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# Application Form:

Accreditation and Renewal as a Third Party Medical Scheme Administrator

(For use by third party administrators of medical schemes in terms of Section 58 of the Medical Schemes Act and Chapter 6 of the Regulations to the Medical Schemes Act.)

\*This form is also available on the Council’s website: [www.medicalschemes.com](http://www.medicalschemes.com)

**Applicants are requested to send the required information to:**

|  |  |
| --- | --- |
| **Postal Address:**  General Manager: Accreditation  Council for Medical Schemes  Private Bag X34 **HATFIELD**  0028 | **Delivery address:**  Block A, Eco Glades 2 Office Park  420 Witch-Hazel Avenue  **CENTURION**  0157 |
| **Enquiries**:  Mr Khathutshelo Mulidzi  Senior Accreditation Analyst  Tel: 012 431 0586  E-mail: [k.mulidzi@medicalschemes.co.za](mailto:k.mulidzi@medicalschemes.co.za) | **Enquiries**:  Ms Hannelie Cornelius  Accreditation Manager: Administrators and MCOs  Tel: 012 431 0406  E-mail: [h.cornelius@medicalschemes.co](mailto:h.cornelius@medicalschemes.com).za |

# SECTION A: To be completed by all administrators

1. Registered name of administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Company registration number of entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­
3. State the translated, abbreviated name, trading name or derivative, if any, of the name in question 1.

|  |  |
| --- | --- |
| a) Translated: | b) Abbreviated: |
| c) Trading name: | d) Derivative: |

1. Furnish the particulars of the head office of the applicant administrator:

(a) Physical address: (b) Postal address:

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(c) Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(d) Website address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(e) Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (f) Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. State names, identity numbers and nationality of directors:

Name: ID Number: Nationality:

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Questions 6 to 13 below refer to the Chief Executive Officer (CEO) of the administrator company (Note that a full *curriculum vitae* must be provided for this person.)

(If the CEO is not the same person as the head of the administrator’s business kindly also complete Questions 14 – 21)

1. Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Identity no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Postal address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Telephone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Office) ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home)
7. Cell no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Questions 14 to 21 below refers to the administrative/operational head of the administrator’s business: (Note that a full *curriculum vitae* must be supplied for this person.)

1. Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Identity no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Postal address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Telephone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Office) ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home)
7. Cell no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. State the financial year end of the applicant:

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1. Names of the audit firm appointed by the applicant in terms of Regulation 20 promulgated in terms

of the Act, and the responsible partner at the firm:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Supply the names of all medical schemes with whom the applicant has contracted to provide administration services *(Copies of the latest signed administration agreement/s, including all subsequent signed addenda, must be provided)*:

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1. Provide details of any and all other agreements in place with the above medical schemes for services other than administration or managed care, provided by the applicant or other group companies or related parties *(Copies of the latest signed agreement/s, including all subsequent signed addenda, must be provided)* :

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1. Supply the names of all managed care organisations with whom the applicant has contracted to provide services *(Copies of the latest signed managed care agreement/s, including all subsequent addenda, must be provided)*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Supply the names of all persons or entities with whom the applicant has contracted or sub-contracted to provide outsourced administration services *(Copies of the latest signed agreement/s, including all subsequent addenda must be provided)*:

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1. Supply full details (name, nature of interest / relationship, etc.) of all entities in which the applicant has a financial interest and/or with whom the applicant has a related party relationship (“related party” as defined in IAS 24), including any of the following:
2. an administrator of medical schemes;
3. a broker organisation;
4. a managed care organisation;
5. a group of health care providers;
6. any other organisation which provides healthcare or associated services to medical schemes; or
7. a short or long term insurance company or re-insurer.

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1. Provide full details of shareholding **in the** applicant:

|  |  |
| --- | --- |
| Organisation/Individual | % Shareholding |
|  |  |
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1. Provide a brief description of the main business of the persons / entities in question 29:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Attach a copy of the detailed group structure of the group to which the applicant belongs, clearly indicating the respective shareholders (and percentage shareholding) in each, as well as the directors of each entity.
2. Indicate what other business, if any, apart from administration business, is / will be conducted by the applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# SECTION B: To be completed by administrators applying for renewal of accreditation

**Note:** The following information relates to the period from the previous accreditation evaluation up to the date of the renewal application:

1. Provide details of any changes in shareholding as well as the effective date of the changes:

a) in the applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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b) by the applicant in other entities:

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1. Provide details of any changes in the group structure of the applicant, as well as the effective date of such changes:

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1. Provide details of any changes to the operating, financial, and other administration systems. (Indicate what was changed, when it was done and why it was done):

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1. Provide details of any changes in senior management within the organisation and the impact of such changes on the applicant’s business in terms of availability of skills and expertise:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Provide details of any changes in the nature and / or extent of administration services provided:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Provide details of any changes in services outsourced to other parties:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Indicate the ability of the applicant’s administration system and infrastructure to accommodate growth in existing schemes under administration and / or to take on new business:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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FOR SUBMISSION BY ALL ADMINISTRATORS TOGETHER WITH THE APPLICATION FORM:

1. I hereby enclose the following documents:
2. A copy of the detailed group structure of the group to which the applicant belongs (Question 31).
3. Curriculum Vitae in respect ofthe Chief Executive Officer and the head of the administrator’s business (Questions 6 and 14).
4. The report prepared by the auditor in the form set out in Annexure C1 of the Regulations to the Medical Schemes Act. (Regulation 17(2)(d) - First time applicants only.)
5. Latest signed copies of all administration agreements or proposed administration agreements between the administrator and medical schemes, including all subsequent addenda (Question 24)
6. Latest signed copies of all other agreements between contracted medical schemes and the applicant or group / related party entities, including all subsequent addenda. (Question 25)
7. Latest signed copies of all sub-contracting agreements between the administrator and any other party, including all subsequent addenda. (Question 27)
8. Latest signed copies of all agreements with managed care organisations. (Question 26)
9. Valid certificate of good standing from the South African Revenue Service (tax clearance certificate).
10. Copies of the latest signed and audited annual financial statements as well as the most recent management accounts (Balance Sheet and Income Statement) with notes thereto.
11. Proof of payment of the non-refundable application fee as prescribed for accreditation as an administrator. (Kindly refer to Regulation 31 of the Regulations to the Medical Schemes Act, 1998)

[Please note that the application fee has increased to R14 000 with effect from 2 September 2016.]

(Banking details are provided below)

1. Please provide a copy of the organisation’s current B-BBEE certificate if available (for statistical purposes only).
2. The completed and signed “Declaration of conflict of interest” form (attached as Annexure A to this application form).

Declaration by head of the applicant organisation:

1. I declare that, to the best of my knowledge, the information supplied herein is complete, true and correct and not misleading in any respect.

2. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.

3. I undertake to supply any further information requested by the office of the Registrar, or the Council for Medical Schemes, as and when required for purposes of carrying out the provisions of the Medical Schemes Act, 1998 and regulations published thereunder.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full names: (Please print) Designation**

COUNCIL FOR MEDICAL SCHEMES: BANKING DETAILS

Bank : ABSA

Branch : ABSA Corporate Branch

Branch Code : 517245

Account number : 4051 163 394

Reference : Administrator accreditation number (As indicated on the accreditation certificate) (If a new application – use company name)

***Annexure A***

**DECLARATION OF CONFLICT OF INTEREST**

**(ADMINISTRATOR / MANAGED CARE ORGANISATION ACCREDITATION APPLICATION – FITNESS AND PROPRIETY EVALUATION)**

**Registered name of applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Director(s) of the applicant:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Director full name** | **Date appointed** | **Director ID number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |

1. **Director(s) of the applicant’s holding company - [add name of the holding company]:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Director full name** | **Date appointed** | **Director ID number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |

1. **Director(s) of the applicant’s ultimate holding company - [add name of the ultimate holding company]:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Director full name** | **Date appointed** | **Director ID number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

1. **Details of any company within the applicant’s group structure who have contracts in place to provide any other services to any of the medical scheme(s) to whom administration or managed care services are provided:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Company name** | **Type of services** | **Medical scheme** | **Effective date** |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |

1. **Director(s) of** **the companies listed in section 4 above:**
2. **Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Director full name** | **Date appointed** | **Director ID number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |

1. **Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Director full name** | **Date appointed** | **Director ID number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

1. **Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Director full name** | **Date appointed** | **Director ID number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

1. **Indicate whether any of the director(s) of the applicant and / or other companies indicated above is / was a trustee, Principal Officer or member of any board of trustees or committee(s) (e.g. Audit or Risk Committees, etc.), of any of the medical schemes with whom the applicant is contracted to provide administration or managed care services:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Director name** | **Director ID number** | **Medical scheme** | **Date appointed** | **Date resigned** |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |

1. **Indicate whether any of the companies or director(s) of the applicant and/or other companies indicated above is / was accredited as a broker in terms of the Medical Schemes Act, 1998.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Director name** | **Director ID number** | **Broker registration number** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |

1. **Please provide details of any contracts for the provision of services to any of the medical schemes to whom the applicant provides administration and/or managed care services, in which any of the above directors’ family members participate in or have any interest, whether directly or indirectly (e.g. spouse, life partner, child, sibling, or parent):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Director name** | **Director ID number** | **Medical scheme** | **Family member name** | **Family member ID no** | **Nature of contract** |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |

1. **Please provide details of any \*\*conflict of interest or potential conflict of interest declared by any of the companies / directors indicated above with regards to any contracts for the provision of services to any of the medical schemes to whom the applicant provides administration and / or managed care services.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Director name** | **Conflict of interest / potential conflict of interest declared** | **Date declared** | **Action taken to manage** |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |

**\*\* Conflict of interest or potential conflict of interest –**

* Means any situation in which a person or organisation, through its personal or business interests or involvement, could favour or benefit one interest or involvement over another to the benefit of that person or organisation, which could adversely affect a third party.
* E.g. an administrator or managed care organisation may take decisions or unduly influence the medical schemes with whom they contract to provide administration or managed care services to, that are not in the best interest of the medical schemes.

Declaration by head of the organisation:

1. I declare that, to the best of my knowledge, the information supplied herein is complete, true and correct and not misleading in any respect.

2. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.

3. I undertake to supply any further information requested by the Council for Medical Schemes, as and when required for purposes of evaluating the applicant’s fitness and propriety.

**Note:**

1. The office of the Registrar or the Council for Medical Schemes may verify certain information provided in this declaration form to the Companies and Intellectual Property Commission website.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full names: (Please print) Designation\***

**\* The declaration form must be signed by the Chief Executive Officer or Managing Director of the applicant.**