

fedhealth member

RECORD AMENDMENT FORM 2022



PLEASE MAIL COMPLETED FORM TO:
Fedhealth Medical Scheme
Private Bag X3045
Randburg
2125

OR FAX TO:
Fedhealth Membership
Fax No: 011 671 3647

OR E-MAIL TO:
update@fedhealth.co.za

- Change of address / contact details**
Sections 1, 2, 8 and 9 must be completed
- Change of bank details**
Sections 1, 3, 8 and 9 must be completed
- Change of marital status**
Sections 1, 4, 8 and 9 must be completed
- Termination of dependant membership**
Sections 1, 5, 8 and 9 must be completed
- Registration of:** • Births and adoptions • Additional adult and child dependants
Sections 1, 6, 7, 8 and 9 must be completed
- Change of MediVault bank details**
Sections 1, 3, 8 and 9 must be completed

SECTION 1 DETAILS OF PRINCIPAL MEMBER

| | | | |
|-------------------------------|----------------------|---------------------------|----------------------|
| First name/s | <input type="text"/> | Initials | <input type="text"/> |
| Surname | <input type="text"/> | Preferred name | <input type="text"/> |
| Membership no. | <input type="text"/> | | |
| ID number | <input type="text"/> | Passport number, if no ID | <input type="text"/> |
| Country Of Origin of Passport | <input type="text"/> | | |
| Income Tax Number | <input type="text"/> | | |

SECTION 2 CHANGE OF ADDRESS / CONTACT DETAILS

| | | | | |
|------------------|----------------------|---------------|----------------------|----------------------|
| Telephone (H) | <input type="text"/> | Telephone (W) | <input type="text"/> | |
| Cellular | <input type="text"/> | Fax | <input type="text"/> | |
| E-mail address | <input type="text"/> | | | |
| Postal address | <input type="text"/> | | Postal code | <input type="text"/> |
| Physical address | <input type="text"/> | | Postal code | <input type="text"/> |

SECTION 3 BANK DETAILS OF PRINCIPAL MEMBER

Refund of claims and debit order instruction

I hereby instruct Fedhealth to electronically collect contributions and MediVault instalments as a single debit order and to deposit refunds, using the information provided below (Direct Paying Members only). Should the collection date fall on a public holiday, the Scheme reserves the right to collect prior to or after the holiday. I understand that transfers cannot be done to and from credit card accounts. I hereby authorise Fedhealth to reverse any erroneous transactions and/or rectify any EFT errors without prior notice. **Note:** Direct paying members can select from the following dates for debit order collections:

- 1st of the month 5th of the month 20th of the month **OR** 25th of the month

Should you miss a payment, Fedhealth reserves the right to deduct on a different date to collect the missed premium. Bank charges will apply for rejected debit orders. The debit order collection description will have the following prefix before your membership number for **current** contribution collections: FDHSUBS, for **arrears** contribution collections: FDHARR and a MediVault instalment collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT any arrear collection will include ARR with previous abbreviates.

| |
|---|
| <input type="checkbox"/> 1. USE THIS ACCOUNT FOR ALL TRANSACTIONS INCLUDING MEDIVault REPAYMENTS |
| <input type="checkbox"/> 2. USE THIS ACCOUNT FOR ALL COLLECTIONS ONLY NB. If you tick this option, then you must complete bank details for claims refunds on the right. |
| Bank name <input type="text"/> |
| Branch name <input type="text"/> |
| Bank branch code <input type="text"/> |
| Type of account <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/> Savings |
| Name of account holder <input type="text"/> |
| Bank account number <input type="text"/> |

| |
|--|
| <input type="checkbox"/> USE THIS ACCOUNT FOR REFUNDS ONLY NB: If you ticked no. 2 on the left then bank details must be completed here. |
| <input type="checkbox"/> USE THIS ACCOUNT FOR MEDIVault DEDUCTIONS ONLY |
| Bank name <input type="text"/> |
| Branch name <input type="text"/> |
| Bank branch code <input type="text"/> |
| Type of account <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/> Savings |
| Name of account holder <input type="text"/> |
| Bank account number <input type="text"/> |

If only one bank account is provided, it will be used for both collections and refunds.

Please note:

Should a third party pay the contribution/and MediVault Instalment on your behalf, the following supporting documents are required, certified by a commissioner of oaths and not older than three months:

- The account holder's identity document
- The account holder's bank statement
- Account holder's letter of authority to the Scheme to deduct contributions on behalf of the member. This also needs to include the relationship of the account holder to the principal member as well as a physical address, and where an individual, their Income Tax Number.

Account/ s holder's signature

Date

SECTION 4 CHANGE OF MARITAL STATUS

Marital status: Date of marriage :

Surname:

myFED members:
Please note that if you pay your own contributions and you add a spouse/ partner, you will be required to complete an Income Verification Form.

SECTION 5 TERMINATION OF BENEFICIARY REGISTRATION DUE TO DEATH, DIVORCE, CHILD SELF SUPPORTING ETC.

Please attach certified copy of death certificate if termination is due to death

| Full name/s as reflected on your membership card | Date of birth | Deletion date (last day of the month) |
|--|---|---|
| <input type="text"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> |
| <input type="text"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> |
| <input type="text"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> |
| <input type="text"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> | <input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> |

Reason for termination

SECTION 6 REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT

I confirm that I am authorised to provide and disclose the personal information of these listed dependants to the Scheme for the purpose of receiving benefits and related services.

1 Adult Child*

Title Initials First name/s

Preferred name

Surname

Relationship to principal member Gender

Income Tax Number

ID number Date of birth

If none, passport number, Nationality

Cell E-mail address

If adult, is the dependant financially dependent on the principal member?

Does the dependant receive an income, e.g. pension, salary? If yes, what is the monthly income?

Has this dependant had previous medical aid cover? If yes, please provide details below.

| Name of previous medical scheme | Membership number | Date joined | Date left |
|---------------------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet

flexiFED 1, flexiFED 1^{Elect}, flexiFED 2, flexiFED 2^{Grid}, flexiFED 2^{Elect}, flexiFED 3, flexiFED 3^{Grid}, flexiFED 3^{Elect}, myFED members are required to nominate a GP (General Practitioner) from the Fedhealth network for themselves and their dependants. Please note that only visits to a nominated GP will be covered on these options. For a list of GPs on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the GP locator button on the page. For a list of GPs on the myFED GP network, please contact the Customer Contact Centre on 0860 002 153.

| NOMINATED GP (GENERAL PRACTITIONER) DETAILS | | |
|---|-----------------|-----------------|
| Name | Practice number | Contact details |
| 1. | 1. | 1. |
| 2. | 2. | 2. |

*Child Dependant = the member's dependent child up to the age of 21 or 27 if a full time student.

Please note:

- Any dependant turning 21, and over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- Any dependant, other than your biological children: supporting legal documentation of adoption or foster arrangement; as well as an affidavit confirming residency, income, employment and marital status of both child and natural parents.
- Adult dependants: an affidavit confirming residency, marital status, employment status and income.

SECTION 6

REGISTRATION OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT *Continued***2**Adult Child* Title Initials First name/s Preferred name Surname Relationship to principal member Gender M FIncome Tax Number ID number Date of birth If none, passport number, Nationality Cell E-mail address If adult, is the dependant financially dependent on the principal member? Yes NoDoes the dependant receive an income, e.g. pension, salary? Yes No If yes, what is the monthly income? RHas this dependant had previous medical aid cover? Yes No If yes, please provide details below.

| Name of previous medical scheme | Membership number | Date joined | Date left |
|---------------------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes No

flexiFED 1, flexiFED 1^{Elect}, flexiFED 2, flexiFED 2^{GRIP}, flexiFED 2^{Elect}, flexiFED 3, flexiFED 3^{GRIP}, flexiFED 3^{Elect}, myFED members are required to nominate a GP (General Practitioner) from the Fedhealth network for themselves and their dependants. Please note that only visits to a nominated GP will be covered on these options. For a list of GPs on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the GP locator button on the page. For a list of GPs on the myFED GP network, please contact the Customer Contact Centre on 0860 002 153.

NOMINATED GP (GENERAL PRACTITIONER) DETAILS

| Name | Practice number | Contact details |
|-------------------------|-------------------------|-------------------------|
| 1. <input type="text"/> | 1. <input type="text"/> | 1. <input type="text"/> |
| 2. <input type="text"/> | 2. <input type="text"/> | 2. <input type="text"/> |

*Child Dependant = the member's dependent child up to the age of 21 or 27 if a full time student.

Please note:

- Any dependant turning 21, and over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- Any dependant, other than your biological children: supporting legal documentation of adoption or foster arrangement; as well as an affidavit confirming residency, income, employment and marital status of both child and natural parents.
- Adult dependants: an affidavit confirming residency, marital status, employment status and income.

3Adult Child* Title Initials First name/s Preferred name Surname Relationship to principal member Gender M FIncome Tax Number ID number Date of birth If none, passport number, Nationality Cell E-mail address If adult, is the dependant financially dependent on the principal member? Yes NoDoes the dependant receive an income, e.g. pension, salary? Yes No If yes, what is the monthly income? RHas this dependant had previous medical aid cover? Yes No If yes, please provide details below.

| Name of previous medical scheme | Membership number | Date joined | Date left |
|---------------------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes No

