

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 six excellent healthcare benefit options: Tanzanite One, Beryl, Ruby, Emerald Value, Emerald and Onyx.

For more information on how to join GEMS, please visit www.gems.gov.za, or call 0860 00 4367, or SMS "please call me" to 083 450 4367 and an agent will call you.

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)

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)

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)

Additional documentation required for each dependant

| Description of dependant | Documentation required |
|---|---|
| Spouse | <ul style="list-style-type: none"> • If legally married, a copy of marriage certificate is required • If in a customary marriage, a declaration* from the member confirming obligation towards his/ her spouse is required |
| Ex-spouse | <ul style="list-style-type: none"> • Evidence of 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 of 21 and older | <ul style="list-style-type: none"> • For students: <ul style="list-style-type: none"> - Proof of registration at 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* confirming factual dependency on the main member, 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 disabled dependants, 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 at least an annual eligibility review. You must provide proof of dependency of all dependants over the age of 21 every year. Proof of eligibility may be required, for example proof of student registration.

Submitting your completed form

Submit your completed form in any of the following ways:

Email: enquiries@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, c/o Gillwell Road and Fleet Street | <ul style="list-style-type: none">Mthatha: Savoy Complex, Unit 11 & 12A, Nelson Mandela Drive |
| Free State | <ul style="list-style-type: none">Bloemfontein: Bloem Plaza, Shop 124, Charlotte Maxeke Street | <ul style="list-style-type: none">Welkom: Gold Fields Mall, Shop 51A, c/o Stateway & Buiten Street |
| Gauteng | <ul style="list-style-type: none">Johannesburg: Traduna House, 118 Jorissen Street, Ground Floor, c/o Jorissen and Civic Boulevard (opposite Civic Centre), Braamfontein | <ul style="list-style-type: none">Pretoria: Sancardia Building, Shop 51, First Floor, c/o Beatrix & Church Streets, Arcadia |
| KwaZulu-Natal | <ul style="list-style-type: none">Durban: The Berea Centre, Shop G18, Entrance 1, 249 Berea Road, Berea | <ul style="list-style-type: none">Pietermaritzburg: Deloitte House, Suite 3, Block A, 181 Hoosen Haffejee Street (Berg Street) |
| Limpopo | <ul style="list-style-type: none">Polokwane: Shop 1, 52 Market Street | <ul style="list-style-type: none">Thohoyandou: Unit G3, Metropolitan Centre |
| Mpumalanga | <ul style="list-style-type: none">Nelspruit: Shop No. 18, Nedbank Centre, 30 Brown Street, Nelspruit CBD | <ul style="list-style-type: none">eMalahleni (Witbank): Safeways Crescent Centre, Shop S67, c/o President & Swartbos Streets, Die Heuwel |
| Northern Cape | <ul style="list-style-type: none">Kimberley: New Park Centre, Shop 14, Bultfontein Way & Lawson Street | <ul style="list-style-type: none">Upington: 61A Mark Street |
| North West | <ul style="list-style-type: none">Klerksdorp: City Mall, Shop 101, c/o OR Tambo & President Street, Klerksdorp CBD | <ul style="list-style-type: none">Mafikeng: Mmabatho Megacity Shopping Centre, Shop 39, c/o Sekame & James Moraka Streets, Mmabatho |
| Western Cape | <ul style="list-style-type: none">Worcester: Mountain Mill Shopping Centre, Shop 125 A & B, Mountain Mill Drive | <ul style="list-style-type: none">Cape Town: Constitution House, 124 Adderley Street |

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

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| <ul style="list-style-type: none">Section 1: Main member employment detailsSection 2: Main member detailsSection 3: Preferred method of communication and language preferenceSection 4: Dependents you wish to registerSection 5: Previous medical scheme details | <ul style="list-style-type: none">Section 6: Medical history and general health informationSection 7: Benefit option selectionSection 8: Payment of contributionsSection 9: Your bank account detailsSection 10: Terms and Conditions (your responsibilities) |
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Important to note

- If you have not heard from us within 7 days of submitting your application, please call us on 0860 00 4367 or email us on enquiries@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 as defined in the Scheme Rules.

Membership

Application Form



This is an application form for GEMS membership. 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

Previous employment

| | | | | | | | | | | | | | |
|------------------------------|-----------------|--|--|--|--|--|---------------------|-----------------|--|--|--|--|--|
| (1) Previous employer's name | | | | | | | | | | | | | |
| Employment start date | DDMMYYYY | | | | | | Employment end date | DDMMYYYY | | | | | |
| Reason for leaving | | | | | | | | | | | | | |
| (2) Previous employer's name | | | | | | | | | | | | | |
| Employment start date | DDMMYYYY | | | | | | Employment end date | DDMMYYYY | | | | | |
| Reason for leaving | | | | | | | | | | | | | |

Section 2: Main member details

| | | | | | | | | | | | | | |
|--------------------------------------|------|--------|----------------|---|---------|---------------------------------|---------|-------------|--|--|--|--|--|
| Names | | | | | | | | | | | | | |
| Surname | | | | | | | | | | | | | |
| ID/Passport no. | | | | | | Date of birth DDMMYYYYYY | | | | | | | |
| Country of origin | | | | | | | | | | | | | |
| Country in which passport was issued | | | | | | | | | | | | | |
| Visa number | | | | Race <i>(for statistical purposes only)</i> | | | | | | | | | |
| Gender | Male | Female | Marital status | Single | Married | Divorced | Widowed | Co-habiting | | | | | |

| | | | | | | |
|--|---|--|---|---|---|---|
| Residential address | Unit/Apartment no. | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | Complex/Building name | <input style="width: 200px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 100px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | |
| Street no. | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | Street name | <input style="width: 150px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 100px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 100px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | |
| Suburb | <input style="width: 450px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | | | | | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> |
| City | <input style="width: 450px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | | | | | Postal code <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> |
| Telephone (H) | <input style="width: 100px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | Telephone (W) | <input style="width: 100px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 100px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 100px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | |
| Mobile no. | <input style="width: 450px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | | | | | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> |
| Email address | <input style="width: 450px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | | | | | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> |
| Postal address | If postal address is the same as residential address - tick box <input type="checkbox"/> | | | | | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> |
| <input type="checkbox"/> PO Box | <input type="checkbox"/> Private Bag X | Number (<i>complete the number</i>) | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | |
| <input type="checkbox"/> Postnet Suite | <input type="checkbox"/> Apartment | Number (<i>complete the number</i>) | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | |
| Suburb | <input style="width: 450px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | | | | | <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> |
| City | <input style="width: 450px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> | | | | | Postal code <input style="width: 50px; height: 20px; border: 1px solid black; border-radius: 5px; margin-right: 10px;" type="text"/> |

In case of emergency please contact _____ (name and relationship)

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: Dependents 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
Date of birth DDMMYY 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 Income of dependent
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 financial dependency on member

Dependant 2

Names Surname
Date of birth DDMMYY 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 Income of dependent
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 financial dependency on member

Dependant 3

Names Surname
Date of birth DDMMYY 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 Income of dependent
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 financial dependency on member

Section 5: Previous medical scheme details

Have you ever been a main member or a dependant of GEMS?

Yes No

If Yes, provide your previous membership number

Complete previous scheme details 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 dependent with resignation date (if applicable).

Section 6: Medical history and general health information

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.

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. Pregnant or suspecting pregnancy?
 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 |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
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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 |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
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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 |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
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15. Any accident, including motor vehicle accidents
 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 |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
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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 |
|--------------|----------------------|----------------------|-------------------------|--|-------------------------|--------------------------|
| | | | | | | |
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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 - tick 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 1st 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 1st 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 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 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 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 0860 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. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.
13. 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.
14. 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.
15. 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.
16. 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.
17. You agree that the Scheme and its administrator may process you and your dependants' personal information for, inter alia, the following purposes:
 - 17.1. to assess and process this application for membership;
 - 17.2. for the administration of your health plan;
 - 17.3. for the provision of managed care services to you on your health plan;
 - 17.4. for the provision of relevant information to a contracted third party who requires this information in order to provide a healthcare service to you on your health plan;
 - 17.5. to profile and analyse risk;
 - 17.6. to share your personal information with external health specialists for them to assess or evaluate certain clinical information, in the event that you are subject to such a clinical assessment;
- 17.7. For administrative, historical, research and statistical purposes if required; and
- 17.8. to enable benefit confirmation(s) to be performed and to facilitate electronic claims submissions; and
- 17.9. For any other lawful purpose.
18. 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.
19. 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.
20. 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.
21. 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