MEDSHIELD medical scheme

ACTIVE SWAPPING OF MEMBERSHIP

Please complete all the relevant sections of this form in BLOCK LETTERS.

Email: newapplication@medshield.co.za

This form needs to be completed in the event that the principal member becomes the dependant and his/her spouse becomes the principal member. No termination of beneficiaries are allowed during the swapping of membership process. Swapping of membership is subject to Scheme approval.

For benefit option Medivalue and Mediphila a completed MEM013 Family Practitioner Nomination form is required with this form.

Selection of Benefit Option: _____

Broker code

Previous Membership number:

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Date membership to commence: Y Y Y Y M M D D

DOCUMENT CHECK LIST

In order to avoid rejection of your application please provide the following documents:	PLEASE TICK
ID document copy/s for all beneficiaries (e.g. ID / Birth certificate)	
Student certifcate (child dependant age 21-28 that is studying or turning 21 in the next 3 months).	
Proof of previous medical scheme (certifcate of membership refecting an end date)	
Mem02 - Member Record Amendment (for special dependants: e.g. parents, foster child, neice, nephew, brother,sister, grandchild).	
Persal payslip (for persal members only)	
Stamped bank statement, stamped confirmation letter from the bank, copy of cancelled cheque, signed letter of authority for 3rd parties	
MEM013 - Family Practitioner Nomination form (Medivalue and Mediphila option only)	

Section A TO BE COMPLETED BY NEW PRINCIPAL MEMBER :

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Postal Address:

Postal Code:

Residential Address:

Postal Code:

E-mail Address:

Telephone No. (W): (H): C O D E

Cell: Fax: C O D E

Section B DEPENDANT DETAILS (must be beneficiaries from previous membership)

Name of Beneficiary	Surname (if different to Principal Member	ID Number	Gender (M/F)	Relationship to principal member	Adult over 21
1					Y N
2					Y N
3					Y N
4					Y N
5					Y N
6					Y N

Section C EMPLOYER INFORMATION

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date: Y Y Y Y M M D D

COMPANY STAMP

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section F have been completed:

Employer's Email Address:

Employer Representative's Name:

Employer Representative's Designation:

Date: Y Y Y Y M M D D

Employer Representative Signature: _____

Section D BANK DETAILS OF PRINCIPAL MEMBER

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account.
A stamped bank statemnet, cancelled cheque or a stamped confirmation letter from the bank in the name of the principal member is required.
Should contributions be paid by a 3rd party, a stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank together with a signed letter of authorisation from the account holder must accompany this form. For Organisations a signed letter of authorisation needs to be on a company letterhead.
NB: If contributions are not deducted by PERSAL or your employer, payment via debit order is the preferred method for the collection of contribution payment.

☐ Use this account for contribution collections and claims refunds

☐ Use this account for contribution only

Bank Name: _____

Branch Name: _____

Bank Branch Code: _____

Type of Account: Current | Transmission | Savings

Name of Account Holder: _____

Bank Account Number:

Date: Y Y Y Y M M D D

Signature of Account Holder: _____

☐ Use this account for claims refunds only

Bank Name: _____

Branch Name: _____

Bank Branch Code: _____

Type of Account: Current | Transmission | Savings

Name of Account Holder: _____

Bank Account Number:

Date: Y Y Y Y M M D D

Signature of Account Holder: _____

Section E MEMBER DECLARATION

1. I, the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree to abide by its Rules and Regulations in accordance with the provisions of the Medical Schemes Act (Act 131 of 1998) as amended. I have been informed that the Scheme rules will be made available on request and that I am responsible to read and be bound by them.

2. I certify that all the information given is true and correct and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void and that 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 dependant's behalf, under such contracts.

3. I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

4. As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

5. Notwithstanding point 3 and 4, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

6. As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

7. I hereby authorise the Scheme, or any of its nominated representatives, to confirm my bank details.

8. Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

9. I hereby authorise and request any doctor, medical professional, 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 death, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of any nature, which may be made against them as a result of, or arising out of, the disclosure of any test results or medical information.

10. The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi which will be deemed to be my postal address unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi shall be deemed to have been received by me on the 7th day after the date of posting.

11. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

    - a 3 (three) month general waiting period in respect of all benefits;
    - a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
    - a late joiner contribution penalty.

12. Should my state of health change significantly from the date of signing this application to the date of acceptance, I will notify the Scheme in writing.

13. I hereby confirm that I am not an active beneficiary on another medical scheme.

14. I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: _____

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form is submitted to the Scheme within 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

Date: Y Y Y Y M M D D

Consent for Disclosure of Information to 3rd Party

Please complete the below should you require a nominated person to contact/make changes to your Medshield Medical Scheme membership on your behalf (i.e. a family member, attorney, etc.) - Please note that this is not complusory and merely for your convenience, should you so choose.

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Relationship to Member

Email address

Cellphone number

Title: Initials:

First Name/s:

Surname:

ID/Passport Number: Date of Birth: Y Y Y Y M M D D

Relationship to Member

Email address

Cellphone number

MEDSHIELD MEDICAL SCHEME

P.O. Box 4346, Randburg, 2125
www.medshield.co.za
newapplication@medshield.co.za or fax to 010 597 4710
Contact Centre: 086 000 2120
Mon - Fri 8:30 - 17:00

BANK DETAILS

Account Holder: Medshield Medical Scheme
Bank: Nedbank
Branch: Rivonia, 196905
Account number: 1969125969