

# Health Declaration 2024

This is a form to declare your health status

## Contact details

Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • [www.malcormedicalaid.co.za](http://www.malcormedicalaid.co.za)

## Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

## How to complete this form

1. Please use one letter per block, complete in black ink and print clearly or complete digitally.
2. To avoid administration delays, please ensure this application is completed in full.
3. Please include a copy of each applicant's identity document. We also accept valid passports and birth certificates for children.
4. Send the completed and signed form to [membership@totalmed.co.za](mailto:membership@totalmed.co.za) or fax **011 372 157**.
5. If you have any questions, please call **0860 100 698**.

When you sign this form, you confirm that the information you have given is true and correct

## Declaration from main applicant

Membership number	<input type="text"/>
ID or passport number	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>
Surname	<input type="text"/>

I,  (first name and surname)

declare that my dependants and I have not suffered any deterioration in health. We have not had any medical advice or treatment since my/our previous medical scheme membership ended. We do not intend seeking medical advice or treatment in the next eight weeks. This declaration forms part of my application to join the Malcor Medical Aid Scheme and this information is true, correct and complete. I understand that any false statement or not disclosing information will make my membership invalid.

If you are unable to sign the declaration, please give complete details of any changes in your health.

<input type="text"/>
<input type="text"/>
<input type="text"/>

Signed at (town or city)  on 

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Signature of main applicant

**The main applicant must sign and date any changes.  
Please do not sign an incomplete application form.  
I confirm the information is accurate and complete.**