fedhealth member

RECORD AMENDMENT FORM

FEDHEALTH
Sanlam healthcare partner

PLEASE MAIL COMPLETED FORM TO:
Fedhealth Medical Scheme
Private Bag X3045
Randburg
2125

E-MAIL TO:
maintenanceFDH@fedhealth.co.za

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AON001M16

☐ **Change of address / contact details**
Sections 1, 2, 9 and 10 must be completed

☐ **Change of bank details**
Sections 1, 3, 9 and 10 must be completed

☐ **Change of marital status**
Sections 1, 4, 9 and 10 must be completed

☐ **Termination of dependant membership**
Sections 1, 5, 9 and 10 must be completed

☐ **Registration of:** • **Births and adoptions** • **Additional adult and child dependants**
Sections 1, 6, 7, 9 and 10 must be completed

☐ **Change of Fedhealth Savings bank details (Fedhealth Savings refers to the innovative MediVault and Wallet facility for day-to-day expenses)**
Sections 1, 3, 9 and 10 must be completed

SECTION 1 DETAILS OF PRINCIPAL MEMBER

First name/s | Initials
Surname | Preferred name
Membership no.
ID number | Passport number, if no ID
Nationality | Country of issue of passport
Income Tax Number

SECTION 2 CHANGE OF ADDRESS / CONTACT DETAILS

Telephone (H) ( ) | Telephone (W) ( )
Cellular ( ) | Fax ( )
E-mail address
Postal address | Postal code
Physical address | Postal code

SECTION 3 BANK DETAILS OF PRINCIPAL MEMBER

Refund of claims and debit order instruction

I hereby instruct Fedhealth to electronically collect contributions and Fedhealth Savings instalments as a single debit order and to deposit refunds, using the information provided below (Direct Paying Members only). Should the collection date fall on a public holiday, the Scheme reserves the right to collect prior to or after the holiday. I understand that transfers cannot be done to and from credit card accounts. I hereby authorise Fedhealth to reverse any erroneous transactions and/ or rectify any EFT errors without prior notice. Note: Direct paying members can select from the following dates for debit order collections:

☐ **1st of the month** ☐ **5th of the month** **OR** ☐ **25th of the month**

Should you miss a payment, Fedhealth reserves the right to deduct on a different date to collect the missed premium. Bank charges will apply for rejected debit orders. The debit order collection description will have the following prefix before your membership number for current contribution collecitons: FDHSUBS, for arrear contribution collections: FDHARR and a Fedhealth Savings instalments collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT any arrear collection will include ARR with previous abbreviates.

Due to changes in cross-border payment regulations within the Common Monetary Area (CMA), which includes South Africa, Namibia, Lesotho, and Eswatini, Fedhealth can no longer debit your account. Payments must now be paid directly into the Scheme bank account.
Nedbank SA,
Account number: 1984563009, Branch Code:198405.

☐ 1. USE THIS ACCOUNT FOR ALL COLLECTIONS INCLUDING FEDHEALTH SAVINGS INSTALMENTS AND REFUNDS

☐ 2. USE THIS ACCOUNT FOR ALL COLLECTIONS ONLY
NB: If you tick this option, you must complete bank details for claims refunds on the right.

Bank name
Branch name
Bank branch code
Type of account: Cheque | Transmission | Savings
Name of account holder
Bank account number

☐ USE THIS ACCOUNT FOR REFUNDS ONLY
NB: If you ticked no. 2 on the left, bank details must be completed here.

☐ USE THIS ACCOUNT FOR FEDHEALTH SAVINGS DEDUCTIONS ONLY

Bank name
Branch name
Bank branch code
Type of account: Cheque | Transmission | Savings
Name of account holder
Bank account number

If only one bank account is provided, it will be used for both collections and refunds.

Account/ s holder's signature ..... Date d d m m y y y y

SECTION 3 BANK DETAILS OF PRINCIPAL MEMBER *Continued* *Refund of claims and debit order instruction*

3rd Party Payor

Should a third party pay the contribution and/or Fedhealth Savings instalment on your behalf, the following supporting documents are required, certified by a commissioner of oaths and not older than three months:

- Account holder's identity document
- Account holder's bank statement
- Account holder's letter of authority to the Scheme to deduct contributions on behalf of the member. This also needs to include the relationship of the account holder to the principal member as well as a physical address, and where an individual, their Income Tax Number.

3rd Party Details

Surname

Title | First name/s

Physical address

Relationship to principal member | Nationality

ID number | Passport number, if no ID

Country of issue

Income Tax Number | Company registration number

SECTION 4 CHANGE OF MARITAL STATUS

Marital status: Single | Married | Divorced | Widowed | Common law partner/ spouse

Date of marriage : d d m m y y y y

Surname:

myFED members:
Please note that if you pay your own contributions and you add a spouse/ partner, you will be required to complete an Income Verification Form.

SECTION 5 TERMINATION OF BENEFICIARY REGISTRATION DUE TO DEATH, DIVORCE, CHILD SELF SUPPORTING ETC.

Please attach certified copy of death certificate if termination is due to death

Full name/s as reflected on your membership card	Date of birth	Deletion date (last day of the month)
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y

Reason for termination

SECTION 6 REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT

I confirm that I am authorised to provide and disclose the personal information of these listed dependants to the Scheme for the purpose of receiving benefits and related services.

1 Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname

Relationship to principal member | Gender M F

ID number | Date of birth d d m m y y y y

If none, passport number, | Nationality

Country of issue of passport | Income Tax Number

Cell | E-mail address

If adult, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No | If yes, what is the monthly income? R

Has this dependant had previous medical aid cover? Yes No | If yes, please provide details below.

Name of previous medical scheme/s	Membership number	Date joined	Date left

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes No

SECTION 6 REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT *Continued*

flexiFED 1, flexiFED 1[Elect], flexiFED 2, flexiFED 2[GRID], flexiFED 2[Elect], flexiFED 3, flexiFED 3[GRID], flexiFED 3[Elect], myFED members are required tonominate a GP (General Practitioner) from the Fedhealth network for themselves and their dependants. Please note that only visits to a nominated GP will be covered on these options. For a list of GPs on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the GP locator button on the page. For a list of GPs on the myFED GP network, please contact the Customer Contact Centre on 0860 002 153.

NOMINATED GP (GENERAL PRACTITIONER) DETAILS		
Name	Practice number	Contact details
1.	1.	1.
2.	2.	2.

**Child Dependant = the member's dependent child up to the age of 27.*

Please note:
- Any dependant, other than your biological children: supporting legal documentation of adoption or foster arrangement; as well as an affidavit confirming residency, income, employment and marital status of both child and natural parents.
- Adult dependants: an affidavit confirming residency, marital status, employment status and income.

2

Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname

Relationship to principal member | Gender M F

ID number | Date of birth d d m m y y y y

If none, passport number, | Nationality

Country of issue of passport | Income Tax Number

Cell | E-mail address

If adult, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No | If yes, what is the monthly income? R

Has this dependant had previous medical aid cover? Yes No | If yes, please provide details below.

Name of previous medical scheme/s	Membership number	Date joined	Date left

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes No

flexiFED 1, flexiFED 1[Elect], flexiFED 2, flexiFED 2[GRID], flexiFED 2[Elect], flexiFED 3, flexiFED 3[GRID], flexiFED 3[Elect], myFED members are required tonominate a GP (General Practitioner) from the Fedhealth network for themselves and their dependants. Please note that only visits to a nominated GP will be covered on these options. For a list of GPs on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the GP locator button on the page. For a list of GPs on the myFED GP network, please contact the Customer Contact Centre on 0860 002 153.

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- Adult dependants: an affidavit confirming residency, marital status, employment status and income.

3

Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname

Relationship to principal member | Gender M F

ID number | Date of birth d d m m y y y y

SECTION 6 REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT *Continued*

If none, passport number, | Nationality

Country of issue of passport | Income Tax Number

Cell | E-mail address

If adult, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No If yes, what is the monthly income? R

Has this dependant had previous medical aid cover? Yes No If yes, please provide details below.

Name of previous medical scheme/s	Membership number	Date joined	Date left

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes No

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NOMINATED GP (GENERAL PRACTITIONER) DETAILS		
Name	Practice number	Contact details
1.	1.	1.
2.	2.	2.

**Child Dependant = the member's dependent child up to the age of 27.*

Please note:
- Any dependant, other than your biological children: supporting legal documentation of adoption or foster arrangement; as well as an affidavit confirming residency, income, employment and marital status of both child and natural parents.
- Adult dependants: an affidavit confirming residency, marital status, employment status and income.

SECTION 7 MEDICAL DETAILS

It is compulsory to answer each question. Failure to disclose information is fraudulent and may result in membership not being granted, or termination of membership without refund of contributions paid.

HAVE ANY OF THE DEPENDANTS INDICATED IN SECTION 6 SOUGHTANYADVICE, BEEN DIAGNOSED WITH, OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS IN THE PAST 12 MONTHS?

1. A chronic illness? (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and/ or thyroid disorders). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

2. Gastro intestinal disorder? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/ or a spastic colon). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

3. Muscle, bone, skin or nerve illnesses or disorders? (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

4. Urinary or genital disorders? (e.g. kidney stones, prostates, endometriosis, ovarian cysts, menstrual disorders). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
			Yes	No	Yes	No	
			Yes	No	Yes	No	

SECTION 7 MEDICAL DETAILS *Continued*

5. Ear, nose or throat disorders? (e.g. Glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics). If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating GP, Dentist or Specialist
			Yes / No	Yes / No	
			Yes / No	Yes / No	

6. Blood disorders, immune deficiency state, HIV/AIDS, cancer etc? If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating GP, Dentist or Specialist
			Yes / No	Yes / No	
			Yes / No	Yes / No	

7. Are you or any of your dependants pregnant? If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating GP, Dentist or Specialist
			Yes / No	Yes / No	
			Yes / No	Yes / No	

8. Are there any other conditions not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months? If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and date	Name of medication and dosage	Are you currently receiving treatment?	Have you been hospitalised?	Name and contact number of treating GP, Dentist or Specialist
			Yes / No	Yes / No	
			Yes / No	Yes / No	

SECTION 8 DISCLOSURE OF HEALTH CONDITIONS IMPACTING FUNCTIONALITY / DISABILITY DISCLOSURE

Details of person(s) living with a disability

First name/s

Initials Surname

Date of birth (d d m m y y y y) ID number

Passport number, if no ID

Description of Disability

Disability Type *(Please tick the applicable box)*

- ☐ Hearing Disability
- ☐ Intellectual Disability
- ☐ Mental Disability
- ☐ Physical Disability
- ☐ Speech Disability
- ☐ Vision Disability

Nature of Disability *(Please tick the applicable box)*

- ☐ Temporary
- ☐ Permanent

Limitation *(Please tick the applicable box)*

- ☐ Mild
- ☐ Moderate
- ☐ Severe

Start Date (d d m m y y y y) End Date (d d m m y y y y)

Treating Provider Details

Practice number Name(s)

Initial(s) Surname

Cellphone Telephone ( )

Practitioner Email

Should this space be insufficient, please attach a separate sheet.

SECTION 9 EMPLOYER INFORMATION *This section must be completed by your employer only if employer pays your contribution*

Name of employer

Division code

Dept. name

Fedhealth Paypoint code

Employee number

Dependant/s subsidised Yes No

Persal number *if applicable*

The above details have been noted and contributions will be adjusted in terms of the scheme rules on d d m m y y y y and include arrears, if applicable.

Total current contribution: R

Total new contribution: R

Arrears (if applicable): R

Fedhealth Savings instalment (if applicable): R

Company stamp

Name of salary administrator

Designation

Signature .....

Date signed d d m m y y y y

SECTION 10 DECLARATION BY PRINCIPAL MEMBER *This section must be completed*

I declare that to the best of my knowledge the information provided above is true and correct. I consent with the permission of my dependants that the Scheme may collect, use, process, retain and share my and my dependants Personal Information (PI) for the purpose of providing Medical Scheme benefits and managed healthcare services. This includes the collecting and sharing of my PI with the Scheme's partners and facilities who are essentail to the administration and membership process.*

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

Signature of principal member:.....

Date signed d d m m y y y y