CMAC
Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

MEDSHIELD medical scheme

# MEMBER RECORD AMENDMENT/DEPENDANT REGISTRATION

- Please complete in block letters.
- Complete blocks from left to right, one letter/number per block.
- Registration and amendments are subject to the rules of the Scheme.
- Scheme must be notified within 30 days from date of change.
- **Please note that if the benefit option selected is either MediValue or MediPhila, then this form needs to be accompanied by a completed MEM013 Family Practitioner nomination form.**

Please note: ID/passport numbers are to be provided for the principal members as well as all beneficiaries.
Should this be outstanding, your amendment cannot be processed. Please include copies of all I.D. documents and/or birth certifcates.

Membership certificates, which reflects the termination date, must be attached to this amendment. Failure to provide this information may result in your application being rejected.

## SECTION 1 DETAILS OF PRINCIPAL MEMBER (must be completed)

MEMBERSHIP NUMBER

INITIALS AND SURNAME

## SECTION 2 CHANGE OF ADDRESS / CONTACT DETAILS

TEL. NUMBER (W)

TEL. NUMBER (H)

FAX NUMBER

CELL NO

POSTAL ADDRESS

POSTAL CODE

EMAIL ADDRESS

## SECTION 3 REGISTRATION OF DEPENDANT

Please mark with an ☒

☐ Life Partner / Spouse ☐ Aged Parent ☐ Sibling ☐ Grandchild ☐ Over Aged Child ☐ Late registration of own child

☐ New born / foster or adopted ☐ Other (please specify)

TITLE INITIALS SURNAME

FIRST NAMES

ID. NO. GENDER M F

RELATIONSHIP TO PRINCIPAL MEMBER DATE OF BIRTH Y Y Y Y M M D D

MAIDEN SURNAME

MARITAL STATUS

TELEPHONE NO (W) (H)

CELL NO FAX

EMAIL ADDRESS

RACE

If student dependant over the age of 20, please provide a copy of student proof for the current year
Please answer the following compulsory questions – mark the appropriate block with an "x"

1. Does the dependant receive a monthly income? Y N

If yes, complete the following

NAME OF EMPLOYER

MONTHLY SALARY R

PENSION (Old Age, military or disability) R

PENSION (Other, including an annuity) R

TOTAL R

Provide proof of income e.g. 3 months

2. Is the dependant entirely reliant on you for maintenance and support? Y N

Give reasons and attach certified affidavit

3. Does the dependant live with you? Y N

Give reasons and attach certified affidavit

4. Is the dependant a resident of an institution? Y N

If Yes, provide the name of the institution and state clearly whether the institution is responsible for medical care.

5. Is the dependant a student? Y N

If Yes, state whether full-time or part-time, name of academic institution and expected period of study. Also attach proof of current year student registration (stamped by tertiary institution).

6. Has the dependant been a beneficiary of any medical scheme before this application? Y N If yes, provide Certificate of membership

**Where applicable, please provide details and proof of membership of all previous medical schemes cover. (Membership certificates which reflect a termination date must be attached to this application). Failure to provide this information may result in a late joiner penalty fee.**

NAME OF SCHEME MEMBERSHIP NUMBER

DATE JOINED Y Y M M D D DATE LEFT Y Y M M D D

Reason Membership Terminated

7. Has the dependant been employed during the past 2 years? Y N

If yes, give name(s) of employer(s) and dates employed

If no, please elaborate

## SECTION 4 MEDICAL HISTORY (tick yes or no)

**Failure to disclose pre-existing conditions could limit and/or exclude certain benefits or result in termination of your membership. (Refer to point 2 in member declaration)**

Has the dependant sought any advice, been diagnosed with, been treated for; or suspect that they might have any of the following conditions during the last 12 months?

1. Any chronic illnesses? e.g. Cardio and vascular conditions, Obstructive lung disease, Diabetes, insulin or non insulin dependent diabetes mellitus, Thyroid or other glandular or blood disorders, etc. Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

2. Skin, muscle or bone disease? e.g. Any skin rash, acne, eczema or psoriasis, multiple sclerosis, osteo or rheumatoid arthritis,osteoporosis, injury, back / neck or joint problems or replacement, fibromyalgia, prosthetic limbs, lumbago sciatica, spasms, etc. Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

3. Digestive system, stomach, liver, gall bladder or pancreas? e.g. Stomach or duodenal ulcer, GORD/heartburn, hiatus hernia, Crohn's disease, ulcerative colitis, irritable bowel syndrome, rectal bleeding, hepatitis, cirrhosis, liver failure, etc. Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

4. Psychiatric conditions? e.g. Schizophrenia, bipolar mood disorder, substance abuse, eating disorder, depression, panic attacks and / or Anxiety, ADHD or post traumatic stress disorder, etc. Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

5. Complaints of the nervous system or brain? e.g. Epilepsy, stroke, blackouts, migraine, headaches, paralysis, Parkinson's or Alzheimers. Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

6. Complaints/disorder of the Ear, nose, throat or eye? e.g. Defective vision, cataracts, glaucoma, eye disorders, blindness, retinitis, disorders of the cornea or wear spectacles or contact lenses, hearing loss, ear discharge, otitis media, allergies or recurrent tonsillitis, etc. Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

7. Urinary tract, genital system or gynaecological disorders? e.g. UTI , kidney stones, kidney failure, prostatitis, sexually transmitted disease, HRT, ovarian cysts, fibroids, menstrual disorders or any abnormality of pregnancy or confinement, etc. Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

8. Are you or any of your dependants pregnant or suspect that you are pregnant? Y N

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | Attending Doctor |
|---|---|---|---|---|---|
| | | YES | NO | | |
| | | YES | NO | | |

9. Malignant or Benign neoplasms? e.g. cancers, malignant or non-malignant tumours/growths of any kind including removal of malignant or benign moles, etc.

| Y | N |
|---|---|

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | | | | | | | | Attending Doctor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | YES | NO | | | | | | | | | |
| | | YES | NO | | | | | | | | | |

10. Dentistry? e.g. Specialised dentistry/maxillo-facial treatment (currently undergoing or anticipating any specialised/ orthodontic or maxillofacial treatment), etc.

| Y | N |
|---|---|

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | | | | | | | | Attending Doctor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | YES | NO | | | | | | | | | |
| | | YES | NO | | | | | | | | | |

11. Any other medical condition not listed in question 1 - 10?

| Y | N |
|---|---|

| Name of Beneficiary | Condition and Date Diagnosed | Currently On Treatment | | Date of Last Treatment | | | | | | | | Attending Doctor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | YES | NO | | | | | | | | | |
| | | YES | NO | | | | | | | | | |

12. PRESCRIBED MEDICATION

A SEPERATE CHRONIC MEDICINE APPLICATION HAS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.

Please supply details of any prescribed medication that you or any of your dependants are currently taking or expect to take in the future. Your doctor or pharmacist can contact MHRS on 086 010 0608 to telephonically register you for chronic medication.

| Question No. | Name of Beneficiary | Condition & Duration of condition | Attending Doctor | Date of treatment |
|---|---|---|---|---|
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13. SURGERY AND HOSPITAL ADMISSIONS

Please supply details of any surgery or HOSPITAL ADMISSIONS that you or any of your dependants have undergone in the past 12 months, and/or details of all planned surgical procedure(s) and HOSPITAL ADMISSIONS that you or any of your dependants expect to undergo in the future.

| Name of Beneficiary | Details of Surgical /Hospital Admission | Date | Reason | Doctor | Current Condition |
|---|---|---|---|---|---|
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## IMMUNE DEFICIENCY STATUS (confidential disclosure)

If you or any of your dependants have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Program on 086 050 6080 for more information on how to join the Programme.

## SECTION 5 EMPLOYER INFORMATION (Only For Existing Paypoints)

NAME OF EMPLOYER

PAYPOINT (IF APPL.) ( ) ORGANISATION CODE (If applicable)

EMPLOYMENT DATE D D M M Y Y Y Y

| NO. OF DEPENDANTS | Adult | Child | Non-Subsidised |
|---|---|---|---|
| PLAN CONTRIBUTION | | | |
| TOTAL | | | |

COMPANY STAMP

BENEFIT DATE D D M M Y Y Y Y

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

EMPLOYER REPRESENTATIVE NAME

EMPLOYER REPRESENTATIVE'S DESIGNATION

Employer Representative's Signature

Date: D D M M Y Y Y Y

## IMPORTANT CONDITIONS OF MEMBERSHIP

1. Disclaimer
   Brochures are summaries and do not supersede the registered Rules of the Scheme. All benefits are paid in accordance with the registered Rules of the Scheme which are available both on request and the Scheme's website.

2. Are all benefits available once I am a dependant?
   Benefits are based on a 12-month period (January to December). Your benefits will be pro-rated depending on which month of the year you join the Scheme or add a dependant, i.e. should you join in March, you will have 10 months' benefits available. If a benefit for the year is R1 800 you will have R1 800/12 x 10 = R1500. Waiting periods are applied to some pre-existing conditions, for example pregnancy.

3. Do I have to wait before I can claim for benefits?
   Yes, on pre-existing conditions, e.g. a condition prior to joining the Scheme. In certain instances the Scheme may also apply general waiting periods of up to three months. You will receive written notification if waiting periods are imposed.

4. Will contributions increase after I add a dependant?
   Yes. All medical schemes increase contributions from time to time when the cost of medical, dental, hospital or other health services increase or when benefits are changed or a dependant is added.

5. What happens when I exceed my annual benefit limits?
   You will be liable for the payment of any excess amount directly to the service provider.

6. Can I or a dependant resign from the Scheme at any time?
   The Scheme requires one month calender notice in writing of your intention to cancel your or your dependants membership.

## 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.

   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.

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's Signature: _____

Date: D D M M Y Y Y Y

## DOCUMENT CHECK LIST

| In order to avoid delays in processing your application, please provide the following documents: | PLEASE TICK |
|---|---|
| ID copies\Birth certificate (of all beneficiaries) | |
| Affidavids for special dependants: e.g. parents, foster child, neice, nephew, brother,sister, grandchild. | |
| Student certifcate ( child dependant age 21-28 that is studying or turning 21 in the next 3 months). | |
| Proof of previous medical scheme (certificate of membership with end date) | |


## MEDSHIELD MEDICAL SCHEME

P.O. Box 4346, Randburg, 2125
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Contact Centre: 086 000 2120
Mon - Fri 8:30 - 17:00