NEW MEMBER APPLICATION FORM (M1.00)

Who must complete this form?

- HR must first complete Sections A and B of this form on behalf of all prospective permanent employees.
- The employee must then complete Sections C and D of this form and put together all relevant documentation (see below).
- HR must then check the form and relevant documentation, and complete and sign Section E before submitting all to the Society.

What should accompany this form?

- A certified copy of the employee's ID
- Membership certificates of all previous medical schemes, if relevant
- Beneficiary's Medical History, (M2.1A) for each beneficiary joining the Society
- All relevant supporting documents and additional forms per case – please see page 2.

By when should this form be returned?

HR must submit a signed version of this form, together with accompanying documents as listed, to the Society within 7 days of the employee starting work. Emailed versions must be sent to the Society's Registrations Department on registrations@dbbs.co.za and the original documents must be sent to De Beers Benefit Society, Registrations Department; either via post to PO Box 1922, Kimberley, 8300; or via courier to 84 Du Toitspan Road, Kimberley, 8301.

SECTION A: EMPLOYER INFORMATION (TO BE COMPLETED BY HR)

Name of employer and operation /section	
Area of employment (what city or town)	
Address of employer	

SECTION B: EMPLOYEE INFORMATION (TO BE COMPLETED BY HR)

Date the employee is to join the Society (mandatory)	
Membership number if spouse is an existing member of the Society	
Date the employee joined the employer (mandatory)	
Membership number issued by employer	

Employee number

Title (Mr, Ms, etc.) Initials

Surname

First names

Prefered name

Date of birth Gender Male Female

Marital status Single Married Divorced Widow Partnership Custom Law

Nationality Home language

Ethnic origin African Coloured Indian Asian White

Other (specify)

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SECTION B: EMPLOYEE INFORMATION – Continued

Identity number

Passport number (if available) | Country of issue

Contact details — Home | Work

Fax | Cell

Email*

*If supplied, all Society communication will be sent to this email address.

Postal address | Code

Physical address | Code

Name of family member not living at same address

Contact number of family member not living at same address

Address of family member not living at same address | Code

SECTION C: DEPENDANTS' DETAILS (TO BE COMPLETED BY EMPLOYEE)

Please provide details of your spouse/life partner and all children and then indicate if membership is required by choosing **"YES"** or **"NO"** below.

SUPPORTING DOCUMENTATION TO BE SUBMITTED IF MEMBERSHIP IS REQUIRED

- For **spouse**, a certified copy of ID or passport and marriage certificate must be attached.
- For **life partner**, a certified copy of ID or passport and affidavit for registration of life partner (M2.1B) with supporting documentation must be attached.
- For **children**, certified copies of IDs, birth certificates or passports must be attached. Should main member's surname differ from that of the child, birth certificates and affidavits by both parents confirming the child's paternity must also be attached.

ADDITIONAL FORMS TO BE COMPLETED

- For a **child over the age of 21** also complete M2.20, M2.21, M2.22 and M2.24.
- For a **dependant adult** also complete M2.20, M2.21, M2.23 and M2.24.

1. SPOUSE AND/OR LIFE PARTNER

INTERNAL NUMBER	Membership required	Initials	First names	Date of marriage	Date of birth	Maiden surname	Previous surname if divorced	M2.1A completed
	Yes No							
	Yes No							
	Yes No							

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SECTION C – DEPENDANTS' DETAILS – Continued

2. CHILDREN

INTERNAL NUMBER	Membership required	Initials	First names	Date of birth	Gender	Surname	Own, stepchild, or adopted child	M2.1A completed
	Yes No				Male Female			
	Yes No				Male Female			
	Yes No				Male Female			
	Yes No				Male Female			
	Yes No				Male Female			

3. PREVIOUS MEDICAL AID DETAILS

- List all registered South African medical schemes that you/your dependants have ever belonged to, either as a member or dependant.
- Attach certificates of membership that reflect the start and end date of all previous medical aid cover.

NOTE: Waiting periods and late joiner penalties may be imposed if a certificate of membership is not attached to prove transferability.

Member/ dependant name	Scheme name	Membership number	Start date	End date	Certificate attached

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SECTION D – DECLARATION BY EMPLOYEE (TO BE COMPLETED AND SIGNED BY EMPLOYEE)

1. I declare that the information supplied by me on this form is correct according to the best of my knowledge and belief.
2. I hereby authorise the **DE BEERS BENEFIT SOCIETY** (the Society) to pay medical accounts on my behalf. I further agree to repay any amount owing by myself to the Society and accept that the statement provided by the Society will be proof of my indebtedness.
3. I hereby authorise the Society to recover any debt due by me to the Society from any monies due to me from the employer by deduction monthly or in a lump sum, in accordance with the Rulings of the Board of Trustees.
4. I acknowledge that the Board of Trustees shall take all reasonable steps in accordance with the Protection of Personal Information Act (POPIA) to protect the confidentiality of the medical records concerning me or my dependant's state of health. I therefore irrevocably authorise the Society to collect, process and share my or my dependants' personal information with any contracted Third-Party Provider to allow the Society to fulfil its functions, duties and obligations. I agree that this authorisation shall remain in force after my/their death/s and understand that this may partially limit my right to privacy and that I further accept the Privacy Policy as published on the Society's public website.
5. By signing this document, I understand that I am entering into a binding agreement and that it is my responsibility to make sure that all my dependants listed in this application as well as any dependants I add in the future are fully informed about all aspects of the Society.

Signed this ____________ day of ____ 20____________ at ____

in the presence of the undersigned witnesses:

Member's signature

Name of witness 1 Signature

Name of witness 2 Signature

SECTION E – CERTIFICATION BY EMPLOYER (TO BE COMPLETED AND SIGNED BY HR)

I hereby certify that:

(a) I have checked the details supplied in Sections A to D herein and certify that they are complete and are in accordance with the employee's personal records kept by the employer.

(b) Checklist of supporting documents:

- Member ID/passport
- Spouse ID/passport
- Marriage certificate
- Life partner affidavit
- Child birth certificate/ID/passport
- All previous medical aid certificates
- M2.1A for the main member
- M2.1A per dependant joining

Name

Designation

Telephone number

Signature

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