

CHANGES IN MEMBERSHIP STATUS

Membership number		Date	Y	Y	Y	Y	M	M	D	D
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DETAILS OF THE PRINCIPAL MEMBER Race - A = African/Black, I = Indian/Asian W = White C = Coloured

Dr		Ref		Mr		Mrs		Miss		
Surname										
Full Names										
Member's date of birth	Y	Y	Y	Y	M	M	D	D	Race	
ID number										
Residential address										
									Code	
Postal address										
									Code	
Telephone number (H)										
Telephone number (W)										
Cellphone number										
Email address										
Name of employer					Employee number					
HR Department contact person					Telephone number					

ONLY COMPLETE THE SECTION(S) RELATING TO THE MEMBER OR APPLICANT

REGISTRATION AS DEPENDANT Race - A = African/Black, I = Indian/Asian W = White C = Coloured

Births

Full Names		Surname										
Date of birth	Y	Y	Y	Y	M	M	D	D	Gender		Race	
ID number												
Date of registration as dependant	Y	Y	Y	Y	M	M	D	D	(Please attach a copy of Birth Certificate)			

CHANGES IN MEMBERSHIP STATUS

MEMBERSHIP NUMBER

Marriage

Date of marriage	Date	Y	Y	Y	Y	M	M	D	D
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(Please note that a spouse must be registered from month of marriage, within 30 days, to enjoy full benefits)

(Please attach the following documents: **i**) Copy of the marriage certificate **ii**) Certificate of membership of previous medical scheme)

NOT APPLICABLE ON CORPORATE GROUPS

Surname													
Full Names													
Date of birth	Y	Y	Y	Y	M	M	D	D	Gender		Race		
ID number													
Date of registration as dependant	Y	Y	Y	Y	M	M	D	D					

Child dependant - until age of 21 years

Surname													
Full Names													
Date of birth	Y	Y	Y	Y	M	M	D	D	Gender		Race		
ID number													
Date of registration as dependant	Y	Y	Y	Y	M	M	D	D	(Please attach a copy of Birth Certificate)				
Relationship to principal member													

Adult dependant - 21 years and older

Surname													
Full Names													
Date of birth	Y	Y	Y	Y	M	M	D	D	Gender		Race		
ID number													
Date of registration as dependant	Y	Y	Y	Y	M	M	D	D	(Please attach a copy of ID document)				
Relationship to principal member													
Dependant's membership from previous medical aid, if any													

MEDICAL QUESTIONNAIRE

Complete the following by ticking YES (Y) or NO (N)

Full Names					Surname								
Date of birth	Y	Y	Y	Y	M	M	D	D	Gender				
ID number													
Date of registration as dependant	Y	Y	Y	Y	M	M	D	D	(Please attach a copy of Birth Certificate)				
1. Heart and circulation. Includes high blood pressure, heart valve problems, blocked blood vessel, stroke, blood clots, rheumatic fever, varicose veins, heart rhythm problems, ischemic heart disease, etc.	Y	N											
2. COPD / Chronic bronchitis / Emphysema. Includes asthma, recurrent infections such as bronchitis and pneumonia, sinus problems, emphysema, tuberculosis, disease that makes breathing difficult, tonsillitis, adenoid problems, snoring and sleep apnoea, etc. If any beneficiaries smoke, this must be indicated.	Y	N											
3. Cancer. Includes all types of cancer and their treatments.	Y	N											
4. HIV/Immune deficiencies. include all immune deficiencies, cancer-related immune suppression, use of drugs that lowers the immune systems capabilities such as chemotherapy, continuous use of cortisone, HIV, AIDS, etc.	Y	N											
5. Pregnancy. Includes if you are currently pregnant or suspect that you are pregnant, previous pregnancy-related problems such as high blood pressure, miscarriage, caesarean section, etc.	Y	N											
6. Other. Includes any serious medical condition that needed treatment in the 12 months. Rather list problems that you think are irrelevant than not to mention them.	Y	N											

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Please elaborate on the questions answered "YES" above and mention for whom it is

PREVIOUS MEMBER STATUS

Note: This section is not applicable on corporate group members

IMPORTANT: If the applicant is currently a member / dependant of a medical scheme or was a member / dependant of a medical scheme for the past two years, please furnish a **CERTIFICATE OF MEMBERSHIP** together with the application form (not a member card)

Is or the applicant a Member / Dependant of a medical scheme
If "YES" please state

Y N

SCHEME'S PARTICULARS		STATUS		PERIOD	
Name of scheme	Member number	Member	Dependant	From	To

Is or was the applicant subject to any restriction / exclusions on another medical scheme?

Y N

If "YES" please state the names of the principal member / dependant in question and the nature of the restriction / exclusions

CANCELLATION OF DEPENDANT 1 Race - A = African/Black, I = Indian/Asian W = White C = Coloured

Surname												
Full Names												
Date of birth	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> D	Gender	<input type="checkbox"/>	Race	<input type="checkbox"/>
ID number	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of deletion	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> D				
Reason												

CANCELLATION OF DEPENDANT 2 Race - A = African/Black, I = Indian/Asian W = White C = Coloured

Surname												
Full Names												
Date of birth	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> D	Gender	<input type="checkbox"/>	Race	<input type="checkbox"/>
ID number	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of deletion	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> D				
Reason												

CHANGES IN MEMBERSHIP STATUS

MEMBERSHIP NUMBER

RETIREMENT / EARLY RETIREMENT / RETIREMENT DUE TO INDISPOSITION / DISABILITY

Date of retirement / disability

Reason for retirement / disability as set out in the heading

Effective date of retirement on membership

Does the retiree want to retain his / her membership with the scheme after retirement? Y N

If "YES", please supply us with banking details

Bank

Branch Code Branch

Account number

Name of account holder

Type of account (e.g. current, savings)

DEATH OF MEMBER

Date of birth Y Y Y Y M M D D

Employer, if applicable, of surviving spouse

ID number of surviving spouse

(Please attach hereto a copy of the death certificate and a copy of the surviving spouse's ID document)

Does surviving spouse retain his / her membership of the scheme Y N

If "YES" please supply us with banking details

Bank

Branch Code Branch

Account number

Name of account holder

Type of account (e.g. current, savings)

REMARKS / ADDITIONAL INFORMATION

Member Signature

Date Y Y Y Y M M D D

Namestamp of employer

Human Resource Manager / Practitioner Signature

Date Y Y Y Y M M D D