MEDSHIELD medical scheme

BROKER APPOINTMENT FORM FOR MEMBERS/EMPLOYERS

1. Amendments are subject to the rules of Medshield Medical Scheme and the Council for Medical Schemes.
2. For employers, please attach an original letter on a company letterhead signed by the duly authorised person. i.e. Chief Executive Officer, Chief Financial Officer, Chief Operations Officer or the Director of Human Resources.
3. A transfer of a member's request by a broker must be on a company letterhead and signed by both parties who are the key individuals.
4. For members, please attach a copy of the identity document.
5. Please email or fax completed form to commissions@medshield.co.za or 010 597 4709.
6. This form is valid for three months from the date of signature.

SECTION A NEW BROKER DETAILS

Broker Name:	Broker Code:
Email Address:	Contact Number:
Region:	

SECTION B TO BE COMPLETED BY THE PRINCIPAL MEMBER

Membership Number:

Member ID Number:

Member Name/s:

Member Surname:

Employee Number:
(where applicable)

Contact Number: C O D E

Email Address:

Physical Address:

Member's reason for change in broker: _____

SECTION C EMPLOYER DETAILS (For employer appointments only)

Employer Name:

Employer Code:

Contact Person Name:

Contact Number: C O D E

Employer's reason for change in broker: _____

SECTION D

FINANCIAL ADVISER/BROKER/EMPLOYER REPRESENTATIVE CONSENT
(To allow disclosure of information to a third party)

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words.
Mark with a tick where required. All sections must be completed.

ABOUT THE INFORMATION WE PROVIDE TO THE THIRD PARTY (Broker/Financial Advisor/Employer Representative)

This section needs to be completed if you want to nominate someone to manage your medical aid membership on your behalf. For instance your financial adviser/broker or a family member or a friend who you trust to administer your membership. We call this giving a Third Party Consent by nominating them on this form, which provides us with your approval that the Scheme may share specific personal information and/or discuss your membership with the specific Third Party you nominated below.

Additonally, please specify what type of information may be accessed by your financial adviser, employer representative and/or nominated Third Party, and for how long (if no date is specified, the consent will be in effect from the signature date until you revoke the consent in writing).

FINANCIAL ADVISER/BROKER

Your Financial Adviser/Broker ☐

Broker code:

Financial Adviser/Brokerage Name:

Financial Adviser Email address:

Financial Adviser Telephone Number (W):

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my Financial Adviser/Broker as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

EMPLOYER REPRESENTATIVE (If applicable)

Your employer representative (if you form part of a group membership by virtue of employment) ☐

Company Name:

Employer Representative Name and Surname:

Employer Representative Email address:

Employer Representative Telephone Number (W):

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my employer representative as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

SECTION D AUTHORISATION

I hereby acknowledge the appointment of the above broker.

Name of Principal Member/Authorised Person:

Signature of Principal Member/Authorised person: _____ Date: D D M M Y Y Y Y

Name of Broker:

Signature of Broker: _____ Date: D D M M Y Y Y Y