continuation form

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

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

OR MAIL COMPLETED FORM TO:
Fedhealth Membership
Private Bag X3045
Randburg
2125

Current Membership no. ______ (NB: this will change)

Change effective from 0 1 m m y y y y

Change of principal member ☐
Subject to Scheme approval only

Supporting documents required:
Signed and dated request from principal member stating reason for the change. Should the member be part of an emloyer group, the request needs to have employer approval and a company stamp affixed.

Death of principal member ☐

Supporting documents required:
A copy of death certificate

Immigration of principal member ☐

Supporting documents required:
Signed and dated request from principal member stating date of departure and destination and a copy of the flight detail. Should the member be part of an emloyer group, the request needs to have employer approval and a company stamp affixed.

SECTION 1 DETAILS OF PRINCIPAL MEMBER

Surname

Title

First name/s

Preferred name

Date of birth d d m m y y y y

ID number/ Passport

SECTION 2 INTERMEDIARY / FINANCIAL ADVISOR

The details of the existing Intermediary/Financial Advisor will remain in place. Should there be a change in Advisor, a new letter of appointment will need to be attached.

SECTION 3 ADDRESS / CONTACT DETAILS

Telephone (H) ( )

Telephone (W) ( )

Cellular

Fax ( )

E-mail address

Postal address

Postal code

Physical address

Postal code

SECTION 4 BANK DETAILS OF NEW PRINCIPAL MEMBER *Refund of claims and debit order instruction*

I hereby instruct Fedhealth to electronically collect contributions and to deposit refunds, using the information provided below.
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 either of the following two dates for debit order collections. Should the banking details belong to another party other than the member, the following supporting documents are required: a copy of a cancelled cheque or full bank statement, a copy of ID and a letter of authorisation from that party stating approval of the use of their bank details for contributions and/or refunds (state which applies)

☐ **25th of the month OR** ☐ **1st 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.

☐ 1. USE THIS ACCOUNT FOR ALL TRANSACTIONS

☐ 2. USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS ONLY
NB. If you tick this option, then you must complete bank details for claims refunds on the right.

Bank name ......

Branch name ......

Bank branch code

Type of account: Cheque | Transmission | Savings

Name of account holder ......

Bank account number

☐ USE THIS ACCOUNT FOR REFUNDS ONLY
NB: If you ticked no. 2 on the left then bank details must be completed here.

Bank name ......

Branch name ......

Bank branch code

Type of account: Cheque | Transmission | Savings

Name of account holder ......

Bank account number

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

Please note:
Should a 3rd party pay the contribution on your behalf, the following supporting documents are required:
• A copy of the account holder's identity document
• A copy of the account holder's bank statement
• Account holder's letter of authority to the Scheme to deduct contributions on behalf of the member.

Account/ s holder's signature ......

Date d d m m y y y y

SECTION 5 CONFIRMATION OF EXISTING BENEFICIARIES TO REMAIN ON MEMBERSHIP

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	2
	Adult ☐ Child* ☐	Adult ☐ Child* ☐
Title	☐ Initials ☐ Relationship to member ☐	☐ Initials ☐ Relationship to member ☐
Surname		
First name/s		
Preferred name	☐ Marital status ☐	☐ Marital status ☐
ID number / passport number		
Date of birth	d d m m y y y y Gender M F	d d m m y y y y Gender M F
E-mail address	☐ Cell ☐	☐ Cell ☐

	3	4
	Adult ☐ Child* ☐	Adult ☐ Child* ☐
Title	☐ Initials ☐ Relationship to member ☐	☐ Initials ☐ Relationship to member ☐
Surname		
First name/s		
Preferred name	☐ Marital status ☐	☐ Marital status ☐
ID number / passport number		
Date of birth	d d m m y y y y Gender M F	d d m m y y y y Gender M F
E-mail address	☐ Cell ☐	☐ Cell ☐

** 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 EMPLOYER INFORMATION

This section must be completed by your employer only if employer pays your contribution

Name of employer

Division code | Dept. name

Fedhealth Paypoint code | Employee number

Dependant/s subsidised Yes No | Persal number *if applicable*

The above details have been noted and contributions will be adjusted in terms of the scheme rules on d d m m y y y y and include arrears, if applicable.

Total current contribution: **R**

Total new contribution: **R**

Arrears (if applicable): **R**

Name of salary administrator

Designation

Company stamp

Signature ....

Date signed d d m m y y y y

SECTION 7 FLEXIFED MEMBERS ONLY - MEDIVAULT DETAILS

Should you choose to activate MediVault and transfer funds into your wallet on your new membership, complete a new MediVault Application form and refer to the MediVault benefit in your brochure

SECTION 8 DECLARATION BY PRINCIPAL MEMBER

1. I, the undersigned hereby apply for membership of Fedhealth Medical Scheme (the Scheme) and also nominate my dependants as specified.

2. I hereby undertake to observe and carry out the provisions of the Medical Schemes Act 131 of 1998 (the Act) and of the rules of the Scheme as amended from time to time.

3. I agree that the Scheme shall not be bound in any way by any representations or undertakings made or given by any person or agent which is in contradiction with the registered rules of the Scheme.

4. I further agree that the commencement of my membership and the liability of the Scheme as a result of this application is conditional upon the first contribution being paid and received by the Scheme. In addition, should I default on payment of any subsequent contributions, and fail to remedy such default within the time periods allowed in the rules, any benefits paid by the Scheme on my behalf after the receipt of my last contribution shall be reversed and payment of these claims shall be for my account.

5. I hereby authorise and request any doctor or medical professional person, or any other person who may be in possession of, or may hereafter acquire, any information concerning my/ the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my/ their deaths, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of, or arising out of the disclosure of any test results or medical information.

6. I accept that any penalties/ waiting periods applying to the current membership will remain in place.

7. I hereby authorise the Scheme to deduct from my salary or any other available funds via debiting of my bank account, all contributions or any other amounts that may become due by me in terms of the Scheme's rules. In the event of arrears, I will be responsible for any legal costs that may arise in the recovery thereof.

8. It is my sole responsibility as a member to ensure that the monthly contribution is received by the Scheme.

9. I hereby acknowledge that any credit extended by the Scheme to myself or my dependants whilst a member of the Scheme will become payable in full on termination of my membership and that interest may be charged on all amounts due and owing to the Scheme.

10. I acknowledge that the Scheme may obtain any information regarding myself from any credit bureau, national loans register, South African Fraud Prevention Service or any other agent I have dealt with, with regards to my profile and credit history.

11. I understand that the Scheme may provide written notification, to my e-mail address, failing which, my financial adviser's e-mail address as supplied by my financial adviser, of changes to its rules.

12. I acknowledge that non-disclosure of any information by myself or my dependants relevant to the assessment of this application shall render any contracts to which this application relates null and void, and all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me or any person on my or my dependants' behalf under such contracts.

13. Should there be any additional information required by the Scheme which is not received within 7 days, the Scheme will automatically suspend the application.

14. I acknowledge that I am not a member of more than one Medical Scheme.

15. I hereby authorise the Scheme or any of its nominated representatives to verify and confirm my bank details.

16. If applicable, I hereby appoint the financial adviser who has submitted this application on my behalf, to be my nominated financial adviser. I acknowledge that a monthly commission of 3% of my total monthly contribution up to a maximum, as legislated from time to time, will be paid to the financial adviser in terms of the Act (or as amended). I am aware that I can cancel this appointment at any time.

17. I agree to provide the Scheme with 3 months' written notice to inform Fedhealth of my intention to terminate my membership.

18. I acknowledge that it is my responsibility to notify the Scheme of any changes to the facts, or any changes in my or my dependants' state of health, between the date of signing this application form and the date when my membership commences. If this is not done before my membership commences, future claims may be rejected.

19. I hereby confirm that I understand the various partnership arrangements (either Designated Service Provider and/ or Preferred Provider) applicable to my option and am aware that co-payments and/ or lower reimbursement rates may apply to the non-use of Fedhealth partners.

20. I declare that this personal statement, whether in my handwriting or not is complete, true and correct and that I have not concealed, withheld or misstated any material facts.

21. 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 personal information 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 **www.fedhealth.co.za**. When you accept these terms and conditions you will allow us to provide your family with the full range of our Medical Scheme services.*

Signed at ………………………… on this …………………….. day of …………………………….. 20................

Signature of principal member ……………………………….................................. Identity number [ ]

Print name ………………………………...

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

Customer Contact Centre number:
0860 002 153