Optipharm Customer Care Centre – 0860 90 60 90 Office hours: Monday to Friday – 8h00 to 16h30
Enquiries - Fax no: 086 239 8482; Email: spesbona@optipharm.co.za Office hours: Monday to Friday – 8h00 to 16h30
New Enrolments only – Fax no: 086 6500809; Email: SBMC@spesbona.com

Application form for enrolling to the Spesbona Medicine Club (SBMC)

Please select one of the following

SB Employer Group ☐ SpesBona 4I Member ☐ Private Member ☐

Employer details: _____

A. Main Member and Medical Scheme details

Medical Scheme

Membership number

Scheme Option

B. About the patients

PRINCIPAL MEMBER

Title Initial(s)

First name(s)
Surname

ID number

Dependant Code Gender M F

1ST DEPENDANT

Title Initial(s)

First name(s)
Surname

ID number

Dependant Code Gender M F

Relationship to Principal Member

2ND DEPENDANT

Title Initial(s)

First name(s)
Surname

ID number

Dependant Code Gender M F

Relationship to Principal Member

3RD DEPENDANT

Title | Initial(s)

First name(s)

Surname

ID number

Dependant Code | Gender M F

Relationship to principal Member

4TH DEPENDANT

Title | Initial(s)

First name(s)

Surname

ID number

Dependant Code | Gender M F

Relationship to Principal Member

If you have more than 4 dependants please supply the detail on a separate sheet in the same format

C. Client contact details of Principal Member and Spouse

(H) | (H)

(W) | (W)

Cell | Cell

Email | **Email**

Address	Residential Address	Postal Address
Unit Number		
Street Address		
Suburb		
City / Province		
Postal Code		

PREFERRED DELIVERY DETAILS

Home Address: | Work | Doctor's rooms | Postal

Address	
Town	
Province	
Code	

D. About the prescription

Do you allow generic substitution by using the Spesbona formulary if applicable? Yes ☐ No ☐ Some ☐

If you selected "Some", please elaborate:

E. Debit order details

PRIVATE CLIENTS ONLY

The form will allow SBMC/Optipharm Healthcare to debit your bank account with your monthly charges on the day specified by you.

The form will also allow your account to be debited with the once off registration fee.

NOTE: Verification of your banking details is required either in the form of a cancelled cheque or with your bank's official stamp. This needs to be submitted with your application form.

Any charges incurred due to dishonoured payments will be for your account.

BANKING DETAILS

Bank

Branch

Branch Code

Account Type

Account Number

Account Holder

I hereby authorize Optipharm Healthcare (Pty) Ltd, to debit my account on the _____ day of every month.

Maximum Debit Order Amount

_____ _____

SIGNATURE **DATE**

Please send the completed and signed form back to us

Please attach your prescription to this application, without a valid script we cannot dispense your medication. Authorization of chronic medication by your Medical Scheme remains your responsibility; Optipharm will be unable to dispense your medication unless it is correctly authorized.

DISCLAIMER

Patient confidentiality

All member / patient information disclosed by means of this application will be treated as confidential and will not be revealed in any form to any other party other than the member's referring/treating Doctor, Medical Scheme or administrator, unless written consent has been given to Optipharm by the patient. The patient herewith authorizes the referring doctor/centre and current and future healthcare service providers to disclose test results and examination findings as well as the provision of prescriptions to Optipharm.

Prescription

A prescription of your current medication must be faxed to Optipharm or any other means convenient to you. Optipharm will not accept responsibility for any side effects or conditions arising from taking the prescribed medication or from not following the instructions as supplied by the treating Doctor & pharmacist. No medication will be supplied without a current valid prescription. Optipharm will notify you and your Doctor when script renewal is required, but the responsibility remains yours to provide valid prescriptions to remain eligible for medication supply.

Responsibility

The applicant acknowledges that his/her treating Doctor retains responsibility for the patient's treatment and diagnosis. Optipharm will not accept responsibility for any failure on behalf of the patient to collect medication when notified on time to his/her selected address. Optipharm is unable to accept medication returns as governed by the Council and code of conduct for good pharmacy practice.

The applicant acknowledge that he/she is ultimately responsible for payment of services to the provider and as such undertake to pay Optipharm any such monies due for services supplied, levies, co-payments or rejections and to inform Optipharm of any changes pertaining to their Medical Scheme. Optipharm reserves the right to hand over any member/patient to its collection agent for the recovery of monies due in lieu of services rendered. The applicant acknowledges that providing correct and authenticated delivery details remains the responsibility of the applicant. Optipharm cannot be held liable for any breach of confidentiality perpetrated by the applicant or any 3rd party service provider.

Signed on _____ on this _____ day of _____ 20_____

_____ _____

APPLICANT SIGNATURE DATE

G. Introducing intermediary – FOR OFFICE USE ONLY

S	**B**	**M**	**C**							

H. CHECKLIST

CHECKLIST	**YES**	**NO**
Enrolment Application Form		
Prescription		
Cancelled cheque or official bank stamped confirmation of bank account details		