CrisisOnCall

Member no: | | | | | | | | | |

Reg no. 2002/0249 66/07

FOR OFFICE USE ONLY

MEMBERSHIP APPLICATION FORM

PO Box 31021
Wonderboompoort
0033

Marketing office: (0861) 57 47 47
Email: marketing@crisisoncall.co.za

PLEASE COMPLETE ELECTRONICALLY IN FULL. USE (TAB) NOT ENTER. E-MAIL COMPLETED FORM OR COMPLETE WITH BLACK PEN IN CAPITAL LETTERS AND FAX TO 012 335 1881. IF COMPLETED IN ANY OTHER THAN BLACK PEN OR INCOMPLETE, THIS FORM WILL NOT BE ACCEPTED

MAIN MEMBER'S PERSONAL AND MEDICAL DETAILS												
REFFERAL NAME / AGENT KODE												
FULL NAMES AND SURNAME									TITLE			
ID NUMBER			PREFERRED NAME			GENDER		MALE		FEMALE		
HOME ADDRESS												
CITY / TOWN			PROVINCE					CODE				
POSTAL ADDRESS												
CITY / TOWN			PROVINCE					CODE				
HOME TEL NO			WORK TEL. NO					CELL NO				
E-MAIL								FAX NO				
MEDICAL AID NAME					MEDICAL AID PLAN							
MEDICAL AID NO					MEDICAL AID TEL NUMBER							
LANGUAGE PREFERENCE	AFRIKAANS		ENGLISH		BLOOD GROUP OPSIONAL							
IDENTIFICATION ARMBAND (choose between two options with X)	WOVEN		RUBBER		(Measure circumference around wrist-fairly tightly. Order next available size)							
RUBBER (Indicate size)	14 cm		16 cm		18 cm		20 cm		22 cm		24 cm	
SPECIAL REQUESTS/ DISABILITIES												
MAJOR SURGERY IN THE PAST 5 YEARS												
ALLERGIES												

CHRONIC MEDICATION - (IF NOT ENOUGH SPACE, COMPLETE ON SEPARATE SHEET AND ATTACH)	*Only mark what is applicable below with an X*				
	HYPERTENSION	YES		NO	
	EPILEPSY	YES		NO	
	LOW BLOODSUGAR	YES		NO	
	DIABETES	YES		NO	
	KIDNEY FAILURE	YES		NO	
	ASTHMA	YES		NO	
	CONTACT LENSES	YES		NO	
	FALSE TEETH	YES		NO	
	PACEMAKER	YES		NO	
	ORGAN DONOR	YES		NO	

I/we understand that membership may not be cancelled during the first three months.

I/we understand that one month's written notice of cancellation is required. (Send to **members@crisisoncall.co.za)**

I/we undertake to make payments as follows: (Mark applicable date with an **X**)

DEBIT ORDER		FIRST (1st)		SEVENTH (7 th)		FIFTEENTH (15th)		TWENTY SIXTH (26 th)		ANNUAL PREMIUM	

For DEBIT ORDER facility, please complete the attached DEBIT AUTHORISATION

I acknowledge that all payment instructions carried out by my bank in this regard, are deemed to be authorised by me.

I acknowledge that cancellation of this payment instruction, does not constitute cancellation of the contract of membership.

I cannot claim back any monies which have been legally, correctly paid.

CrisisOnCall may not hand over, cede or delegate this payment instruction to any third party without my written permission.

I hereby grant permission to CrisisOnCall to keep my personal and medical records on a protected database and to process them to my/our benefit in order to ensure a more effective service by emergency medical personnel.

I confirm/ that I understand this contract and enter into it willingly. [ ]

I confirm that I can afford the monthly membership fee. [ ]

DATE		INITIALS AND SURNAME		SIGNATURE	

SPOUSE AND DEPENDENTS - PERSONAL AND MEDICAL INFORMATION

	SPOUSE						1st DEPENDENT					
FULL NAMES												
SURNAME												
ID NO												
PREFERRED NAME												
CONTACT NUMBER												
GENDER												
MEDICAL AID												
MEDICAL AID - PLAN												
MEDICAL AID - NUMBER												
MEDICAL AID TEL NUMBER												
BLOOD GROUP OPSIONAL												
IDENTIFICATION WRIST BAND: WOVEN	YES			NO			YES			NO		
IDENTIFICATION WRIST BAND: RUBBER (mark wrist size with X)	14 cm	16 cm	18 cm	20 cm	22 cm	24 cm	14 cm	16 cm	18 cm	20 cm	22 cm	24 cm
SPECIAL REQUESTS/ DISABILITIES												
MAJOR SURGERIES IN THE PAST 5 YEARS												
ALLERGIES												
CHRONIC MEDICATION (IF NECESSARY USE SEPARATE SHEET AND ATTACH TO ORIGINAL)												
Mark only what is applicable with an X hereunder												
HYPERTENSION	YES			NO			YES			NO		
EPILEPSY	YES			NO			YES			NO		
LOW BLOOD SUGAR	YES			NO			YES			NO		
DIABETES	YES			NO			YES			NO		
ASTHMA	YES			NO			YES			NO		
KIDNEY FAILURE	YES			NO			YES			NO		
CONTACT LENSES	YES			NO			YES			NO		
FALSE TEETH	YES			NO			YES			NO		
PACEMAKER	YES			NO			YES			NO		
ORGAN DONOR	YES			NO			YES			NO		

DEPENDENTS - PERSONAL AND MEDICAL INFORMATION

	2nd DEPENDENT						3rd DEPENDENT					
FULL NAMES												
SURNAME												
ID NO												
PREFERRED NAME												
CONTACT NUMBER												
GENDER												
MEDICAL AID												
MEDICAL AID - PLAN												
MEDICAL AID - NUMBER												
MEDICAL AID TEL NUMBER												
BLOOD GROUP OPSIONAL												
IDENTIFICATION WRIST BAND: WOVEN	YES			NO			YES			NO		
IDENTIFICATION WRIST BAND: RUBBER (mark wrist size with X)	14 cm	16 cm	18 cm	20 cm	22 cm	24 cm	14 cm	16 cm	18 cm	20 cm	22 cm	24 cm
SPECIAL REQUESTS/ DISABILITIES												
MAJOR SURGERIES IN PAST 5 YEARS												
ALLERGIES												
CHRONIC MEDICATION (IF NECESSARY USE SEPARATE SHEET AND ATTACH TO ORIGINAL)												
Mark only what is applicable with an X hereunder												
HYPERTENSION	YES			NO			YES			NO		
EPILEPSY	YES			NO			YES			NO		
LOW BLOOD SUGAR	YES			NO			YES			NO		
DIABETES	YES			NO			YES			NO		
ASTHMA	YES			NO			YES			NO		
KIDNEY FAILURE	YES			NO			YES			NO		
CONTACT LENSES	YES			NO			YES			NO		
FALSE TEETH	YES			NO			YES			NO		
PACEMAKER	YES			NO			YES			NO		
ORGAN DONOR	YES			NO			YES			NO		

DEPENDENTS - PERSONAL AND MEDICAL INFORMATION

	4th DEPENDENT						5th DEPENDENT					
FULL NAMES												
SURNAME												
ID NO												
PREFERRED NAME												
CONTACT NUMBER												
GENDER												
MEDICAL AID												
MEDICAL AID - PLAN												
MEDICAL AID - NUMBER												
MEDICAL AID TEL NUMBER												
BLOOD GROUP OPSIONAL												
IDENTIFICATION WRIST BAND: WOVEN	YES			NO			YES			NO		
IDENTIFICATION WRIST BAND: RUBBER (mark wrist size with X)	14 cm	16 cm	18 cm	20 cm	22 cm	24 cm	14 cm	16 cm	18 cm	20 cm	22 cm	24 cm
SPECIAL REQUESTS/ DISABILITIES												
MAJOR SURGERIES IN PAST 5 YEARS												
ALLERGIES												
CHRONIC MEDICATION (IF NECESSARY USE SEPARATE SHEET AND ATTACH TO ORIGINAL)												
Mark only what is applicable with an X hereunder												
HYPERTENSION	YES			NO			YES			NO		
EPILEPSY	YES			NO			YES			NO		
LOW BLOOD SUGAR	YES			NO			YES			NO		
DIABETES	YES			NO			YES			NO		
ASTHMA	YES			NO			YES			NO		
KIDNEY FAILURE	YES			NO			YES			NO		
CONTACT LENSES	YES			NO			YES			NO		
FALSE TEETH	YES			NO			YES			NO		
PACEMAKER	YES			NO			YES			NO		
ORGAN DONOR	YES			NO			YES			NO		

GENERAL INFORMATION IN CASE OF EMERGENCY

MINISTER OF RELIGION	NAME AND SURNAME		TEL. NO.	
DOMESTIC WORKER 1	NAME AND SURNAME		ID NO.	
DOMESTIC WORKER 2	NAME AND SURNAME		ID NO.	
DOCTOR (GENERAL PRACTITIONER)	NAME AND SURNAME		TEL. NO.	
FIRE STATION	NAME AND SURNAME		TEL. NO.	
POLICE	NAME AND SURNAME		TEL. NO.	
NEXT OF KIN 1 (NOT LIVING WITH YOU)	NAME AND SURNAME		TEL. NO.	
NEXT OF KIN 2 (NOT LIVING WITH YOU)	NAME AND SURNAME		TEL. NO.	
NEIGHBOUR 1	NAME AND SURNAME		TEL. NO.	
NEIGHBOUR 2	NAME AND SURNAME		TEL. NO.	
EXECUTER	NAME AND SURNAME		TEL. NO.	
SECURITY COMPANY	NAME:		TEL. NO.	

VEHICLE DETAILS – MUST BE COMPLETED

INDICATE ROADSIDE ASSISTANCE WITH CRISISONCALL YES/NO – ONLY VEHICLES REGISTERED FOR ROADSIDE ASSISTANCE WIL BE HELPED

		VEHICLE 1				VEHICLE 2				VEHICLE 3				VEHICLE 4			
MAKE																	
MODEL																	
YEAR																	
COLOUR																	
REG NO																	
INSURER	NAME																
	TEL																
	POLICY NO.																
TRACKING DEVICE																	
ROADSIDE ASSISTANCE **@R48 P/M P/V**		YES		**NO**		YES		**NO**		YES		**NO**		YES		**NO**	

CLEARLY MARK WHICH SERVICES YOU WISH TO REGISTER FOR

	INDICATE CHOICE YES	NO	AMOUNT (R)
ALPHA PACKAGE ONLY (COMPULSORY)			**R 99.00**
ROADSIDE ASSISTANCE PER VEHICLE @ R50 PM – (INDICATE NO OF VEHICLES)			R
HOUSEHOLD ASSISTANCE @ R38 PM			R
TAKE ME HOME @ R42 PM (TRANSPORT AFTER SOCIAL EVENT WITH YOUR OWN VEHICLE – ONLY METROPOLITAN AREAS)			R
TAXI SERVICE @ R60 PM			R
EXTENDED FAMILY (LIVING WITH YOU) @ R49 PM – (INDICATE NO OF PEOPLE)			R
TEACHER ON LINE @ R15 PM			
DOMESTIC WORKERS ASSISTANCE @ R35 PM – (INDICATE NO OF WORKERS)			R
TOTAL MONTHLY MEMBERSHIP FEE			R
WOVEN ID WRISTBANDS @ R28 EACH (INDICATE NO OF WRISTBANDS) **Only one wristband per person, either woven or rubber.**			R
RUBBER ID WRISTBANDS @ R40 EACH (INDICATE NO OF WRISTBANDS) **Only one wrist band per person, either woven or rubber.**			R

DELIVERY OF WRISTBANDS – indicate choice with an X	Collect at:		Ordinary mail – only woven We accept no responsibility for lost or no delivery	Registered post We accept no responsibility R45	Speed post We accept no responsibility R125	Courier PTA & JHB R100 all other areas R150
	MOOT	**MONUMENT PARK**				R
ONCE-OFF ADMIN FEE (complete as provide by office – standard rate R150)						R150
					TOTAL FIRST PAYMENT	**R**

I/We authorise the first payment according to the above for the amount of R

I/We authorise all successive monthly limited to my/our monthly premium as amended from time to time R for the duration that I/we make use of the agreed services.

AUTHORISATION:

DATE:	22 Jan 2017	SURNAME & INITIALS:		SIGNATURE:	

MEMBERSHIP NO: | | | | | | | | | |

AUTHORISATION AND MANDATE FOR PAYMENT INSTRUCTIONS

A AUTHORISATION

1 I/We authorise **CrisisOnCall** to issue and submit payment instructions to your bank to recover the sum of aforesaid instruction against my/our bank account provided that aforesaid sum does not exceed my/our obligation as contained in the Agreement.

2 The individual payment instruction must be processed **monthly/annually** in accordance with the Agreement**. (delete what is not appropriate)**

3 The aforesaid payment instruction must at all times use the **Membership Number** for reference and tracing purposes.

4 I/We agree that the first payment takes place on

1st	7th	15th	26th

of ....
(Date)

and subsequent payments will continue while this Agreement is in place or until written notice (not less than agreed period as in “2” above) of cancellation is received. (The onus is on the member to prove that such notice has been given.)

B MANDATE

5 I/We acknowledge that all payment instructions issued by you to my/our bank, will be deemed to have come from me/us personally.

C CANCELLATION

6 I/We agree that while I/we can cancel this authorisation and mandate, it does not cancel the Agreement. I/We understand that we have no claim against any amounts paid to you in terms of this agreement while it is in force.

D INSTRUCTION

7 I/We acknowledge that **CrisisOnCall** may not cede, delegate or transfer any of the rights concerning my/our Agreement to a third party without my/our written permission, and I/we may not delegate to any third party any of my our commitments according to the Agreement, without previously written agreements by all parties.

NOTA: The NAEDO- and/or EFT user may add to above minimum requirements.

ACCOUNT HOLDER (Name and surname)		TYPE OF ACCOUNT	CHEQUE	SAVINGS	TRANSMISSION
BANK NAME		BRANCH NAME			
ACCOUNT NUMBER		BRANCH NUMBER			
MEMBERSHIP NUMBER (OFFICE USE ONLY)		DATE			2017
SIGNATURE		PLACE			