

# fedhealth member

## RECORD AMENDMENT FORM



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

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

- Change of address / contact details**  **Change of bank details**  **Change of marital status**  
Sections 1, 2, 8 and 9 must be completed Sections 1, 3, 8 and 9 must be completed Sections 1, 4, 8 and 9 must be completed
- Termination of dependant membership**  **Registration of:** • **Births and adoptions** • **Additional adult and child dependants**  
Sections 1, 5, 8 and 9 must be completed Sections 1, 6, 7, 8 and 9 must be completed
- Change of MediVault bank details**  
Sections 1, 3, 8 and 9 must be completed

**SECTION 1 DETAILS OF PRINCIPAL MEMBER**

First name/s		Initials	
Surname	Preferred name		
Membership no.			
ID number	Passport number, if no ID		
Nationality	Country of issue of Passport		
Income Tax Number			

**SECTION 2 CHANGE OF ADDRESS / CONTACT DETAILS**

Telephone (H)		Telephone (W)	
Cellular		Fax	
E-mail address			
Postal address			Postal code
Physical address			Postal code

**SECTION 3 BANK DETAILS OF PRINCIPAL MEMBER** *Refund of claims and debit order instruction*

I hereby instruct Fedhealth to electronically collect contributions and MediVault instalments as a single debit order and to deposit refunds, using the information provided below (Direct Paying Members only). Should the collection date fall on a public holiday, the Scheme reserves the right to collect prior to 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 from the following dates for debit order collections:

**1st of the month**     **5th of the month**    **OR**     **25th 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. The debit order collection description will have the following prefix before your membership number for **current** contribution collections: FDHSUBS, for **arrear** contribution collections: FDHARR and a MediVault instalment collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT any arrear collection will include ARR with previous abbreviates.

<input type="checkbox"/> 1. USE THIS ACCOUNT FOR ALL TRANSACTIONS INCLUDING MEDIVault REPAYMENTS <input type="checkbox"/> 2. USE THIS ACCOUNT FOR ALL COLLECTIONS ONLY <b>NB. If you tick this option, then you must complete bank details for claims refunds on the right.</b>	<input type="checkbox"/> USE THIS ACCOUNT FOR REFUNDS ONLY <b>NB: If you ticked no. 2 on the left then bank details must be completed here.</b> <input type="checkbox"/> USE THIS ACCOUNT FOR MEDIVault DEDUCTIONS ONLY
Bank name: <input style="width: 90%;" type="text"/> Branch name: <input style="width: 90%;" type="text"/> Bank branch code: <input style="width: 90%;" type="text"/> Type of account: <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/> Savings Name of account holder: <input style="width: 90%;" type="text"/> Bank account number: <input style="width: 90%;" type="text"/>	Bank name: <input style="width: 90%;" type="text"/> Branch name: <input style="width: 90%;" type="text"/> Bank branch code: <input style="width: 90%;" type="text"/> Type of account: <input type="checkbox"/> Cheque <input type="checkbox"/> Transmission <input type="checkbox"/> Savings Name of account holder: <input style="width: 90%;" type="text"/> Bank account number: <input style="width: 90%;" type="text"/>

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

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

**SECTION 3 BANK DETAILS OF PRINCIPAL MEMBER** *Continued*

*Refund of claims and debit order instruction*

**3rd Party Payor**

Should a third party pay the contribution and/or MediVault instalment on your behalf, the following supporting documents are required, certified by a commissioner of oaths and not older than three months:

- Account holder's identity document
- 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.

**3rd Party Details**

Surname

Title  First name/s

Physical address

Relationship to principal member  Nationality

ID number  Passport number, if no ID

Country of issue

Income Tax Number  Company registration number

**SECTION 4 CHANGE OF MARITAL STATUS**

Marital status:  Single  Married  Divorced  Widowed  Common law partner/ spouse  Date of marriage :  d  d  m  m  y  y  y  y

Surname:

**myFED members:**

Please note that if you 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 reflected on your membership card	Date of birth	Deletion date (last day of the month)
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Reason for termination

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

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\*

Title  Initials  First name/s

Preferred name

Surname

Relationship to principal member

ID number  Date of birth  d  d  m  m  y  y  y  y

If none, passport number,  Nationality

Country of issue of passport  Income Tax Number

Cell  E-mail address

If adult, is the dependant financially dependent on the principal member?  Yes  No

Does the dependant receive an income, e.g. pension, salary?  Yes  No If yes, what is the monthly income?  R

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

Name of previous medical scheme	Membership number	Date joined	Date left
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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  Yes  No

## SECTION 6

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

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NOMINATED GP (GENERAL PRACTITIONER) DETAILS		
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.

**2** Adult  Child\*

Title  Initials  First name/s

Preferred name

Surname  Gender

Relationship to principal member

ID number  Date of birth

If none, passport number,  Nationality

Country of issue of passport  Income Tax Number

Cell  E-mail address

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

Does the dependant receive an income, e.g. pension, salary?   If yes, what is the monthly income?

Has this dependant had previous medical aid cover?   If yes, please provide details below.

Name of previous medical scheme	Membership number	Date joined	Date left

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

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- Adult dependants: an affidavit confirming residency, marital status, employment status and income.

**3** Adult  Child\*

Title  Initials  First name/s

Preferred name

Surname  Gender

Relationship to principal member

ID number  Date of birth



