GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

FOR OFFICE USE ONLY	
Membership number	

APPLICATION FOR MEMBERSHIP

PLEASE COMPLETE IN BLOCK LETTERS

INSTRUCTIONS
It is imperative that all sections of this application form be completed in full. Failure to do this may cause a delay in the processing of the application, as the incomplete form will be returned to the applicant.

If you require assistance in completing this form, please contact the Client Service Department on **0860 104 122**.

PLEASE SELECT YOUR OPTION:

☐ **STANDARD OPTION**
☐ **ADVANCED OPTION**

1. APPLICANT'S INFORMATION

Title ____ Initials ____ Gender ☐ Male ☐ Female

First names ____

Surname ____

Identity/Passport number ____ (copy of identity document to be attached to the application form)

Date of birth ____ (DD/MM/YYYY)

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er ☐ Co-habitee

Date of marriage ____ (DD/MM/YYYY)

Date of divorce ____ (DD/MM/YYYY)

(**If divorced**, attach a copy of final order of divorce with addendums, if any)

Race ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

Employee/Pensioner number ____

Tax reference number ____

Contact numbers ____ Home ____ Work ____

____ Cell phone ____ Fax ____

Physical address ____

____ Postal code ____

Postal address ____

____ Postal code ____

Email address ____

2. EMPLOYMENT DETAILS

FOR OFFICE USE ONLY

Depot name ____ Employee number ____

Depot address ____

Gross income **R** ____

Date of employment ____ (DD/MM/YYYY)

Scheme admission date ____ (DD/MM/YYYY)

3. BANK DETAILS FOR DIRECT CREDIT OR REFUND

Account holder

Account number

Name of bank

Branch name

Branch code

Account type

- ☐ Current
- ☐ Savings
- ☐ Transmission

I hereby request and authorise you to credit any medical aid benefits which may accrue to me to the account mentioned above.

Signature

Date (DD/MM/YYYY)

4. DEPENDANT CLASSIFICATION AND PROOF REQUIRED

Definition of dependant	Documentation required
Spouse	ID and marriage certificate
Traditional spouse	ID and certified proof of traditional marriage
Natural child	ID, birth certificate and adult dependant affidavit if over 21 years
Student	If over 21, provide ID, proof of registration at educational institution
Natural child with different surname to principal member	ID, birth certificate and affidavit if over 21 years
Stepchild	ID, affidavit (proof of stepchild) and affidavit if over 21 years
Adopted child	ID and affidavit (proof of adoption)
Disabled child	ID, recent doctor's report of disability and proof of state grant/pension

5. DEPENDANT INFORMATION

Please complete the contact number, postal address and email address fields of your spouse/dependant that is 18 or older. See **Section 4** for dependant classification and the proof that is required in each instance.

Spouse

Title

Initials

Gender ☐ Male ☐ Female

First names

Surname

Identity/Passport number (copy of identity document to be attached to the application form)

Date of birth (DD/MM/YYYY)

Contact number

Relationship to applicant (e.g. wife)

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Postal address

Postal code

Email address

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

Dependant information continued on page 3

5. DEPENDANT INFORMATION (CONTINUED)

Dependant 1

Title | Initials | Gender ☐ Male ☐ Female

First names

Surname

Identity/Passport number | (copy of identity document to be attached to the application form)

Date of birth | (DD/MM/YYYY)

Contact number | Relationship to applicant (e.g. wife)

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Postal address

Postal code

Email address

Dependant 2

Title | Initials | Gender ☐ Male ☐ Female

First names

Surname

Identity/Passport number | (copy of identity document to be attached to the application form)

Date of birth | (DD/MM/YYYY)

Contact number | Relationship to applicant (e.g. wife)

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Postal address

Postal code

Email address

Dependant 3

Title | Initials | Gender ☐ Male ☐ Female

First names

Surname

Identity/Passport number | (copy of identity document to be attached to the application form)

Date of birth | (DD/MM/YYYY)

Contact number | Relationship to applicant (e.g. wife)

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Postal address

Postal code

Email address

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

Dependant information continued on page 4

5. DEPENDANT INFORMATION (CONTINUED)

Dependant 4

Title | Initials | Gender ☐ Male ☐ Female

First names

Surname

Identity/Passport number (copy of identity document to be attached to the application form)

Date of birth (DD/MM/YYYY)

Contact number | Relationship to applicant (e.g. wife)

Race* ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Don't wish to disclose

Postal address

Postal code

Email address

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

6. PREVIOUS MEDICAL SCHEME MEMBERSHIP

PLEASE ATTACH COPIES OF ALL PREVIOUS MEDICAL AID CERTIFICATES.

Are or were you or any of your nominated dependants members of a registered medical fund during the last two years? ☐ Yes ☐ No

If 'Yes', a certificate of membership (not a membership card) must be attached to this application.

CURRENT MEDICAL FUND MEMBERSHIP

Name of fund

Membership number

Date of commencement (DD/MM/YYYY)

Date of termination (DD/MM/YYYY)

Exclusions imposed

PREVIOUS MEDICAL FUND MEMBERSHIP

(If more information is needed, please use a separate sheet of paper and attach it to the application)

Name of fund

Membership number

Date of commencement (DD/MM/YYYY)

Date of termination (DD/MM/YYYY)

Exclusions imposed

PLEASE NOTE: If you belong to another medical fund, but did not declare your membership during your registration on the Fund, the Fund will hold you responsible for any costs incurred during your membership of the Fund.

7. QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please provide all the required information by ticking the relevant box. If the answer to any question is 'Yes', provide details in the table on page 6.

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

1. Have you or any of your dependants had any of the following?

1.1	Any disorder/dysfunction of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	☐ Yes	☐ No
1.2	High blood pressure or disorder/dysfunction of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder/dysfunction)?	☐ Yes	☐ No
1.3	Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis/persistent cough or tuberculosis)?	☐ Yes	☐ No
1.4	Any disorder/dysfunction of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, hepatitis B or persistent diarrhoea)?	☐ Yes	☐ No
1.5	Any disorder/dysfunction of the kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)?	☐ Yes	☐ No
1.6	Any nervous or mental disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)?	☐ Yes	☐ No
1.7	Any ear, nose or throat disorder/dysfunction (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment or chronic sinusitis)?	☐ Yes	☐ No
1.8	Any disorder/dysfunction of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)?	☐ Yes	☐ No
1.9	Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder/dysfunction?	☐ Yes	☐ No
1.10	Any lumps, growths (benign or malignant), types of cancers (including Hodgkin's and leukaemia), skin cancers or skin disorders/dysfunctions?	☐ Yes	☐ No
1.11	Any tropical diseases (e.g. bilharzia, malaria or cholera)?	☐ Yes	☐ No
1.12	Any other condition, illness, disease, disorder/dysfunction, disability or accident that required medical, radiological, surgical, pathological or dental investigations during the past 12 months?	☐ Yes	☐ No
1.13	Been tested for or received or expected to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or an AIDS-related condition or any sexually transmitted infection (e.g. hepatitis B, gonorrhoea or syphilis)?	☐ Yes	☐ No
1.14	A weight change or the weight of your dependants changed by more than 5 kg over the past 12 months?	☐ Yes	☐ No

2. Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? ☐ Yes ☐ No

3. Do you or any of your dependants currently use medication on a daily basis? ☐ Yes ☐ No

4. Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire relating to past or present diseases, accidents, operations, tests or other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months? ☐ Yes ☐ No

5. Are you or any of your dependants expecting to undergo any medical procedure, operation or to receive any major dental treatment during the next 12 months? ☐ Yes ☐ No

6. Are you and/or any of your dependants pregnant? ☐ Yes ☐ No

   Name of person _____ Number of months _____

If you answered 'Yes' to any of the questions above, please provide full details in the table on page 6. If additional space is required, provide the details on a separate sheet of paper and attach it to the application.

Questions regarding medical history and general health continued on page 6

7. QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH (CONTINUED)

		1	2	3
Question number				
Name of person suffering from the illness				
Type of illness/condition (diagnosis)				
Date on which the illness began (DD/MM/YYYY)				
Frequency of attacks (hourly/daily/weekly/monthly)				
Date of last occurrence (DD/MM/YYYY)				
If hospitalised, when and for how many days				
Duration of illness or condition				
Treatment and/or type of medication received in the past	Treatment			
	Medication			
Current treatment and/or type of medication received	Treatment			
	Medication			
Approximate monthly cost of treatment/type of medication	Treatment			
	Medication			
Details of operations previously performed				
Operations and/or treatment needed in future				
Name of attending medical practitioner				

8. ADDITIONAL INFORMATION

9. CONSENT FOR GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND TO PROCESS PERSONAL INFORMATION

We request your consent to process and obtain your personal information from any other person for the purposes set out below.

While your consent is voluntary, it is a requirement for your membership of GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and the Administrator will keep your personal information confidential and will adhere to the Protection of Personal Information Act, 2013 when processing your personal information. Your personal information will be processed for the purpose of the Medical Schemes Act 131 of 1998.

If you fail to provide the personal information required or if you are not willing to agree to the processing of your personal information, then GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND will not be able to administer or offer you membership of the medical scheme.

Please read the statements below and sign your acceptance thereof.

1. I authorise, and give consent to GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and the Administrator to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of my GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND membership risk profiling and management, administration of my membership and as set out in this section.

2. If I have consented to the disclosure of my personal information, GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND or the Administrator may provide my personal information to any natural or juristic person (which could include a company, corporation, state, or agency of a state, association, trust or partnership) or if a contractual relationship exists between GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND or the Administrator which requires them to do so.

3. I acknowledge that I must give GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and the Administrator all information and evidence they may require from time to time. I authorise GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and the Administrator to obtain from any person, including 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, any information GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND may require concerning my or any of my dependants in assessing any risk or claim in relation to this application, my membership of GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and risk profiling or management. I consent to that person providing, and instruct that person to provide, GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and the Administrator with this information on request. I waive the provisions of any law or regulation that restricts the disclosure of this information.

4. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.

5. I have the right to object on reasonable grounds relating to my particular situation, to the processing of my personal information unless processing is required by law.

6. I have the right to request my personal information which is in the possession of GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and the Administrator, provided that I furnish adequate identification.

7. I have the right to request GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and the Administrator where necessary, to correct or delete my personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading, or obtained unlawfully.

8. If I have a complaint relating to the processing of my personal information, I agree to refer it to the Administrator to resolve it in terms of their internal complaints process first. If I am not satisfied with the outcome of the complaint, I understand that I may refer the complaint to the Information Regulator who can be contacted on **012 406 4818** or via email at **inforeg@justice.gov.za**.

9. My personal information will be shared between GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND, the Administrator and contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to my membership of GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and to provide any credit bureau or registered credit provider with my credit information as defined in the National Credit Act, 2005 (credit information includes, for example, my credit history, financial history, pattern of payment or default under any credit agreements, debt re-arrangement arrangements or judgments obtained for outstanding debts).

Signature

Date

(DD/MM/YYYY)

10. DECLARATION BY THE APPLICANT

I hereby make application to be registered as the principal member of GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND and agree that I will be bound by the rules of the Fund as amended from time to time.

GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND is hereby authorised to debit my salary/pension/banking account with my share of accounts paid on my behalf by the Fund, as well as the monthly contributions paid to the Fund. GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND is authorised to continue thereafter to pay each month such subscriptions and any other amounts as are due until the end of the month in which GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND is notified of my resignation.

I agree that should any sum due to the Fund not be timeously paid by me for any reason, I shall be liable for all costs incurred by the Fund in the recovery of such sums, including tracing charges and all fees due by the Fund to its attorneys, including commission.

Please note that as the GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND regards itself as a proactive medical aid, all clinical data is reviewed by the clinical professionals of our Administrator and the Fund's medical team. People who would potentially benefit from clinical interventions, such as adjusting medication and/or disease management, will be referred to our clinical partners. All information remains confidential within the clinical teams. Should it therefore be deemed necessary, I hereby authorise the health care professionals to obtain from my service providers information relating to my claims.

I accept that I will not be able to resign from GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND whilst in the employ of Golden Arrow Bus Services, except if I am to join another medical fund through marriage.

I declare that the answers to the above questions are to the best of my knowledge true in every respect and agree, in the event of it being found subsequently that any of these answers are knowingly inaccurate, to forfeit all benefits from the Fund, to refund in full all grants that may have been paid on my behalf by the Fund and to waive all claims to any contributions paid by me to the Fund.

IMPORTANT: SHOULD THE APPLICATION FORM BE INCOMPLETE OR IF THE REQUIRED DOCUMENTS ARE NOT ATTACHED, REGISTRATION WILL BE DELAYED AS THE FORM WILL BE RETURNED FOR CORRECTION.

Identity number

Signature

Date

(DD/MM/YYYY)

THIS SECTION MUST BE COMPLETED BY AN AUTHORISED OFFICIAL AFTER THOROUGH SCRUTINY.

I certify that the applicants are eligible for membership of Golden Arrow Employees' Medical Benefit Fund.

Employer

Signature

Date

(DD/MM/YYYY)

OFFICIAL EMPLOYER'S STAMP

12/2025

Golden Arrow Employees' Medical Benefit Fund

Tel 0860 104 122
Email enquiries@goldenarrowmed.co.za
Website www.goldenarrowmed.co.za