quick guide to completing this application form



Who we are

The Government Employees Medical Scheme (GEMS) [Registration Number 1598] is a restricted medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), to provide qualifying public service employees and their families with equitable access to affordable and comprehensive healthcare benefits. GEMS offers excellent benefit options: Tanzanite One, Beryl, Ruby, Emerald, and Onyx. Emerald Value is categorised as an Efficiency Discount Option (EDO) and serves as a cost-saving alternative for eligible members.

Compulsory documentation required from main member

For member:

- Clear copy of Green ID Book/Smart ID with both sides/SA Passport
- Latest salary advice or letter of appointment (not older than 3 months)
- Bank statement with stamp (not older than 3 months)
- Previous medical aid certificate with resignation date (if applicable), OR creditable coverage documents i.e. sworn affidavit (if applicable)

For each dependant:

- Clear copy of Green ID Book/Smart ID with both sides/Birth Certificate/SA Passport
- Previous medical aid certificate with resignation date (if applicable), OR creditable coverage documents i.e. sworn affidavit (if applicable)

For pensioner:

- Clear copy of Green ID Book/Smart ID with both sides/SA Passport
- Z583 (stamped by Commissioner of Oaths)
- Previous medical aid certificate with resignation date (if applicable)

If there are outstanding documents, **GEMS will send you an SMS from the following numbers; 27870500008 for Vodacom & MTN or 2787085121500118 for Cell C & Telkom.** Please click on the SMS link and upload the outstanding documents so that we can complete your application.

Additional documentation required for each dependant

| Description of dependant | Documentation required |
|---|--|
| Spouse | <ul style="list-style-type: none"> • If legally married, a copy of the marriage certificate is required • If you're in a customary marriage, a declaration* from the member confirming the obligation towards his/her spouse is required. |
| Ex-spouse | <ul style="list-style-type: none"> • Evidence of the legal obligation to provide medical support per divorce settlement or court, e.g. the Divorce Order. |
| Life Partner | <ul style="list-style-type: none"> • A declaration* confirming that the dependant is the member's life partner. |
| Child under the age of 21 | <ul style="list-style-type: none"> • A declaration* confirming obligation towards the child and reason for difference in surname if the child's surname differs from the main member. • Legal documentation if child is adopted. |
| Child aged 21 and older | <ul style="list-style-type: none"> • For students: <ul style="list-style-type: none"> - Proof of registration from a recognised tertiary institution; and - A declaration* confirming factual dependency on the main member. • For mental or physical disability: <ul style="list-style-type: none"> - Proof of disability from a medical practitioner (a medical assessment report completed by a medical practitioner); and - A declaration (proof of registration, a letter, email or telephone call) from the member confirming factual dependency, and that the child is not in a state institution. • If the child is not a student nor disabled: <ul style="list-style-type: none"> - A declaration* confirming factual dependency on the main member. |
| Extended family (Parents, step parents, parents-in-law, step-parents-in-law, grandparents or grandparents-in-law) | <ul style="list-style-type: none"> • A declaration* confirming factual dependency of any such dependants. |

Declaration* - A declaration may be a letter, email, or telephone call from the main member.

Factual dependence - A factual dependant depends on the main member for family care and support.

Take Note:

- Adult dependant rates are payable for all eligible dependants who are 21 years of age or older.
- Child rates are payable for dependants with disabilities, and dependants under 28 years who are enrolled for any course(s) or undergoing supervised practical training.
- Your adult dependant(s) will be subject to an annual eligibility review. You must provide proof of dependency of all dependants over the age of 21 every year. Proof of eligibility must be provided every year, for example proof of student registration.

Submitting your completed form

Submit your completed form in any of the following ways:

Email: newapps@gems.gov.za • **Fax:** 0861 00 4367 • **Post:** GEMS at Private Bag X782, Cape Town 8000

Walk-in Centres: Drop it off at any of the following GEMS Walk-in Centres:

| | | |
|----------------------|--|---|
| Eastern Cape | <ul style="list-style-type: none"> • East London: Shop LG36, Lower Level, Gillwell Shopping Centre, Cnr Gillwell Road and Fleet Street, erf 72885, Eastern Cape | <ul style="list-style-type: none"> • Mthatha: Unit 10/11/12A, Savoy Complex, Nelson Mandela Drive, Mthatha, Eastern Cape |
| Free State | <ul style="list-style-type: none"> • Bloemfontein: Shop 124, Cnr Charlotte Maxeke and East Burger Street, Bloemfontein Plaza, Free State | <ul style="list-style-type: none"> • Welkom: Shop 051, Gold Fields Mall, Cnr Strateway and Buiten Street, Welkom, Free State |
| Gauteng | <ul style="list-style-type: none"> • Johannesburg: 118 Jorrisen Street, Ground Floor, Traduna House, Cnr Jorrisen and Civic, Braamfontein, Johannesburg, Gauteng | <ul style="list-style-type: none"> • Pretoria: 541 Madiba St, Arcadia, Suncardia Shopping Centre Level 3, Shop 51 & 52, Pretoria, Gauteng |
| KwaZulu-Natal | <ul style="list-style-type: none"> • Durban: Shop 33 Berea Centre, Entrance 1, 249 King Dinuzulu, Road Bulwer, Durban, KwaZulu-Natal | <ul style="list-style-type: none"> • Pietermaritzburg: 39/45 Chief Albert Luthuli Street, Pietermaritzburg, KwaZulu-Natal |
| Limpopo | <ul style="list-style-type: none"> • Polokwane: Shop 1, Dada Square, 52 Market Street, Polokwane, Limpopo | <ul style="list-style-type: none"> • Thohoyandou: Stand 2, Venda, Thohoyandou, Limpopo |
| Mpumalanga | <ul style="list-style-type: none"> • Nelspruit: 30 Brown Street, Nedbank Centre, Nelspruit CBD, Mpumalanga | <ul style="list-style-type: none"> • eMalahleni (Witbank): Shop No 7, Saveways Crescent Centre, Witbank, Mpumalanga |
| Northern Cape | <ul style="list-style-type: none"> • Kimberley: Shop 14 & 26 1-17 Long Street, New Park Centre, Kimberley, Northern Cape | <ul style="list-style-type: none"> • Upington: 61 A Market Street, Upington, Northern Cape |
| North West | <ul style="list-style-type: none"> • Klerksdorp: Shop 101, Cnr OR Tambo and Naser Street, CBD Klerksdorp, North West | <ul style="list-style-type: none"> • Mafikeng: Mmabatho Megacity, Shopping Centre, Shop 39, Cnr Sekame and Dr James Moraka Street, erf 3139, Mmabatho, North West |
| Western Cape | <ul style="list-style-type: none"> • Worcester: 29 Baring Street, Q Squared Shopping Centre, Worcester, Cape Town | <ul style="list-style-type: none"> • Cape Town: Shop 1, Cnr of Church and Adderley Street, Constitution House, Cape Town, Western Cape |

Use this checklist to ensure that you have completed all the relevant sections.

- | | |
|--|--|
| <ul style="list-style-type: none"> ■ Section 1: Main member employment details ■ Section 2: Main member details ■ Section 3: Preferred method of communication and language preference ■ Section 4: Dependants you wish to register ■ Section 5: Previous medical scheme details | <ul style="list-style-type: none"> ■ Section 6: Medical history and general health information ■ Section 7: Benefit option selection ■ Section 8: Payment of contributions ■ Section 9: Your bank account details ■ Section 10: Terms and Conditions (your responsibilities) |
|--|--|

Important to note:

- If you have not heard from us within 7 working days of submitting your application, please call us on 0800 00 4367 or email us on newapps@gems.gov.za.
- **“Cooling off period”:** GEMS allows new members to cancel their GEMS membership within 15 days after the start of membership, provided no healthcare benefits have been claimed.
- Read the terms and conditions on page 10 carefully. They contain important provisions about this application and your GEMS membership.
- As a GEMS member, you and your registered dependants will be bound by the Scheme Rules accessible on: www.gems.gov.za
- GEMS reserves the right to impose waiting periods and late joiner penalties as defined in the Scheme Rules.



Scan the QR code using your phone or tablet to conveniently access and complete the GEMS digital membership application form.

Membership Application Form



Please complete all the sections in full.

Please indicate the type of membership you are applying for: ☐ New membership ☐ Continuation from deceased ☐ Pensioner

Section 1: Main member employment details

Current employment

Persal, Employee or Pension number

Current employer's name

Organisation code ☐ Permanent Employee ☐ Temporary Employee

Employment start date Pensioner retirement date

Income tax no.

Previous employment

(1) Previous employer's name

Employment start date Employment end date

Reason for leaving

(2) Previous employer's name

Employment start date Employment end date

Reason for leaving

Section 2: Main member details

Names

Surname Initials

ID/Passport no. Date of birth

Country of origin

Country in which passport was issued

Visa number Race (for statistical purposes only)

Gender ☐ Male ☐ Female Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Co-habiting

Residential address Unit/Apartment no. Complex/Building name

Street no. Street name

Suburb

City Postal code

Telephone (H) Telephone (W)

Mobile no.

Email address

Postal address If postal address is the same as residential address - tick box ☐

☐ PO Box ☐ Private Bag X Number (complete the number)

☐ Postnet Suite ☐ Apartment Number (complete the number)

Suburb

City Postal code

In case of emergency please contact (name and relationship)

Telephone (H) Mobile no.

Section 3: Preferred method of communication and language preference

Preferred method of communication ☐ Post ☐ Email

Please indicate in which language you prefer to receive your communication? Please note that if you do not choose any language, your language preference will be registered as English.

☐ Afrikaans ☐ English ☐ Ndebele ☐ Sepedi ☐ Sesotho ☐ SiSwati
☐ Setswana ☐ Tshivenda ☐ isiXhosa ☐ Xitsonga ☐ isiZulu

Section 4: Dependants you wish to register

(If you wish to add more dependants please include the additional dependants on a separate sheet of paper when submitting this application)

Dependant 1

Names Surname Initials
 Date of birth ID/Passport no. Gender ☐ Male ☐ Female
 Race (for statistical purposes only) Country of origin
 Country in which passport was issued Visa number
 Email address Mobile no.
 Relationship to main member
 Is the dependant factually dependent on main member? ☐ Yes ☐ No Is the dependant ☐ Student ☐ Mentally/Physically disabled
 Dependant type ☐ Spouse ☐ Ex-spouse ☐ Partner ☐ Child under the age of 21 ☐ Child of 21 and older
☐ Extended family (Parents, step parents, parents-in-law, step-parents-in-law, grandparents or grandparents-in-law)
 Extent of dependency on member ☐ The dependant is financially dependent on me
 (tick the one or two that apply) ☐ The dependant is factually dependent on me for family care and support

Dependant 2

Names Surname Initials
 Date of birth ID/Passport no. Gender ☐ Male ☐ Female
 Race (for statistical purposes only) Country of origin
 Country in which passport was issued Visa number
 Email address Mobile no.
 Relationship to main member
 Is the dependant factually dependent on main member? ☐ Yes ☐ No Is the dependant ☐ Student ☐ Mentally/Physically disabled
 Dependant type ☐ Spouse ☐ Ex-spouse ☐ Partner ☐ Child under the age of 21 ☐ Child of 21 and older
☐ Extended family (Parents, step parents, parents-in-law, step-parents-in-law, grandparents or grandparents-in-law)
 Extent of dependency on member ☐ The dependant is financially dependent on me
 (tick the one or two that apply) ☐ The dependant is factually dependent on me for family care and support

Dependant 3

Names Surname Initials
 Date of birth ID/Passport no. Gender ☐ Male ☐ Female
 Race (for statistical purposes only) Country of origin
 Country in which passport was issued Visa number
 Email address Mobile no.
 Relationship to main member
 Is the dependant factually dependent on main member? ☐ Yes ☐ No Is the dependant ☐ Student ☐ Mentally/Physically disabled
 Dependant type ☐ Spouse ☐ Ex-spouse ☐ Partner ☐ Child under the age of 21 ☐ Child of 21 and older
☐ Extended family (Parents, step parents, parents-in-law, step-parents-in-law, grandparents or grandparents-in-law)
 Extent of dependency on member ☐ The dependant is financially dependent on me
 (tick the one or two that apply) ☐ The dependant is factually dependent on me for family care and support

Section 5: Previous medical scheme details

Please provide the details of all South African medical schemes that you and the dependants you wish to add were previously members of. This information will help us determine whether any late-joiner penalty fees are applicable. Additionally, we may use the information from your membership certificates to decide if waiting periods should be applied.

Were all your dependants covered under the same medical scheme?

☐ Yes

☐ No

If you and your dependants were members of different medical schemes, please list them below.

| Member/Dependant Name | Scheme name | Start date | Is the dependant still a member? | End date if already resigned | Reason for leaving |
|-----------------------|-------------|------------|--|------------------------------|--------------------|
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please remember to attach your previous medical aid certificate for each dependant with resignation date (if applicable). If an applicant is unable to obtain documentary proof to substantiate periods of creditable coverage (eg. Medical Scheme ceased to exist), you shall be entitled to produce a sworn affidavit declaring such detailed information. If the reason for leaving is due to change of employment, please send proof of such change.

Section 6: Medical history and general health information

HIV/AIDS

Although you do not have to disclose your HIV status on this form, you must contact our confidential HIV line in order to disclose on 0860 436 736 within seven working days of submitting your membership application to GEMS.

This information will be kept confidential.

Disclosure of medical history

Please answer the questions below by marking the relevant box with an X.

In the last 12 months, have you or any of your dependants (excluding newborns and/or newly-adopted children) received or been recommended for any medical advice, diagnosis, treatment or care for any of the following conditions?

1. Do you or any of your dependants use chronic medicine?

☐ Yes ☐ No

2. Disorders or problems with the heart or cardiovascular system

☐ Yes ☐ No

Example: Heart murmur, high blood pressure, high cholesterol, shortness of breath, palpitations, chest pains, angina, heart attack and/or any other cardiac or blood disorder.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

3. Respiratory or lung disorders

☐ Yes ☐ No

Example: Tuberculosis, asthma, persistent cough or other breathing problems, emphysema, coughing up blood, cystic fibrosis, sinusitis or allergic rhinitis.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

4. Gynaecological disorders

☐ N/A ☐ Yes ☐ No

Example: Abnormal pap smear or mammogram, endometriosis, ovarian cysts, fibroids, infertility, disorders of the cervix, menstrual disorders or any abnormality of pregnancy or confinement.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

5. Are you or any of your dependants pregnant or undergoing treatment or investigation for pregnancy at the time of application for membership? ☐ N/A ☐ Yes ☐ No

| Patient name | Treating doctor | Last menstrual cycle date | Delivery date |
|--------------|-----------------|---------------------------|---------------|
| | | | |
| | | | |

6. Disorders of the digestive system, stomach, gall bladder, pancreas or liver ☐ Yes ☐ No

Example: Gastric or duodenal ulcer, heartburn, hiatus, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, hepatitis cirrhosis, liver failure, or have you ever had gastroscopy or colonoscopy.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

7. Disease or disorders of the kidneys, bladder or reproductive organs ☐ Yes ☐ No

Example: Abnormal urine tests, kidney stones, nephritis, prostatitis, bladder infections or sexually transmitted diseases.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

8. Disorders of the nervous system or brain ☐ Yes ☐ No

Example: Epilepsy, stroke, multiple sclerosis, migraine, headaches, paralysis, Parkinson's disease or have you or any of your dependants been advised to have a MRI or CT scan.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

9. Mental disorders ☐ Yes ☐ No

Example: Depression, anxiety, panic attacks, schizophrenia, eating disorders, attention deficit hyperkinetic disorder (ADHD or post-traumatic stress disorder).

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

10. Ear, nose, throat or eye disorders ☐ Yes ☐ No

Example: Defective vision, cataracts, glaucoma, retinitis, disorders of the cornea, hearing loss, ear discharge, otitis media or allergies.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

11. Disorders or diseases of the skin, muscles, bones, joints, limbs or spine ☐ Yes ☐ No

Example: Any skin rash, arthritis, gout, fibromyalgia, any back/neck/hip/knee or other joint trouble, multiple sclerosis, any joint problems or replacements, acne, eczema or psoriasis.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

12. Diabetes, sugar in urine, thyroid or other glandular or blood disorders

☐ Yes ☐ No

Example: Growth disorders, Cushing's disease or Addison's disease.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

13. Removal of cancer, growth or tumour including moles

☐ Yes ☐ No

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

14. On or anticipating any specialised dental/maxillofacial treatment

☐ Yes ☐ No

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

15. Any accidents

☐ Yes ☐ No

For example, motor vehicle or motorbike accident, fall from a building, sports injuries, etc.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

16. Any surgical procedures

☐ Yes ☐ No

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

17. Awaiting or planning any surgical procedures or admission to any hospital in the next 12 months

☐ Yes ☐ No

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

18. Taking on-going medicine for any condition not listed above

☐ Yes ☐ No

Example: Homeopathic, over the counter.

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

19. Any other condition or symptom, not listed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could result in a medical claim within the next 12 months

☐ Yes ☐ No

| Patient name | Illness or condition | Date first diagnosed | Date of last occurrence | Treatment recommended (medicine, etc.) | Name of treating doctor | Doctor's contact details |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
| | | | | | | |

Non-disclosure disclaimer

If you do not disclose pre-existing conditions, certain benefits could be limited and/or excluded. Failure to disclose any pre-existing medical condition will result in a non-disclosure investigation.

GEMS maintains the right to apply condition-specific waiting periods retrospectively and recover or reverse paid claims for pre-existing conditions that were not disclosed in the application for membership.

Section 7: Benefit option selection

Please select only one benefit option from the list below and mark the applicable block with an **X**.

☐ Tanzanite One ☐ Beryl ☐ Ruby ☐ Emerald Value ☐ Emerald ☐ Onyx

- If you have selected the Tanzanite One or Emerald Value option, you need to indicate a Network doctor for yourself and your dependant(s).
- You can access the Network doctors on www.gems.gov.za
- If you and your dependant(s) will be using the same nominated GP - please tick the following box: ☐
- If you have ticked the above box, you only need to complete the main member GP nomination.
- A 30% co-payment will apply to claims where a GP has not been nominated in line with the Scheme Rules.**

| Member/Dependant | Name of GEMS beneficiary | Name of GP | Practice number | Doctor's telephone number |
|------------------|--------------------------|--------------|-----------------|---------------------------|
| Main member | | PRIMARY GP | | |
| | | SECONDARY GP | | |
| Dependant 1 | | PRIMARY GP | | |
| | | SECONDARY GP | | |
| Dependant 2 | | PRIMARY GP | | |
| | | SECONDARY GP | | |
| Dependant 3 | | PRIMARY GP | | |
| | | SECONDARY GP | | |

*** If you wish to add more dependants please include the additional dependants on a separate sheet of paper when submitting this application.**

Please note: Your start date will always be on the first day of the next month, if all relevant and completed documentation is received. If submission of your application form and last document are received after the Persal cut-off, you may be given the option to register either for the first of the following month with a double deduction, or the month thereafter with a single deduction. Please check your membership certificate to see your start date and if any waiting periods and/or late joiner penalties apply.

For example, should the last document be received on 26 April and the Persal cut-off date is 25 April, you will be given the option of admission to the Scheme either from 1 May or 1 June. In this instance, the 1 May admission will incur a double deduction in June (for contributions of both May and June) due to the Persal cut-off, and the 1 June admission will incur a single deduction in June. Please note, the collection of premiums are collected in arrears.

Section 8: Payment of contributions

Persal employees

Monthly contributions are deducted automatically from the main member's salary.

If you are paying your own contributions

Your membership will be activated upon your consent to pay 100% of your contribution via debit or cash until your subsidy has been confirmed by the Government Employees Pension Fund (GEPF).

Please choose only one payment method ☐ Debit order ☐ Cash ☐ EFT ☐ Stop order

For debit order selected, please take note:

Acknowledgement and declaration

1. This will commence at the beginning of the month following the month of registration date and continue until this authority and mandate is terminated by me giving notice in writing within 20 business working days.
2. In the event that the payment day falls on a Sunday, or a public holiday, the payment will automatically be deducted on the next business day.
3. I acknowledge that all payment instructions issued by you shall be treated by my above-mentioned Bank as if the instructions have been issued by me personally.
4. I agree that although this authority and mandate may be cancelled by me, such cancellation will not cancel the agreement. I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you.
5. I acknowledge that this authority may be ceded or assigned to a third party if the agreement is also ceded or assigned to that third party, but in the absence of such assignment of the agreement this authority and mandate cannot be assigned to any third party.
6. I understand that the subsidy portion of my contribution will only be refunded to me upon receipt of my subsidy from National Treasury.
7. I understand that it is my responsibility to ensure that the full contribution is received by GEMS on the payment due date.
8. For stop orders, please note that you will be required to adjust your stop orders upon any change in the contributions amount.

Account holder's signature _____

Date of signature

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Cash/ EFT/ Stop order payment of contributions

If you choose to pay in cash, please use the following banking details when depositing your contribution:

Bank: First National Bank (FNB)

Account name: Government Employees Medical Scheme

Account no: 62094049593

Branch code: 204109

Reference: Your membership no.

Please use your membership number as reference where EFTs or cash deposits are used for payment of contributions.

Section 9: Your bank account details

This section is compulsory and needs to be completed in full, as we cannot register you as a member of GEMS if we do not have your **bank account details**. We require these details to pay any money that may be due to you, to collect your medical scheme contributions (if applicable) or any money that you may owe GEMS.

Account owner

Main member ☐ Third Party ☐

Name of bank

[illegible]

Name of account holder

[illegible]

Bank account no.

[illegible]

Branch name

[illegible]

Branch code

[illegible]

Type of account

☐ Current ☐ Savings ☐ Transmission

Debit order reference: **GEMSGOVMED** Your Membership no. (e.g. GEMSGOVMED123456789)

I understand that the estimated monthly contributions (which are dependent on the value of any subsidy received) that I will be expected to pay if this application is accepted have also been explained to me prior to me making this application.

I hereby authorise you to issue and deliver payment instructions ☐ Monthly for collection against my bank account.

Please remember to include required FICA Documents:

- Clear copy of Green ID Book / Smart ID with both sides / a valid passport
- Bank Statement with stamp (not older than 3 months)
- Proof of address (not older than 3 months)

If Third Party is selected above, the third party is required to submit their documents for FICA and also sign below

Note: GEMS will under no circumstances ever require contributions to be paid via E-wallet, Instant Money Cash Send and/or Pay-to-Cell. It remains your responsibility as a member to update your banking details with GEMS should your banking details change.

Account holder's signature _____

Date of signature

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|

Private bag X782 Cape Town • **Call Centre:** 0800 00 GEMS (4367) • **Fax:** 0861 00 GEMS (4367)
Email newapps@gems.gov.za • **Fraud Line** 0800 21 2202 • **HIV Aids Helpline** 0860 436 736 • www.gems.gov.za

C

The Government Employees Medical Scheme (GEMS) is an authorised Financial Services Provider (FSP No 52861)

Section 10: Terms and conditions (your responsibilities)

Your application form will not be processed without your signature in this section.

Please read the terms and conditions below carefully. These contain acknowledgements of fact that may impact on your rights. These terms and conditions shall be read together with the Rules of GEMS and the Act, and all these provisions shall be binding on you and your dependants. The Scheme Rules are available on the GEMS website at www.gems.gov.za.

1. These terms and conditions shall be read together with the Registered GEMS Rules, which are available on GEMS' website, www.gems.gov.za, or by calling 0800 00 4367.
2. I hereby apply for my dependants and I to join GEMS and I confirm that I am duly authorised to apply on behalf of the persons listed as dependants in this application form.
3. I understand that if my dependants and I are accepted as members of GEMS, my answers on this form and supporting information supplied will form the basis of our membership. I furthermore confirm that should I fail to disclose any material information, my and my dependant's membership may be cancelled or suspended.
4. I hereby declare that the dependant(s) listed on this application form is unable to support himself/herself financially/factually and that he/she is dependent on me for family care and support.
5. I understand that neither my registered dependants nor I may belong to two medical schemes at the same time.
6. I undertake to notify GEMS of any change in the circumstances or details of my dependants within 30 days of such change occurring.
7. In the event that a dependant wishes to join GEMS as a main member while still active on another GEMS membership as a dependant, GEMS reserves the right to automatically cancel the dependant status on the original membership. This action can be taken without requiring a formal request from the main member under whom the dependant is currently registered.
8. I acknowledge that, in the event of termination of membership, I will be required to refund GEMS any sum of money which has been paid by the Scheme.
9. I understand the benefits that my dependants and I will be entitled to on our selected benefit option and confirm that I have had an opportunity to consider such benefits and raise any queries pertaining thereto.
10. The total monthly contributions that I will be expected to pay have been explained to me prior to me making this application and I understand that it is my responsibility as a member to make sure that GEMS receives my total monthly contribution, failing which my membership and/or benefits may be suspended or cancelled.
11. I hereby authorise and instruct my employer to deduct from my remuneration, any funds for my benefit after I cease employment, or any other sums due by me to my employer, any such amount(s) that I may owe to GEMS from time-to-time and to pay such amounts to GEMS. Insofar as may be necessary, I hereby authorise you to issue and deliver payment instructions to my bank for collection against my above-mentioned bank account.
12. If I am accepted as a member, I must, both now and in future, give GEMS all such information and evidence as it may require from time-to-time for purposes of my dependants and my membership of GEMS. For this purpose, I authorise GEMS and/or its agents to obtain from any person any information that they may require concerning me or any of my dependants for any purpose which directly relates to our medical scheme membership or which is authorised in terms of the Act, the Rules or any other legislation. I direct that person to provide GEMS and/or its agents with such information on request.
13. I hereby authorise any medical doctor or other healthcare provider who has attended to me or my dependants in the past or who will attend to me or my dependants in the future, to provide GEMS and/or its agents with such information as it may require. I expressly grant GEMS the right to access my information and that of my dependants as and when it is necessary.
14. I authorise GEMS on my behalf and that of my dependants to process, which includes collection and storage, of our personal information, which includes our health and biometric information as well as information related to any fraudulent behaviour by us, and which information has been supplied by us to GEMS or which GEMS may lawfully collect from any third party, for the purposes specified above.
15. I consent to the recording of all conversations between myself and/or any of my dependants and GEMS, its agents or contracted parties, and acknowledge and agree for all information obtained through these conversations to form part of the records of GEMS. In addition, I consent to all these records remaining the sole property of GEMS and its agents and which records may be retained for such periods as provided for in the Rules and the relevant legislation.
16. I understand that GEMS will only pay claims if such claims are, in GEMS' sole discretion, deemed valid and comply with the Registered GEMS Rules.
17. I am aware that GEMS reserves the right to impose waiting periods on any beneficiary (myself or any of my dependants). GEMS will notify me should any of these waiting periods apply to me and/or any of my registered dependants, based on the information provided in this application.
18. I understand that Late Joiner Penalty (LJP) calculations are based on information provided by me at the time of this application, GEMS is required to adjust the LJP percentage and contribution amounts if I provide additional evidence of prior creditable coverage after the initial calculation. Any such adjustments will apply from the date that the additional information is provided. I understand that GEMS shall not be liable for any claim, loss, or damage arising from any errors and/or omissions, except as required by law.
19. I agree that the Scheme and its administrator may process mine and my dependants' personal information for, inter alia, the following purposes:
 - 19.1. to assess and process this application for membership;
 - 19.2. for the administration of my health plan;
 - 19.3. for the provision of managed care services to me on my health plan;
 - 19.4. for the provision of relevant information to a contracted third party who requires this information in order to provide a healthcare service to me on my health plan;
 - 19.5. to profile and analyse risk;
 - 19.6. to share my personal information with external health specialists for them to assess or evaluate certain clinical information, in the event that I am subject to such a clinical assessment;
 - 19.7. For administrative, historical, research and statistical purposes if required; and
 - 19.8. to enable benefit confirmation(s) to be performed and to facilitate electronic claims submissions; and
 - 19.9. For any other lawful purpose.
20. I warrant that when I supply personal information to GEMS about my dependants, I have received their permission to share such information with GEMS for the purposes set out herein and any other related purposes. If you are giving consent for a minor, you confirm that you are a competent person in respect of such minor and that you have authority to give their consent for them.
21. I authorise GEMS to engage me to confirm my most recent contact details as a member of the Scheme. I understand that GEMS will use this information to communicate pertinent information to me.
22. I warrant that all and any information supplied in this application form is, to the best of my knowledge and belief, true, correct and complete.
23. I have read and understood the terms and conditions as contained herein and acknowledge that my dependants and I shall be bound by these terms and conditions as well as the Registered GEMS Rules, and my signature below binds my dependants and I thereto.

I have read and understood the above statements. I have had an opportunity to question and consider these and I agree to the responsibilities entrusted to GEMS. My signature below confirms that I give permission to the above on my and my dependants' behalf.

Signature of main member _____

Date

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