MEDSHIELD
medical scheme

MEMBER RECORD AMENDMENT/DEPENDANT REGISTRATION

Email: 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 30 calendar 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 14th 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 all beneficiaries (e.g. ID/birth certificate/passport)	☐
Student(s)-(child dependant age 21-27 that is studying or turning 21 in the next 3 months): Proof of registration at a recognised tertiary institution	☐
Additional documents for Special Dependants (foster/adopted children, niece, nephew, sibling, grandchild): **Adopted/Foster Child:** • Legal documentation of adoption or foster arrangement	☐
A parent or grandparent of the Principal Member: • Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent • Proof of income such as payslip, bank statement, or proof of pension	☐ ☐
A grandchild, niece, nephew or sibling: • Certified affidavit from Principal Member and parent(s) confirming residency, employment, and income of child and both parents • Proof of income if dependant is employed	☐ ☐
Proof of previous medical scheme for dependant (certificate of membership reflecting an end date)	☐
Marriage certificate for the registration of spouse	☐
ID copy(ies) of the nominated 3rd Party(ies) Consent (to whom we may provide specified information)	☐

SECTION B DETAILS OF PRINCIPAL MEMBER (must be completed)

Membership Number:	
Initials & Surname:	
ID/Passport Number:	
Contact Telephone Number:	

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

Postal Address:	
Postal Code:	
Residential Address:	

Please provide at least one email address

Personal Email Address:	
Business Email Address:	
Telephone Number (W):	
Telephone Number (H):	
Cell Number:	

SECTION C REGISTRATION OF DEPENDANTS

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.

For special dependants (e.g. parents, foster/adopted children, niece, nephew, grandchild, parents) please attach the following:

Adopted/Foster Child:
- Legal documentation of adoption or foster arrangement.

A parent or grandparent of the Principal Member:
- Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent.
- Proof of income such as payslip, bank statement, or proof of pension.

A grandchild, niece, nephew or sibling:
- Certified affidavit from Principal Member and parent(s) confirming residency, employment, and income of child and both parents.
- Proof of income if dependant is employed.

Include copies of the dependants' ID, birth certificate or passport.

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

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 ☐	

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

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):						
Dependant Cell Number:						
Gender: (Mark with an X)	M	F	Marital Status:	Single	Married	Divorced	Widowed

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

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 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:								
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	

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

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:						

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:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		Date Terminated:	

Dependant Name & Surname:			
Name of Scheme:			
Membership Number:			
Date Joined:		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**

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

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

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

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:

4. Is any of your dependants, for whom you are applying for planning or reasonably expecting to be hospitalised or to have a procedure or treatment in the next 12 months - including pregnancy? Y N

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:

5. Is there any other conditions or symptoms not mentioned above for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months that you would like to disclose? Y N

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:

IMMUNE DEFICIENCY STATUS (Confidential Disclosure)

If you, or any of your dependants, have been diagnosed with HIV/AIDS or any immunoglobulin deficiencies, please contact Medshield HIV/AIDS Management Programme on 086 050 6080 to register on the HIV/AIDS Disease Management Programme. Failure to do so within 21 days of joining the Scheme will be considered as non-disclosure of information and may result in termination of your membership.

SECTION G EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date:

Benefit Date:

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

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

Employer's Email Address:

Employer's Representative's Name:

Employer's Representative's Designation:

Date:

Employer's Representative's Signature: _____

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

The Scheme understands that your personal information and that of your dependants is important. 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.**

Please carefully read and consent to the items listed below
I hereby consent, with the permission of my dependants, that the Scheme may collect, use, process, retain and share my and my dependant's personal information for the purpose of providing medical scheme benefits, managed healthcare services and medical scheme specific value adds. This includes the collecting and sharing of my personal information with the Scheme's partners and facilities who are essential to the administration and ongoing membership process.

You can access more details on the Protection of your Personal and Health Information on the Medshield website www.medshield.co.za. When you accept these terms and conditions you will allow us to provide your family with the full range of our Medshield services.

(1) I hereby acknowledge and declare that as the Principal Member of the Scheme, I have received the necessary consent from my dependant(s) and 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.
(2) 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 and my employer's appointed broker 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.
(3) Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Advisor/ Broker, if any, who is an accredited Medical Aid Broker of my choice.

Principal Member Signature: _____ Date:

SECTION I MEMBER DECLARATION

Please carefully read and agree to the declarations below.

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

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, as well as my and my dependants' identities, and any other information that I provided in this application form.

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: _____

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form be submitted to the Scheme within 30 calendar days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.