fedhealth member

RECORD AMENDMENT FORM

FEDHEALTH

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

☐ **Change of address / contact details**
Sections 1, 2, 8 and 9 must be completed

☐ **Change of bank details**
Sections 1, 3, 8 and 9 must be completed

☐ **Change of marital status**
Sections 1, 4, 8 and 9 must be completed

☐ **Termination of dependant membership**
Sections 1, 5 8 and 9 must be completed

☐ **Registration of:** • **Births and adoptions** • **Additional adult and child dependants**
Sections 1, 6, 7, 8 and 9 must be completed

SECTION 1 : DETAILS OF PRINCIPAL MEMBER

First name/s		Initials	
Surname		Preferred name	
Membership no.			

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 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.

☐ **25th of the month OR** ☐ **First working day of the following 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 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 :

Blue Door Plus 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)
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y

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 | Gender M F

ID/ passport/ birth certificate number | Date of birth d d m m y y y y

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

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? Yes No

Maxima Basis, Maxima Basis[Grid], Maxima Saver, Maxima Saver[Grid], Maxima EntrySaver and Blue Door Plus members are required to nominate a FP (Family Practitioner) from the Fedhealth network for themselves and their dependants. Please note that only visits to a nominated FP will be covered on these options. For a list of FPs on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the FP locator button on the page. For a list of FPs on the Blue Door Plus FP network, please contact the Customer Contact Centre on 0860 002 153.

NOMINATED FP (FAMILY PRACTITIONER) DETAILS		
Name	Practice number	Contact details

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

2 Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname

Relationship to principal member | Gender M F

ID/ passport/ birth certificate number | Date of birth d d m m y y y y

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

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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

Relationship to principal member | Gender M F

ID/ passport/ birth certificate number | Date of birth d d m m y y y y

Cell | E-mail address

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

SECTION 7 : MEDICAL DETAILS

It is compulsory to answer each question. Failure to disclose information is fraudulent and may result in membership not being granted, or termination of membership without refund of contributions paid.

HAVE ANY OF THE DEPENDANTS INDICATED IN SECTION 6 SOUGHT ANY ADVICE, BEEN DIAGNOSED WITH, OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS IN THE PAST 12 MONTHS?

1. A chronic illness? (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and/ or thyroid disorders). If yes, please provide details. Yes / No

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

2. Gastro intestinal disorder? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/ or a spastic colon). If yes, please provide details. Yes / No

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

3. Muscle, bone, skin or nerve illnesses or disorders? (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc). If yes, please provide details. Yes / No

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

4. Urinary or genital disorders? (e.g. kidney stones, prostates, endometriosis, ovarian cysts, menstrual disorders). If yes, please provide details. Yes / No

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

5. Ear, nose or throat disorders? (e.g. Glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics). If yes, please provide details. Yes / No

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

6. Blood disorders, immune deficiency state, HIV/AIDS, cancer etc? If yes, please provide details. Yes / No

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

7. Are you or any of your dependants pregnant? If yes, please provide details. Yes / No

Name of beneficiary	Expected delivery date	Attending doctor

8. Are there any other conditions or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months? If yes, please provide details. Yes / No

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

SECTION 8 : 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 9 : DECLARATION BY PRINCIPAL MEMBER *This section must be completed*

I declare that to the best of my knowledge the information provided above is true and correct. 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 essentail 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.

Signature of principal member: ..... Date : d d m m y y y y