Medical Needs Analysis

HealthGroup

The Medical Needs Analysis is a statutory requirement of the Financial Services Conduct Authority. This form must be completed by all members wishing to join or amend their scheme or option, and will remain on file. All information contained herein will remain strictly confidential and utilised for the sole purpose of providing advice and / or recommendations.

Section 1 - Member Details

First Name:

Last Name:

Identity Number:

Cell Number:

Email Address:

Province: Select from List

Gross monthly household income: Select from List

Estimated Monthly Budget for Medical Aid: R

Affordability guidance: *The FAIS Act requires recommendations to be both affordable and appropriate. By indicating what you can realistically spend, we avoid options that may cause financial strain or leave you underinsured.*

Current Medical Aid:

Current Option:

Family Size

Main member: 1

Adults (21+):

Children (<21):

Late Joiner Penalty Calculation

Only for applicants over age 35

	Adult 1	Adult 2	Adult 3	Adult 4
Current Age:				
Years on an SA medical aid since age 21:				
On unbroken cover since April 2001?	Y N	Y N	Y N	Y N

Waiting Period Calculation

All applicants are **current** members on an SA registered medical aid: Y N

All applicants have **unbroken** medical aid cover for longer than 24 months: Y N

Section 2 - Type of Medical Aid Plan Required

Full cover will require additional gap cover

◯ Hospital Plan only ◯ Hospital PLUS day to day cover ◯ Add Gap Cover

Section 3 - In Hospital (Risk Benefit) Requirements

Has any applicant been previously diagnosed with cancer? Y N

Does any applicant have planned hospitalisation? Y N

If you answered YES to the above, please provide details (name, dates, diagnosis etc.)

Choice of Hospital

Would you like to use private network hospitals to reduce costs? Y N

Life threatening emergencies are covered at ANY private hospital. Schemes offer reduced rates if you use their private

Section 4 – Chronic Cover

Has any applicant been diagnosed with a chronic condition? Y N

If YES, please provide details separated by commas (name & condition/s)

Section 5 – Out of Hospital (Day to Day) Requirements

*Please provide an **estimate** of the utilisation that you / your family typically experience in a **12 month period***

Provider	Visits		Cost per visit		Estimated Annual Cost
General Practitioner:		x	R	=	R
Acute Medication: *Not chronic medication*					R
Specialists:		x	R	=	R
Optometry:		x	R	=	R
Dentistry:		x	R	=	R
		x	R	=	R
Other		x	R	=	R
Other					

Total Annual Day to Day Requirement

R

Day to Day benefits can be provided through fixed medical savings account, via a separate savings facility or as stated scheme benefits.

Section 6 - Additional Cover Required

Please tick if you would like assistance in any of the following areas. We have a network of trusted partners providing specialist advice.

- ☐ **Wellness Program** — Vitality, Multiply etc
- ☐ **Risk Insurance** — Life / Disability Cover, Income Protection etc
- ☐ **Investments** — Tax Free, Unit Trusts, Endowments, Pension / Preservation Fund etc
- ☐ **Short Term Insurance** — Personal| Business
- ☐ **Up to date Will** — Our legal partners provide free consultations
- ☐ **Health Insurance** — Primary care for domestic or business employees

Section 7 - Notes

Please capture any other pertinent information for consideration here

Section 8 - Client Declaration

I, _____, declare that the information provided is true and correct.

I confirm that my medical aid and / or gap cover needs, have been fully disclosed. I consent to the processing of my personal, financial and medical information for the purposes of advice, product application, and ongoing support, in accordance with the Protection of Personal Information Act (POPIA).

Signed: _____ Place: _____ Date: _____

Product Recommendation

This section to be completed by an accredited intermediary

Scheme Name	Option	Selected
		☐
		☐
		☐
		☐

Reasons for recommendation

Quoted by: _____