fedhealth member

APPLICATION FORM

FEDHEALTH

PLEASE FAX TO:
Fax No: 011 671 3647

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

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

SECTION 1 CHOICE OF OPTION

Choose ONE product option by placing "x" in the appropriate box

myFED

☐ myFED*

*If your contribution is paid by your employer, please also refer to section 6.

*If your contribution is not paid by your employer, please also complete section 10.

flexiFED

☐ flexiFED 1
☐ flexiFED 1 Elect*
☐ flexiFED 2
☐ flexiFED 2 GRID*
☐ flexiFED 2 Elect*
☐ flexiFED 3
☐ flexiFED 3 GRID*
☐ flexiFED 3 Elect*
☐ flexiFED 4
☐ flexiFED 4 GRID*
☐ flexiFED 4 Elect*

maxiFED

☐ Maxima PLUS
☐ Maxima EXEC
☐ Maxima EXEC GRID

*Please also complete Section 9 for nomination of a Fedhealth network GP (General Practitioner).

I wish to join the scheme from 0 1 m m y y y y

☐ Contribution collection in ADVANCE
☐ Contribution collection in ARREARS

SECTION 2 DETAILS OF PRINCIPAL MEMBER

Surname

Maiden name (if applicable)

Title | First name/s

Preferred name | Initials

Gender M F | Date of birth d d m m y y y y | ID number

Passport number, if no ID | Nationality

Income Tax Number

Telephone (H) ( ) | Telephone (W) ( )

Cellphone number | Fax ( )

E-mail address

Postal address

Postal code

Physical address

Postal code

Country

Do you want your membership pack and card: Delivered* ☐ Posted ☐ Collected from nearest Medscheme Branch ☐

*Delivery Address during working hours (Monday - Friday 08:00 - 17:00):

Postal code

Have you had previous medical aid cover? Yes No

If yes, please provide details below

Are you changing your medical scheme due to a change in your employment? Yes No

Name of previous medical scheme/s	Membership number	Date joined	Date left

PLEASE x – FOR STATISTICAL PURPOSES ONLY Ethnic group Black Coloured Indian White Asian Marital status Single Married Divorced Widowed Common law partner/ spouse

SECTION 3 INTERMEDIARY / FINANCIAL ADVISER

This section must be signed by the broker/ agent/ adviser if applicable

Broker code | FSB licence number

Name of brokerage

Name of broker/agent/adviser

Telephone (W) | Cellular

Fax

E-mail address

Postal address

Physical address

FINANCIAL ADVISER DECLARATION

1. I hereby acknowledge that I am an accredited Fedhealth Financial Adviser and that I am licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act 37 of 2002.
2. I acknowledge that the applicant has appointed me as his/ her financial adviser and that the applicant is entitled to cancel my services at any time.
3. I confirm that the applicant was provided with my personal details, physical and postal address and telephone number.
4. I acknowledge that a monthly commission of 3% of the total monthly contribution up to a maximum, as legislated from time to time, will be paid to me in terms of the Medical Schemes Act 131 of 1998 (or as amended).
5. I confirm that there has been no material misrepresentation of any fact by me and that in the event of material misconduct or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation or conduct.
6. The applicant is familiar with the information requested in the application form and all the relevant information was provided by the applicant.
7. The applicant is familiar with the information relating to the Protection of Personal Information (POPI) Act as displayed on www.fedhealth.co.za
8. The advice and assistance given to the applicant was impartial and in the best interest of the applicant.
9. The applicant has personally signed the application form.

Broker's/ agent's/ adviser's signature ..... Date d d m m y y y y

SECTION 4 DETAILS OF YOUR SPOUSE / PARTNER YOU WISH TO REGISTER

SPOUSE / PARTNER Surname

Maiden name (if applicable)

Title | First name/s | Preferred name

Cellphone number | E-mail address | Initials

Relationship to principal member | Gender M F

Income Tax Number | ID number

Passport number, if no ID | Nationality

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below*

Name of previous medical scheme/s	Membership number	Date joined	Date left

SECTION 5 DEPENDANTS YOU WISH TO REGISTER

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

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

SECTION 5 DEPENDANTS YOU WISH TO REGISTER (CONTINUED)

	3 Adult ☐ Child* ☐	4 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 dependants over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- For any dependant, other than your biological children, please supply 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.
- For adult dependants, please supply 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

Employee number

Employment date d d m m y y y y

Division code

Dept. name

Persal number *if applicable*

Fedhealth paypoint code

Medical scheme start date 0 1 m m y y y y

We confirm that the applicant is employed by us and commenced employment on the above date

Name of salary administrator

Designation

Monthly salary of myFED applicant

Company stamp

Signature .....

Date signed d d m m y y y y

SECTION 7 BANK DETAILS OF 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. Should the collection date fall on a public holiday, the Scheme reserves the right to collect prior 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 either of the following two dates for debit order collections.

☐ **25th of the month** **OR** ☐ **First working day 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, 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 d d m m y y y y

SECTION 8 MEDICAL DETAILS

This section must be completed. Failure to disclose information is fraudulent and may result in membership not being granted or termination of membership without refund of contributions paid.

Have you or any of your dependants sought any advice, been diagnosed with or been treated for any conditions in the last 12 months? If yes, please provide details. Yes | No

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

Should this space be insufficient, please attach a separate sheet.

If you or any of your dependants are living with HIV/ AIDS, then please call Aid for AIDS on 0860 100 646 to register on the HIV/ AIDS Disease Management Programme within 90 days of membership.

SECTION 9 NOMINATED GP DETAILS

If you have selected flexiFED 1, flexiFED 1Elect, flexiFED 2, flexiFED 2GRID, flexiFED 2Elect, flexiFED 3, flexiFED 3GRID, flexiFED 3Elect, flexiFED 4GRID, flexiFED 4Elect and myFED you are required to nominate a General Practitioner (GP) from the Fedhealth network for yourself and your 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 right hand side of the page. Alternatively you can phone the Customer Contact Centre on 0860 002 153 for more information. You may nominate up to 2 GPs per beneficiary.

	MEMBER / DEPENDANT NAME	NOMINATED GP DETAILS		
		NAME	PRACTICE NUMBER	CONTACT DETAILS
Principal member		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.

SECTION 10 INCOME VERIFICATION FOR THE MYFED OPTION

Please tick appropriate box

Highest income per family per month
☐ R1 – R5 953
☐ R5 954 – R9 732
☐ R9 733 – R12 021
☐ R12 022 – R13 739
☐ R13 740 – >

Income is considered as the highest income earner per household. Income to declare includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employement (this includes self-employment and informal employment), pension and annuity proceed, interest earned on active and passive investments, rental income from leasing properties and distributions recieved from a trust.

Please note:
Should you declare income lower than your actual income, it will be considered fraud and will lead to the immediate cancellation of your membership.

What you are required to do:
Attach all relevant proof of income and other supporting documents requested in each section to avoid any administrative delays.

SECTION 11 THIRD PARTY POWER OF AUTHORITY

Should you want to give permission to a third party to act on your behalf, when you are unable to, please complete a separate Third Party Power of Authority Consent form.

SECTION 12 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 any penalties/ waiting periods that may be applied in accordance with the Act. I understand that these waiting periods may include a 3-month general waiting period, a 12-month waiting period for pre-existing conditions and, if applicable, a late joiner penalty fee.
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. 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 Medical Schemes Act 131 of 1998 (or as amended).
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 dependant's 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.*

Sanlam Reality Access

Fedhealth members receive FREE Sanlam Reality Access membership – a value-added offering that provides you with R3 000 cover for your pets in case of an accident through PetSure, as well as up to R5 million worth of travel insurance through Travel Insurance Consultants (TIC) and up to R5 000 funeral cover. Your Sanlam Reality Access membership is automatically activated and terminated with your Fedhealth membership. For more information about Sanlam Reality Access you can visit fedhealth.co.za/Sanlam-reality-access/

Please note:
- Once your Sanlam Reality Access membership is activated, you will receive monthly communication from Sanlam Reality.
- You can cancel your Sanlam Reality Access membership at any time without any effect on your Fedhealth membership. Simply email info@sanlamreality.co.za
- In order to offer, activate and maintain your Sanlam Reality Access membership, Fedhealth will supply your personal information to Sanlam Reality, but not your healthcare information.

By signing this section, you agree to the declaration above and give Fedhealth your consent to activate your Sanlam Reality Access membership.

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

Signature of principal member ……

Print name …… Identity number

Sanlam Reality Application form
for Fedhealth medical aid members.

Once completed, please submit to Fedhealth.
Please tick all boxes where applicable.

☐ New medical aid member ☐ Current medical aid member

Personal details

Full names: (As per ID) _____
Preferred name: _____
Surname: _____
Identity number: _____
Medical aid number: _____

Sanlam Reality membership

Please select your membership option.

(Refer to our website or call 0860 732 5489 for more information.)

Membership option	Single option	Family option
Reality Health	R195 pm ☐	R250 pm ☐

Note: By selecting the family option we will automatically add your dependants as per your medical aid.

Sanlam Reality communication options

I prefer to receive communication via the following channels:

Email ☐ SMS ☐ Phone ☐

I would like to receive information about discounts and special offers available only to members:

Yes ☐ No ☐

Permission to use medical aid information

Sanlam Reality will keep your personal and/or health information, as well as the information of your spouse and dependant/s, confidential. However, by signing this form, you agree to the disclosing and use of disclosed information. You hereby consent that your personal and financial information pertaining to products you have with the Sanlam Group, its strategic partners and membership of Sanlam Reality be shared between the aforementioned entities, directly or through a secure database in order to make certain that your information is accurate for the purpose of improving the Sanlam Reality service to its members. Your personal information shall be shared in accordance with prevailing data privacy legislation and it will not be disclosed to any unauthorised parties. We may collect, process, store, and share all confidential information, as contained in this application and provided to us after the inception of your Sanlam Reality membership, to:

- Administer the Sanlam Reality programme.
- Health data may be shared/utilised in order to qualify for specific benefits.
- Provide any services that you or your spouse or dependant/s may require.
- Enable any contracted third party that requires such information to render a service or provide goods to you or your spouse or any dependant/s on your Sanlam Reality membership, but only if such contracted third party agrees to keep the information confidential.
- Enable any other entity within the Sanlam Group, where you or your spouse or your dependant/s have applied for a product, to administer the product.

☐ I hereby agree and give permission.

Broker details

Complete this section if an intermediary introduced you to Sanlam Reality.

Surname: _____
First name: _____
Intermediary code: _____
Contact number: _____

Debit order authorisation

☐ I hereby authorise that Sanlam Reality can use the banking details provided for my medical aid claims refunds.

OR

☐ Sanlam Reality may create a debit order instruction based on the information indicated below for the specific amount which will be deducted on the first of every month unless otherwise requested. I undertake to inform Sanlam Reality of any changes to my bank details and authorise Sanlam Reality to verify such details. (Total 'SL' Debit or Real Futures Pty Ltd will reflect on your bank statement for this deduction.)

Debit order information:

Account name: _____
Bank: _____
Bank code: _____
Account number: _____
Account type:

Savings ☐ Transmission ☐ Cheque ☐

Signature:

I hereby confirm that the above information is true and correct. I agree that by joining the Sanlam Reality programme I am bound by Sanlam Reality's rules as set out by the programme. For full T&Cs, visit **www.sanlamreality.co.za**.

Signed: _____

at _____ on _____

Print name: _____

Print name: _____