MEDSHIELD
medical scheme

EXISTING BENEFICIARY TRANSFER (To another Membership)

Email: membership@medshield.co.za

This form needs to be completed if existing Medshield beneficiaries (immediate family) needs to be transferred to your membership. There can be no break in membership upon a transfer between the two (2) memberships.

For special dependants (grandchild, niece, nephew, sibling, parent etc.), you need to complete a member record amendment/dependant registration form. Special dependants are subject to Scheme approval.

Please complete in black ink. All sections to be completed in full. Print clearly using capital letters. Only one character per block.
Leave one block between words.

Transfer **FROM** Membership number:	
Transfer **TO** Membership number:	

DOCUMENT CHECKLIST

In order to avoid rejection of your transfer application, please provide one of the following documents:	Please Tick
Signed termination letter from the current Principal Member	
Death certificate of current Principal Member (Applicable if surviving dependants are transferred to their parent(s) active Medshield Membership)	
Marriage certificate for transfer of spouse	

SECTION A TO BE COMPLETED BY THE PRINCIPAL MEMBER (Transfer to)

Initials:	
Surname:	
Membership Number:	
ID/Passport Number:	
Date of Birth:	

SECTION B DETAILS OF BENEFICIARIES TO BE TRANSFERRED

Dependant 1

Initials:	
Surname:	
Relationship to Principal Member:	
Membership Number:	
ID/Passport Number:	
Dependant Email Address:	
Dependant Cell Number:	
Date of Birth:	

Dependant 2

Initials:

Surname:

Relationship to Principal Member:

Membership Number:

ID/Passport Number:

Dependant Email Address:

Dependant Cell Number:

Date of Birth:

Dependant 3

Initials:

Surname:

Relationship to Principal Member:

Membership Number:

ID/Passport Number:

Dependant Email Address:

Dependant Cell Number:

Date of Birth:

SECTION C

FAMILY PRACTITIONER (FP) NOMINATION – MediPhila, MediCurve, MediValue Compact and MediPlus Compact

If you have selected MediPhila, MediCurve or one of the Compact options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP). If you do not nominate a FP as per the criteria listed per option below, your application form will not be processed by the Scheme.

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediCurve: Each beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

MediValue Compact and MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where a FP was nominated from the FP Network & Day-to-Day benefit is depleted the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION D EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date:

COMPANY STAMP

Tick this box if no Company Stamp is available ☐

By selecting this box you confirm that the Employer has granted approval ☐

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section D have been completed:

Employer's Email Address:

Employer's Representative's Name:

Employer's Representative's Designation:

Date:

Employer's Representative's Signature: _____

SECTION E — CONSENT (Consent for Medshield Medical Scheme to process personal information)

The Scheme understands that your personal information and that of your dependants is important to you. Medshield undertakes to keep this information confidential and shall take all reasonable steps to comply with the provisions of legislation protecting your personal information.
We require your consent to obtain, process and disseminate your personal information so we can provide you with the services stipulated in our contractual agreement, as detailed for your chosen benefit option and in compliance with the Medical Schemes Act 131/1998. These services include but is not limited to:

a. Treatment Authorisations;
b. Claims Assessment;
c. Claims Payment;
d. Communication;
e. Disease Management; and
f. Wellness Initiatives.

While your consent is voluntary, it is a requirement for the administration of your Medshield membership. **If you object to the processing of your personal information, the Scheme will not be able to activate and service your membership.**

I, the Principal Member, _____ (Name & Surname),

ID number _____, do hereby:

Please read the items of consent below carefully. All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

☐ Give permission, with the consent of my dependants, that Medshield Medical Scheme may collect, process, store and share our personal information, including health information with the Scheme's contracted service providers to perform their functions for the administration and/or managed care of my membership which include the assessment and processing of my application, eligibility, underwriting, risk assessment, assessment and payment of claims, the provision of managed healthcare services, assessments of non-disclosures, validation and allocation of benefits, reporting to statutory bodies, fraud prevention and detection, member surveys and communication, collection and refund of contributions, members portions and savings and credit reporting.

☐ Authorise Medshield Medical Scheme to obtain from any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my or any of my dependants' health, whether such information relates to the past or future, to disclose such information to the Scheme and it's contracted third parties and agree that this request shall remain in force after my / their death, as well as prior thereto.

☐ Confirm that I am duly authorised to apply for membership and to act for those for whom I am applying for under the age of 18 in any matter relating to this application and the administration of our Medshield membership.

☐ I hereby acknowledge and declare that as the Principal Member of the Scheme, to the extent that it may be required by law, that I have received the necessary consent from my dependant(s) over the age of 18 to act on their behalf in any matter relating to this application and the administration of our Medshield Membership and to access and view their healthcare claims.

☐ Consent that all conversations between me, or any of my dependant(s), and the Scheme or its contracted service providers may be recorded.

☐ Acknowledge that my and my dependants' personal information, shall be retained as part of the records of the Scheme for as long as it is required by the Scheme for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of the applicable law. Medshield Medical Scheme are required to collect and keep personal information in terms of the allowable statutory limits.

☐ Confirm that if I (Principal Member) am part of a group membership by virtue of employment, I grant permission to Medshield Medical Scheme to share information relating to my membership with my employer. This will be limited to information that is relevant to my application, collection of contributions and information that is required for the ongoing servicing of my membership, but will not include any health information unless I have given Medshield permission to do so.

☐ Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Planner, if any, who is an accredited Medical Aid Broker of my choice.

☐ Consent to receive Scheme communication as it pertains to my membership and any information from the Scheme which could enhance my benefits, health and the management of my health.

☐ I have the right to request my personal information and that of my dependant(s), which is in the possession of Medshield Medical Scheme, provided that I furnish adequate identification and written consent from my dependant(s) over the age of 18.

☐ I have the right to request Medshield Medical Scheme where necessary, to correct, or delete my, or any of my dependant(s), personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.

☐ I shall inform the Scheme of any changes relating to my or any of my dependant(s) personal information within 30 days of the change, as required by the Scheme rules, as it may impact the administration of my membership and communication from the Scheme.

☐ I agree that should I have a complaint relating to the processing of my and my dependant(s) personal information, I will refer it to the Scheme to resolve. If I am not satisfied with the outcome of the complaint, I may refer the complaint to the Information Regulator.

Principal Member Signature: _____ Date: _____

SECTION F MEMBER DECLARATION

I, _____ (Principal member's full name) the undersigned, declare that: I understand that Medshield will rely upon the facts set out herein for the accurate loading of details. I understand and accept that should any details contained herein prove to be incorrect, or should I fail to inform Medshield of any subsequent change to the details, Medshield will not be held responsible.

Principal Member Signature: _____ Date: _____