	health member
	L COMPLETED FORM TO: E-MAIL TO: ledical Scheme update@fedhealth.co.za X3045
Sections 1, 2, 8 au Termination o Sections 1, 5, 8 au Change of Me	dress / contact details Change of bank details Change of marital status and 9 must be completed Sections 1, 3, 8 and 9 must be completed Sections 1, 4, 8 and 9 must be completed and 9 must be completed Registration of: • Births and adoptions • Additional adult and child dependants and 9 must be completed Sections 1, 6, 7, 8 and 9 must be completed • Additional adult and child dependants and 9 must be completed Sections 1, 6, 7, 8 and 9 must be completed • Births and adoptions • Additional adult and child dependants
SECTION 1	DETAILS OF PRINCIPAL MEMBER
First name/s Surname Membership no. ID number Nationality	Initials Preferred name Preferred name Passport number, if no ID Country of issue of Descent
Income Tax Number	of Passport
SECTION 2	CHANGE OF ADDRESS / CONTACT DETAILS
Telephone (H) Cellular E-mail address Postal address	() Telephone (W) () Fax ()
Physical address	Postal code Postal code Postal code
below (Direct Payin that transfers canne without prior notice. 1st of the m Should you miss a The debit order coll collections: FDHAF include ARR with p 1. USE TH MEDIVA 2. USE TH NB. If you claims re Bank name	payment, Fedhealth reserves the right to deduct on a different date to collect the missed premium. Bank charges will apply for rejected debit orders. peyment, Fedhealth reserves the right to deduct on a different date to collect the missed premium. Bank charges will apply for rejected debit orders. rection description will have the following prefix before your membership number for current contribution collecitons: FDHSUBS, for arrear contribution Ra and a MediVault instalment collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT any arrear collection will revious abbreviates. IIS ACCOUNT FOR ALL TRANSACTIONS INCLUDING AULT REPAYMENTS IIS ACCOUNT FOR ALL COLLECTIONS ONLY u tick this option, then you must complete bank details for efunds on the right. Bank name Bank name
-	t holder Transmission Savings Type of account Cheque Transmission Savings Name of account holder

SECTION 3	BANK DETAILS OF PRINCIPAL MEMBER Continued Refund of claims and debit order instruction
3rd Party Payor	
not older than thr • Account holder • Account holder • Account holder	rty pay the contribution and/or MediVault instalment on your behalf, the following supporting documents are required, certified by a commissioner of oaths and ee months: s identity document 's bank statement '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 er as well as a physical address, and where an individual, their Income Tax Number.
3rd Party Detail	s
Surname	
Title	First name/s
Physical address	
Relationship to principal membe	r Nationality
ID number	Passport number, if no ID
Country of issue	
Income Tax Nun	nber Company registration number
SECTION 4	CHANGE OF MARITAL STATUS
	Single Married Divorced Widowed Common law partner/ spouse Date of marriage : d d m y y y y
Surname:	
myFED members: Please note that if you	a 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 reflect	ed on your membership card Date of birth Deletion date (last day of the month) d d m m y y y y y
	d d m m y
	d d m m y
L Reason for terminatio	
SECTION 6	REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT
I confirm that I am aut and related services.	horised to provide and disclose the personal information of these listed dependants to the Scheme for the purpose of receiving benefits
1 Adult	Child*
Title	Initials First name/s
Preferred	
Surname	
Relationship to princip	bal member
ID number	Date of birth d d m m y y y y
If none, passport num	
Country of issue of pa	Income Tax Number
Cell	E-mail address
If adult, is the depend	ant financially dependent on the principal member?
Does the dependant r	eceive an income, e.g. pension, salary? Yes No If yes, what is the monthly income? R
Has this dependant h	ad previous medical aid cover? Yes No If yes, please provide details below.
Name of p	revious medical scheme Membership number Date joined Date left
	ic waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership Scheme/s? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach

SECTION 6	REGISTRAT	ION/ UPDATE C	OF SPOUS	E/ PARTNER/ ADDITIONAL A	ADULT OR CH	HILD DEPE	NDANT Continued					
nominate a GP (Ge be covered on thes	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.							
 Please note: Any dependant turr Any dependant, oth income, employme 	ning 21, and over t ner than your biolog nt and marital statu	he age of 21, must f gical children: suppo us of both child and i	urnish either orting legal do natural paren	or 27 if a full time student. proof of registration from a full-time to ocumentation of adoption or foster ar ts. ployment status and income.								
2 Adult	Child*											
Title	Initials	F	First name/s									
Preferred name												
Surname	Gender M F											
Relationship to princ	ipal member											
ID number					Da	ate of birth	d d m m y	у у у				

Nationality

Number

If yes, what is the monthly income?

If yes, please provide details below.

R

Yes

No

Date left

Date joined

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.								

No No

No

Membership number

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

E-mail address

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

Does the dependant receive an income, e.g. pension, salary?

Has this dependant had previous medical aid cover?

Name of previous medical scheme

Please note:

If none, passport number,

Cell

Country of issue of passport

• 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.

3	Adult C	Child*							
Title	Ini	itials	First name/s						
Preferred name									
Surname							Gender	М	F
Relationshi	p to principal memb	er							
ID number		[Date of birth	d d m m	у у	у у

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

If none, passport number,						Natio	nality			
Country of issue of passport						Incon Numb	ne Tax per			
Cell	E-mail address									
If adult, is the dependant financially de	pendent on the principal me	mber?	Yes	No						
Does the dependant receive an incom	e, e.g. pension, salary?		Yes	No	lf yes, wh	at is the m	nonthly in	icome?	R	
Has this dependant had previous med	ical aid cover?		Yes	No	lf yes, ple	ase provid	le details	below.		
Name of previous medical scheme			Membership number				Date joined			Date left
Have condition specific waiting periods any other medical scheme/s? Please p a separate sheet									f Yes	No
flexiFED 1, flexiFED 1 ^{Elect} , flexiFED 2, (General Practitioner) from the Fedh these options. For a list of GPs on th page. For a list of GPs on the myFEL	ealth network for themselv ne Fedhealth network visit	ves and t www.fed	heir dependa health.co.za,	nts. F click	lease note t on member	hat only v tools and	/isits to a I you wil	a nominated GP	will be co	vered on
	NOMINATE	D GP (GI	ENERAL PRA	СТІТІ	ONER) DET	AILS				

110	Nominated of (dehenden hormonen) betwee										
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 7 MEDICAL DETAILS

It is compulsory to answer each question. Failure to disclose information is fraudulent and may result in membership not being granted, or termination of membership without refund of contributions paid.

HAVE ANY OF THE DEPENDANTS INDICATED IN SECTION 6 SOUGHT ANY ADVICE, BEEN DIAGNOSED WITH, OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS IN THE PAST 12 MONTHS?

1. A chronic illness? (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and/ or thyroid disorders). If yes, please provide details.

Name of beneficiary	Diagnosis and date	Name of medication and dosage	-	Are you currently receiving treatment?		ou been alised?	Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

2. Gastro intestinal disorder? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/ or a spastic colon). If yes, please provide details.

Name of beneficiary	Diagnosis and date	Name of medication and dosage		Are you currently receiving treatment?		ou been alised?	Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
<u>`</u>			Yes	No	Yes	No	

3. Muscle, bone, skin or nerve illnesses or disorders? (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc). If yes, please provide details.

Name of beneficiary	Diagnosis and date	Name of medication and dosage		Are you currently receiving treatment?		ou been alised?	Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

4. Urinary or genital disorders? (e.g. kidney stones, prostates, endometriosis, ovarian cysts, menstrual disorders). If yes, please provide details.

Yes No

No

No

No

$\left(\right)$	Name of beneficiary	Diagnosis and date	Name of medication and dosage	1 1	Are you currently receiving treatment?		ou been alised?	Name and contact number of treating GP, Dentist or Specialist
ſ				Yes	No	Yes	No	
ĺ				Yes	No	Yes	No	

SECTION 7 MEI

MEDICAL DETAILS Continued

5. Ear, nose or throat disorders? (e.g. Glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics). If yes, please provide details.

Name of beneficiary	Diagnosis and date	Name of medication and dosage		Are you currently receiving treatment?		ou been alised?	Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

6. Blood disorders, immune deficiency state, HIV/AIDS, cancer etc? If yes, please provide details.

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

7. Are you or any of your dependants pregnant? If yes, please provide details.

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

8. Are there any other conditions not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months? If yes, please provide details.

Name of beneficiary	Diagnosis and date	Name of medication and dosage	1 1	currently treatment?	1 1	ou been alised?	Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

SECTION 8 EMP	LOYER INFORMATION	This section must be co	ompleted by your employer only if	employer pays your contribution			
Name of employer							
Division code			Dept. name				
Fedhealth Paypoint code			Employee number				
Dependant/s subsidised	ies No		Persal number if applie	cable			
The above details have been noted and contributions will be adjusted in terms of the scheme rules on and include arrears, if applicable.							
Total current contribution:	R						
Total new contribution:	R						
Arrears (if applicable):	R						
Vault Instalment (if applicable):	R			Company stamp			
Name of salary administrator							
Designation							
Signature				Date signed d d m m y y y y			
SECTION 9 DECLARATION BY PRINCIPAL MEMBER This section must be completed							
I declare that to the best of my knowledge the information provided above is true and correct. I consent with the permission of my dependants that the Scheme may collect, use, process, retain and share my and my dependants Personal Information (PI) for the purpose of providing Medical Scheme benefits and managed healthcare services. This includes the collecting and sharing of my PI with the Scheme's partners and facilities who are essential to the administration and membership process.*							
* You can access more details on the Protection of your Personal and Health Information on <u>www.fedhealth.co.za</u> . When you accept these terms and conditions you will allow us to provide your family with the full range of our Medical Scheme services.							
Signature of principal membe	ər:	Date: d d m m y y y y					

Yes No

Yes

Yes

Yes

No

No

No