# SELF-ADMINISTERED SCHEMES:

 INITIAL APPLICATION FOR, AND RENEWAL OF CERTIFICATE OF COMPLIANCE

(For use by self-administered medical schemes only, to be read with the “*Requirements for administration of medical schemes*” document available on the CMS website at [www.medicalschemes.com](http://www.medicalschemes.com) .)

Schemes are requested to furnish the required information to:

|  |  |
| --- | --- |
| **Postal Address**:The Head of Accreditation Private Bag X34 **HATFIELD**  0028 | **Physical address**:Block AEco Glades 2 Office Park420 Witch-Hazel AvenueEco Park**CENTURION****PRETORIA** |
| **Enquiries**: Khathu Mulidzi Tel: 012 431 0586  E-mail: k.mulidzi@medicalschemes.co.za  | **Enquiries**:Ms Hannelie CorneliusTel: 012 431 0406E-mail: h.cornelius@medicalschemes.co.za  |

# SECTION A: General

# (To be completed by all self-administered schemes)

1. Registered name of medical scheme: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Registration no of medical scheme: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Furnish the particulars of the registered office of the medical scheme:

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

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

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

1. State names, identity numbers and nationality of Board of Trustee members:

 Name: ID Number: Nationality:

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

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Questions 5 to 11 refer to the **Principal Officer’s details**:

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

Questions 12 to 18 refer to the **Head of the Administration function’s details (if the Head is not the Principal Officer)**:

1. Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Identity no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Home address :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Postal address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Telephone no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Office) ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home)
6. Cell no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. E- mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Supply the names of all entities with whom the applicant has contracted to provide administration and/or managed care related services to the scheme:

|  |  |
| --- | --- |
| Name of entity | Nature of services provided |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. Provide full details of any shareholding by the medical scheme in any other entity:

|  |  |
| --- | --- |
| Entity |  % Shareholding |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. Provide a brief description of the main business of the persons / entities in question 20:

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

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

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

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

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

1. Provide a brief description of the administration, financial and other systems to be employed in the administration of the scheme:

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

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

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

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1. Please attach a copy of the medical scheme’s organogram, clearly illustrating the functions and responsibilities of staff.

# SECTION B: Changes since previous compliance evaluation

# (To be completed by self-administered schemes seeking renewal of the Compliance Certificate)

**The following information relates to the period from the last compliance evaluation to date:**

1. Provide details of any changes in shareholding:

a) By the medical scheme in other entities:

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

1. Provide details of any changes in the operating, financial and other administration and managed care systems employed. (Indicate what was changed and reasons therefore)

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1. Provide details of any significant changes in the benefit design /options offered by the scheme that required changes in the manner of administration thereof.

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1. Provide details of any amalgamations with other medical schemes or any planned amalgamations within the next 12 months, and the impact it had/will have on the operating environment of the medical scheme.

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1. Provide details of any changes in senior management within the scheme and the impact of such changes on the scheme’s operating environment in terms of availability of skills and expertise :

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

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

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

Declaration by the Principal Officer of the medical scheme:

1. I declare that, to the best of my knowledge, that the information herein supplied is complete, true and correct and not misleading in any respect.
2. The Curriculum Vitaes (CVs) of the Principal Officer and Head of the Administration functions are attached.
3. I have attached all required documents and/or information, .e.g. organogram.
4. I hereby confirm that I have the necessary authority to furnish this information and to make the undertakings required herein.
5. 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 there under.

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

Signature Date

**Full names: (Please print)**