

UNIVERSAL NETWORK PROVIDER APPLICATION FORM: GENERAL PRACTITIONERS

We have simplified our provider onboarding process to make your network participation easier and simpler.

Kindly complete Part 2 with the required information. Upon receipt of this application form, a formal contract will be sent to you for your electronic signature.

- **Part 1:** What's new, frequently asked questions (FAQ), and requirements.
- **Part 2:** Healthcare provider and banking information to be completed.

PART 1:

WHAT'S NEW?

This version incorporates changes made to our previous contracts and offerings:

- **POPIA.** Your agreement with us needs to be updated to include a new clause to cover the protection of personal information Act ("POPIA") requirements.
- **New client type (Corporate uninsured).** In the spirit of extending care to those who have never been covered, we have taken on clients, via our mediBucks™ options, whose members earn near minimum wages and consultation fees are set accordingly. You can opt-in to service our new clients in Section 3, paragraph 2 (Schemes) below.

FAQs

- **What is mediBucks™ and uConsult?**

mediBucks™ provides access to a dedicated digital health wallet/ account which allows Corporates and their clients or employees with the ability to contribute, save and manage budgets for health and wellness expenses.

uConsult™ extends the convenience of online consultations to all our Network Providers through our Telehealth uConsult Platform. This offering is accessible, not only the medical Scheme, and UHAP members but also allows registration on uConsult™ to consult with mediBucks™ and Workplace Health Plan (WHP) members as well. Please note that payment for consultations is exclusively facilitated through mediBucks™ and fees are collected upfront.

You will have access to our new corporate client/s on uConsult, for a nominal monthly fee of R99 and a R0.99 usage fee. Please be aware that the patient will pay for the administration, security, switching and banking fees over and above your fee. This will not be deducted from your fee.

Registration Process: Should you choose to take your practice online, the process is straightforward. Simply visit www.u-Consult.co.za, accessible through any web-browser and on any mobile device. Follow the user-friendly process.

- **Who are you contracting with?**
You are contracting with Universal Care (Pty) Ltd which is a subsidiary of the Universal Healthcare Group.
- **What are you agreeing to do for us?**
Continue to provide quality healthcare to your patients. Our medical scheme clients may change overtime but what you do doesn't.
- **What do we agree to do for you?**
Make sure we pay you quickly and correctly. From time to time we will also give you a quality assessment call.
- **What tariff rates are applicable?**
Universal contracts with a number of client schemes. Our comprehensive tariff rates are included in our Provider Manual which accompanies this Application form.
- **Where are the terms and conditions of the full contract?**
Everything you need to get you going is here in simple language. The full contract will be sent to you for electronic signature upon receipt of this Application form.

REQUIREMENTS:

1. Please read this application carefully and sign where indicated.
 - 1.1. Please complete the details in Annexure A, Section I and Section II in full;
 - 1.2. Section I is to be completed by all solo practitioners, every partner in a partnership and all members of a group practice and all associates in a practice, who are to be appointed as Universal Network Providers;
 - 1.3. Section II is to be completed by every solo practitioner; once per partnership, and once for every group practice / association submitting claims under the same practice number.
2. Kindly return the completed, signed document by:
 - 2.1. **Email to:** providers@universal.co.za; or
 - 2.2. **Post to address:** PO Box 1411, Rivonia, 2128.
3. A key point for participating healthcare providers is that they accept the agreed-upon payment amounts from the health plan as payment in full for all services provided to plan members. Providers may not balance-bill beneficiaries for amounts beyond what the health plan pays to the providers for the services provided.
4. **Please note that a healthcare provider will only be loaded on the Universal Network when Universal receives all documentation (eg. dispensing licence and proof of bank details which must not be older than 3 months) duly completed and signed, and after all verification checks have been concluded by Universal.**

PART 2:

SECTION 1: HEALTHCARE PROVIDER DETAILS FORM

HEALTHCARE PROVIDER DETAILS FORM: PLEASE COMPLETE IN FULL AND SUBMIT

EMAIL: providers@universal.co.za | POST: PO Box 1411, Rivonia, 2128
To be completed by ALL solo practitioners, EVERY partner in a partnership and ALL MEMBERS of a group practice / All ASSOCIATES, to be appointed as Universal Network Providers. Please add additional pages(s) with the details of every associate/ member.

ANNEXURE A, SECTION 1

Surname:

Initials: First name:

ID number:

Company reg number:

Individual BHF number: HPCSA number:

Group BHF number: (If applicable) Group practice name:

Dispensing license: (If applicable) Yes No If yes, provide license no:

IPA membership: Yes No If yes, name of IPA:

Primary practice physical address:
 Postal code:

Secondary practice physical address: (If applicable)
 Postal code:

Postal address:
 Postal code:

Office tel no: () Cell no:

Secondary practice tel no: () Fax no:

E-mail address:

Method of submitting claims: (please select the appropriate box) Electronic (e.g. EDI): or Paper:

Software/PMA vendor:

Switching/EDI partner:

Full name:

DATE

SIGNATURE

SECTION 2: HEALTHCARE PROVIDER BANKING DETAILS FORM

HEALTHCARE PROVIDER BANKING DETAILS FORM: PLEASE COMPLETE IN FULL AND POST OR EMAIL BACK

EMAIL: providers@universal.co.za | POST: PO Box 1411, Rivonia, 2128

ANNEXURE A, SECTION 2

Provider name:

Practice number: (BHF Number)

Postal address:
 Postal code:

Physical address:
 Postal code:

Telephone no.: () Cell no:

Fax no: () VAT no:

E-mail address:

Preferred method of communication: E-mail Post If no preference is selected, and an e-mail address is provided, the default method of communication will be e-mail.

Name of practice manager/ bureau for queries: representative:

Email of practice manager/ representative:

Name of account holder: Bank: We hereby confirm that the supplier is a cash practice, please pay the member.

Branch code: Account number:

Account type: Current Savings Transmission

PLEASE REMEMBER TO ATTACH PROOF OF BANK DETAILS WHEN SUBMITTING THIS FORM. (BANK LETTER OR COPY OF BANK STATEMENT NOT OLDER THAN 3 MONTHS)

It is the supplier's responsibility to advise the administrators in writing of any change in banking details. Neither the Scheme nor its administrator will be held liable should an incorrect account be credited under any circumstances.

PLEASE NOTE:

Details need to be updated with the Board of Healthcare Funders (BHF) as well in order for our systems to be updated correctly. Please ensure that this is done when sending the scheme your updated details.

Please sign as confirmation and authorisation of the details above.

 AUTHORISERS SIGNATURE/S

DATE Authorisers's ID no.:

DATE

 HEALTHCARE PROVIDER'S SIGNATURE
 (If different from the authorised signature)

Suppliers's ID no.:

DATE

SECTION 3: SERVICE FEES & NETWORK SELECTION

1. 2026 SERVICE FEES AND SERVICE CODES: GENERAL PRACTITIONERS

There are three categories of service fees. General Practitioners must select one of the following service fee options. Please tick the box representing your selected option:

- 1.1. Category A: Dispensing doctor (Please remember to submit a copy of your Dispensing Licence)**
The Universal Network Provider will receive the full consultation fee as set out below which includes the cost of acute medicines dispensed by the Universal Network Provider. Category A dispensing doctors are not permitted to prescribe medicines to patients unless pre-authorized by UniversalCare.
- 1.2. Category B: Non-dispensing doctors including acute medication.**
The Universal Network Provider will receive the full consultation fee, as set out below, after the cost of the acute medicines prescribed by the Universal Network Provider and dispensed by a Universal Network Pharmacy has been subtracted.
- 1.3. Category C: Non-dispensing doctors excluding acute medication (Consultation only).**
The Universal Network Provider will receive the lower consultation fee, as set out below, which excludes the cost of medicines prescribed by the Universal Network Provider and dispensed by a Universal Network Pharmacy.

1. 2026 SERVICE FEES AND SERVICE CODES: GENERAL PRACTITIONERS

| Category | Category Description | 2026 Fees (incl.VAT) |
|------------|---|----------------------|
| Category A | Dispensing doctors: Consultation fee including acute medication | R538 |
| Category B | Non-dispensing doctors: Consultation fee including acute medication dispensed by Universal Network Pharmacy | R538 |
| Category C | Non-dispensing doctors: Consultation fee excluding acute medication (consultations only) | R372 |

2. CLIENT SCHEMES

| | | |
|---|---|---|
| Medical Schemes | X | CompCare Medical Scheme |
| | X | Massmart Health Plan |
| | X | Old Mutual Staff Medical Aid Fund |
| | X | Consumer Goods Medical Scheme (previously Tiger Brands Medical Scheme) |
| | X | Transmed Medical Fund |
| | X | Foodmed Medical Scheme (Permanent employees, Pensioners, All membership status except Inactive 3) |
| Occupational Health Product | X | Universal Workplace Health Plan (WHP) |
| Health & Insurance Plan | X | Universal Health & Accident Plan (UHAP) |
| mediBucks™ | X | Dedicated Healthcare Savings Plan |
| Corporate uninsured (select Yes/No) Yes <input type="checkbox"/> No <input type="checkbox"/> | | uConsult™ fixed fee Corporate Client |

3. SIGNATURES

Please read and familiarise yourself with the fixed-fee and capitation fee schedules in the Provider Manual. Before signing below note that.

- 1.1. By signing this contract, you:
 - 1.1.1. agree to scheme tariff rates that constitute payment in full for all services provided.

The provided space below must be completed by the witness together with the doctor's Full Names and Signature.

Signed at _____ on this _____ day of _____ 2026.

As witness: _____

Name of witness: _____

Universal Network Provider (Doctor's Signature)

Full names of signatory:
duly authorised thereto

| Check List – Please confirm that the following has been considered before returning this Application Form | | | |
|---|-----|--------------------------|-----------------------------|
| All pages initialed | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| Full signature on page 2 | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| Full signature on page 3 | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| Network Category selected on page 4 | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| uConsult/ Telehealth selected on page 4 | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| Full signature on page 5 | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| Attach dispensing licence if Category A selected | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| Attach banking confirmation (not older than 3 months) | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |