

## MEMBER RECORD AMENDMENT/DEPENDANT REGISTRATION

**Email: [membership@medshield.co.za](mailto:membership@medshield.co.za)**

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary.

This form needs to be submitted to the Scheme within 14 days of the member declaration sign date in order to avoid your application being rejected due to it being stale.

This form needs to be submitted to the Scheme by the 14<sup>th</sup> of the month for a join date of the following month.

SPECIAL DEPENDANTS ARE SUBJECT TO SCHEME APPROVAL.

## SECTION A

## DOCUMENT CHECKLIST

In order to avoid rejection of your application please provide the following documents:	Please Tick
ID copy(ies) for dependants (e.g. ID/birth certificate/passport)	
Student certificate (child dependant age 21-27 that is studying or turning 21 in the next 3 months)	
Proof of income for dependants 21 and older that's not studying	
Certified affidavits for special dependant: - Certified affidavit from Principal Member stating that dependant resides with member and is financially on him/her. - Certified affidavit from dependant's parents providing reasons and permission for dependant to be added to the Principal Member's membership	
Proof of previous medical scheme for dependant (certificate of membership reflecting an end date)	
Legal custody documents	
Marriage certificate for the registration of spouse	

## SECTION B

**DETAILS OF PRINCIPAL MEMBER** (must be completed)[illegible]

### CHANGE OF ADDRESS/CONTACT DETAILS (In the event that your details have changed, please complete the below)

[illegible]

Telephone Number (W):

C	O	D	E								
C	O	D	E								

Telephone Number (H):

Cell Number:

**SECTION C****REGISTRATION OF DEPENDANTS**

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary. All section must be completed.

**DEPENDANT 1**

Life Partner / Spouse	Aged Parent	Sibling	Grandchild	Over Aged Child
Late Registration of Own Child	New Born/Foster or Adopted	Other (please specify):		

Title:

Initials:

First Name/s:

Surname:

Maiden Surname:

ID/Passport Number:

Date of Birth:

Dependant Email Address:

Dependant Telephone Number (W):

Dependant Telephone Number (H):

Dependant Cell Number:

Gender: (Mark with an X)

M

F

Marital Status:

Single

Married

Divorced

Widowed

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:

African

Caucasian/  
White

Coloured

Indian

Asian

Other

I do not wish to disclose:

**DEPENDANT 2**

Life Partner / Spouse	Aged Parent	Sibling	Grandchild	Over Aged Child
Late Registration of Own Child	New Born/Foster or Adopted	Other (please specify):		

Title:

Initials:

First Name/s:

Surname:

Maiden Surname:

ID/Passport Number:

Date of Birth:

Dependant Email Address:

Dependant Telephone Number (W):

Dependant Telephone Number (H):	C	O	D	E															
Dependant Cell Number:																			
Gender: (Mark with an X)	M	F	Marital Status:				Single	Married	Divorced	Widowed									

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/White	Coloured	Indian	Asian	Other
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I do not wish to disclose: ☐

### DEPENDANT 3

Life Partner / Spouse	Aged Parent	Sibling	Grandchild	Over Aged Child
Late Registration of Own Child	New Born/Foster or Adopted	Other (please specify):		

Title:					Initials:														
First Name/s:																			
Surname:																			
Maiden Surname:																			
ID/Passport Number:																			
Date of Birth:	D	D	M	M	Y	Y	Y	Y											
Dependant Email Address:																			
Dependant Telephone Number (W):	C	O	D	E															
Dependant Telephone Number (H):	C	O	D	E															
Dependant Cell Number:																			
Gender: (Mark with an X)	M	F	Marital Status:				Single	Married	Divorced	Widowed									

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/White	Coloured	Indian	Asian	Other
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I do not wish to disclose: ☐

If student dependant is over the age of 20, student proof in the form of a stamped or signed letter, on a letterhead from the accredited institution for tertiary education for the current year must accompany this form.

In the event that you are requesting the Scheme to add a special dependant (e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions – mark the appropriate block with an “x”

Acceptance of special dependants will be in accordance with the Rules of the Scheme.

1. Does the dependant receive a monthly income?	Y	N																	
Name of Employer:																			
Pension (old age, military, disability):																			
Pension (other including annuity):																			

If yes, complete the following:

Monthly Salary:	R																		
	R																		
	R																		
Total Salary:	R																		

2. Is the dependant entirely reliant on you for maintenance and support?

Y	N
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Name of Employer: \_\_\_\_\_

3. Does the dependant live with you?

Y	N
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Give reasons and attach certified affidavit: \_\_\_\_\_

## SECTION D

## PREVIOUS MEDICAL AID HISTORY

Where applicable, please provide details and proof of all previous registered South African medical schemes, which your dependants (for whom you are applying for) belonged to (proof in the form of membership certificates reflecting the join and end dates, must be attached to this application form). This information is used to determine whether waiting periods and or late joiner penalties are applicable.

Where late joiner penalties has already been imposed and evidence of credible cover is produced thereafter, the penalty shall be recalculated and such revised penalty shall be applied from the following month. No backdate will be allowed unless evidence of previous submission is provided to the Scheme.

Select relevant box with a tick:

Dependant Name & Surname:

Name of Scheme:

Membership Number:

Date Joined:

D	D	M	M	Y	Y	Y	Y					D	D	M	M	Y	Y	Y	Y

Date Terminated:

Dependant Name & Surname:

Name of Scheme:

Membership Number:

Date Joined:

D	D	M	M	Y	Y	Y	Y					D	D	M	M	Y	Y	Y	Y

Date Terminated:

Dependant Name & Surname:

Name of Scheme:

Membership Number:

Date Joined:

D	D	M	M	Y	Y	Y	Y					D	D	M	M	Y	Y	Y	Y

Date Terminated:

Dependant Name & Surname:

Name of Scheme:

Membership Number:

Date Joined:

D	D	M	M	Y	Y	Y	Y					D	D	M	M	Y	Y	Y	Y

Date Terminated:

Dependant Name & Surname:

Name of Scheme:

Membership Number:

Date Joined:

D	D	M	M	Y	Y	Y	Y					D	D	M	M	Y	Y	Y	Y

Date Terminated:

## SECTION E

### 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](http://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
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 F

## MEDICAL HISTORY (yes or no)

To be completed for each dependant that you are applying for in respect of himself/herself. All questions must be answered with a "Yes" or "No".

All conditions, symptoms and or disorders have to be declared, no matter how insignificant they may seem. Incomplete, inaccurate information or information that is withheld may result in the termination of your membership effective from date of registration.

If additional space is required, please complete a separate sheet of paper and attach it to the application.

1. Has any of your dependants, for whom you are applying for sought advice, been diagnosed or treated for any condition within the past 12 months?

Y	N
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Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

Any additional information:

2. Does any of your dependants for whom you are applying for take chronic medication or are you expecting them to take medication on an ongoing basis?

Y	N
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Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

**A SEPERATE CHRONIC MEDICINE APPLICATION NEEDS TO BE COMPLETED, ONCE YOUR MEMBERSHIP IS ACTIVATED.**  
Your doctor or pharmacist can contact Chronic Medicine Management on 086 000 2120 to telephonically register you for chronic medication.

Any additional information:

3. Has any of your dependants, for whom you are applying for been admitted to hospital or undergone any procedure (other than routine medical or dental treatment) in the past 12 months?

Y	N
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Name of Beneficiary	Medical Condition	Date Diagnosed	Currently on Treatment		Date of Last Treatment	Attending Doctor
			Y	N		
			Y	N		
			Y	N		

Any additional 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 its 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:

D	D	M	M	Y	Y	Y	Y
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All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

Please read the declarations below carefully.

1. ☐ I the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree that my dependants and I shall abide by its Rules as amended from time to time which are available on Medshield's website [www.medshield.co.za](http://www.medshield.co.za)

2. ☐ I understand that the Scheme's brochures are a summarised version and do not supersede the rules of the Scheme.

3. ☐ I acknowledge that I have familiarised myself with the benefits covered on my benefit option of choice and that I may only change my benefit option during year-end for an effective date of 01 January.

4. ☐ I am aware of the fact that on joining the Scheme during the course of a calendar year, the maximum benefits to which I may be entitled shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular calendar year

5. ☐ I certify that all the information given is true and correct, whether completed by me or on my behalf, and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void, effective from date of registration. In such event, the Scheme will have the right to offset applicable costs against contributions paid and refund the difference, if any.

6. ☐ I understand that should a period greater than three (3-month) lapse since contributions were paid to Medshield, that my membership will not be reinstated and that I have to re-apply subject to full underwriting.

7. ☐ I undertake to give notice to the Scheme to terminate my membership in accordance with the Rules of the Scheme.

8. ☐ Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

If applicable:

9. ☐ I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

If applicable:

10. ☐ As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

11. ☐ Notwithstanding point 9 and 10, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

If applicable:

12. ☐ As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

13. ☐ I hereby authorise the Scheme, or any of its nominated representatives, to verify my bank details.

14. ☐ I acknowledge and agree that it's my responsibility to advise the Scheme in writing of any change in banking details. The Scheme will not be liable should an incorrect account be credited under any circumstances

15. ☐ The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi or by any agreed electronic means unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi or by any agreed electronic means shall be deemed to have been received by me on the 7th day after the date of posting.

16. ☐ I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:

- a 3 (three) month general waiting period in respect of all benefits;
- a maximum 12 (twelve) month exclusion in respect of a pre-existing condition;
- a late joiner contribution penalty.

17. ☐ I agree to inform the Scheme of any deterioration or change in my state of health or in that of my dependant(s) before the commencement date of membership, or the date of acceptance of this application form by the Scheme, or the date of receipt of the first subscription, whichever date is the latest shall entitle Medshield to reconsider the application and propose new terms of admission.

18. ☐ It is illegal to be a member of more than one medical scheme at the same time. I acknowledge that it is my responsibility to resign from my existing medical scheme and agree that neither me, nor any of my dependants, will be registered on both Medshield and another medical scheme simultaneously.

19. ☐ I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: \_\_\_\_\_

Date:

D	D	M	M	Y	Y	Y	Y
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Principal Member Signature: \_\_\_\_\_

NB: Medshield Medical Scheme requires that your application form be submitted to the Scheme within 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.