2024 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.

Section 1 - Member Details

First Name:

Last Name:

Identity Number:

Cell Number:

Email Address:

Province:

Average monthly household income: R

Monthly budget for medical aid: R

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

Are all applicants currently members on an SA registered medical aid? Y N

Have all applicants been on constant medical aid cover for longer than 24 months? Y N

Section 2 - Type of Medical Aid Plan Required / Gap Cover

Hospital Plan
Complete Sections 3, 4, 6 & 8

Hospital PLUS day to day cover
Complete All Sections

Add Gap Cover
Complete Sections 3, 6 & 8

Section 3 - In Hospital (Core Benefit) Requirements

Specialist reimbursement cover rate: 100% 200% 7

Full cover will require additional gap cover

Medical aid rates are at 100%, private specialist rates are generally between 300% and 500%.

Has any applicant been previously diagnosed with cancer? Y N

Does any applicant have planned hospitalisation? Y N

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

Choice of Hospital

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

Emergencies are covered at ANY private hospital. Schemes offer reduced rates if you use their networks.

Section 4 – Chronic Cover

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

If YES, please provide full details (member, condition, medication)

Pharmacy Choice for chronic meds

◯ Courier ◯ Network ◯ Any

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
Medication *(Not Chronic)* :					R
Specialists:		x	R	=	R
Optometry:		x	R	=	R
Dentistry:		x	R	=	R
Other: ______________		x	R	=	R
Other: ______________		x	R	=	R

Total Day to Day Cost 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.	(Y) (N)
Short Term Insurance Personal | Business	(Y) (N)
Risk Insurance Life / Disability Cover, Income Protection etc	(Y) (N)
Up to date Will	(Y) (N)
Investments Tax Free, Unit Trusts, Endowments, Pension / Preservation Fund etc	(Y) (N)
Health Insurance Primary care for domestic or business employees	(Y) (N)

Section 7 - Product Recommendations Made

This section to be completed by an accredited intermediary

Scheme Name	Option	Selected	Reasons for selection
		(Y) (N)	
		(Y) (N)	
		(Y) (N)	
		(Y) (N)	

Section 8 - Client Declaration

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

All my needs, with regards to my medical aid and / or gap cover, have been disclosed and were discussed.

The product recommendations were fully explained to me and I made my selection based on these recommendations. I undertake to read the product specific brochure that I have been provided with.

Signed: Place: Date: