Continuation form

EMAIL TO:
maintenanceFDH@fedhealth.co.za

OR MAIL COMPLETED FORM TO:
Fedhealth Membership
Private Bag X3045
Randburg
2125

FEDHEALTH
Sanlam healthcare partner

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

Current Membership no. _____
(NB: this will change)

Change effective from 0 1 m m y y y y

Change of principal member ☐

Subject to Scheme approval only

Supporting documents required:
Signed and dated request from principal member stating reason for the change. Should the member be part of an emloyer group, the request needs to have employer approval and a company stamp affixed.

The details of the existing Intermediary/Financial Advisor will remain in place. Should there be a change in Advisor, a new letter of appointment will need to be attached.

Death of principal member ☐

Supporting documents required:
A copy of death certificate

The details of the existing Intermediary/Financial Advisor will remain in place. Should there be a change in Advisor, a new letter of appointment will need to be attached.

Immigration of principal member ☐

Supporting documents required:
Signed and dated request from principal member stating date of departure and destination and a copy of the flight detail. Should the member be part of an emloyer group, the request needs to have employer approval and a company stamp affixed.

The details of the existing Intermediary/Financial Advisor will remain in place. Should there be a change in Advisor, a new letter of appointment will need to be attached.

Member move from Group to Direct Paying Member (DPM) status (employment change) ☐

Note:
Member and broker are required to complete section 2

SECTION 1 DETAILS OF PRINCIPAL MEMBER

Surname _____

Title _____ First name/s _____

Preferred name _____

Date of birth d d m m y y y y ID number/ Passport _____

SECTION 2 BROKER APPOINTMENT

I, the member, appoint:

Name of Broker _____

Broker code _____ as my healthcare broker. I understand that this appointment will remain in force until cancelled by myself

Member signature ..... Date signed d d m m y y y y

I, the Broker hereby agree to maintain the appointment signed at ..... on this ..... day of ..... 20 .....

Name of Brokerage ..... Broker code .....

Signature of Broker ..... Name of Broker .....

SECTION 3 ADDRESS / CONTACT DETAILS

Telephone (H) ( ) Telephone (W) ( )

Cellular _____ Fax ( )

E-mail address _____

Postal address _____

_____ Postal code _____

Physical address _____

_____ Postal code _____

SECTION 4 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 collections: FDHSUBS, for **arrear** contribution collections: FDHARR and a Fedhealth Savings instalment 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

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 5 CONFIRMATION OF EXISTING BENEFICIARIES TO REMAIN ON MEMBERSHIP

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* ☐			2 Adult ☐ Child* ☐		
Title		Initials	Relationship to member		Initials	Relationship to member
Surname						
First name/s						
Preferred name		Marital status			Marital status	
ID number / passport number						
Nationality						
Country of issue of passport						
Income Tax Number						
Date of birth	d d m m y y y y	Gender	M F	d d m m y y y y	Gender	M F
Email address		Cell			Cell	

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

SECTION 5 CONFIRMATION OF EXISTING BENEFICIARIES TO REMAIN ON MEMBERSHIP (CONTINUED)

	3 Adult ☐ Child* ☐	4 Adult ☐ Child* ☐
Title / Initials / Relationship to member		
Surname		
First name/s		
Preferred name / Marital status		
ID number / passport number		
Nationality		
Country of issue of passport		
Income Tax Number		
Date of birth / Gender	d d m m y y y y / M F	d d m m y y y y / M F
Email address / Cell		

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

Please note:

- For any dependant, other than your biological children, please supply 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.
- For adult dependants, please supply an affidavit confirming residency, marital status, employment status and income.

SECTION 6 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 7 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 and include arrears, if applicable. (d d m m y y y y)

Total current contribution: R

Total new contribution: R

Arrears (if applicable): R

Name of salary administrator

Designation

Company stamp

Signature .....

Date signed (d d m m y y y y)

SECTION 8 FLEXIFED MEMBERS ONLY - FEDHEALTH SAVINGS DETAILS

Fedhealth Savings refers to the innovative MediVault and Wallet facility for day-to-day expenses

Should you choose to activate Fedhealth Savings on your new membership, complete a new Fedhealth Savings Application form and refer to the Fedhealth Savings benefit in your brochure.

SECTION 9 DECLARATION BY PRINCIPAL MEMBER

1. I, the undersigned hereby apply for membership of Fedhealth Medical Scheme (the Scheme) and also nominate my dependants as specified.
2. I hereby undertake to observe and carry out the provisions of the Medical Schemes Act 131 of 1998 (the Act) and of the rules of the Scheme as amended from time to time.
3. I agree that the Scheme shall not be bound in any way by any representations or undertakings made or given by any person or agent which is in contradiction with the registered rules of the Scheme.
4. I further agree that the commencement of my membership and the liability of the Scheme as a result of this application is conditional upon the first contribution being paid and received by the Scheme, as well as the Fedhealth Savings instalment. In addition, should I default on payment of any subsequent contributions or instalments, and fail to remedy such default within the time periods allowed in the rules, any benefits paid by the Scheme on my behalf after the receipt of my last contribution shall be reversed and payment of these claims shall be for my account.
5. I hereby authorise and request any doctor or medical professional person, or any other person who may be in possession of, or may hereafter acquire, any information concerning my/ the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my/ their deaths, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of, or arising out of the disclosure of any test results or medical information.
6. I accept any penalties/ waiting periods that may be applied in accordance with the Act. I understand that these waiting periods may include a 3 (three) month general waiting period, a 12 (twelve) month waiting period for pre-existing conditions and, if applicable, a late joiner penalty fee.
7. I hereby authorise my employee and/or Payroll of my company to deduct from my salary or any other available funds and/or via debiting of my bank account, all contributions, instalments, arrears, or any other amounts that I may owe to the Scheme as per the rules and agreement selected. In the event of arrears, I will be responsible for any legal costs that may arise in the recovery thereof.
8. It is my sole responsibility as a member to ensure that the monthly contribution, instalments and any amounts that may become due by me in terms of the Scheme rules, is received by the Scheme.
9. I hereby acknowledge that any credit extended by the Scheme to myself or my dependants whilst a member of the Scheme will become payable in full on termination of my membership.
10. I understand and agree to receive written notifications, SMS and other communication to the email address and/or cell number provided by me or my financial advisor. This communication may include changes to the rules of the Scheme as amended from time to time.
11. I understand that should there be any outstanding debt, my account will be suspended and no claims will be paid until payment agreement is reached and payment received.
12. I acknowledge that non-disclosure of any information by myself or my dependants relevant to the assessment of this application shall render any contracts to which this application relates null and void.
13. Should there be any additional information required by the Scheme which is not received within 7 (seven) days, the Scheme will automatically suspend the application.
14. I acknowledge that I am not a member of more than one Medical Scheme.
15. I hereby authorise the Scheme or any of its nominated representatives to verify and confirm my bank details.
16. I acknowledge that a monthly commission of 3% of my total monthly contribution up to a maximum, as legislated from time to time, will be paid to the financial adviser in terms of the Medical Schemes Act 131 of 1998 (or as amended), only if an advisor/ broker is appointed.
17. I agree to provide the Scheme with 3 (three) months' written notice to inform Fedhealth of my intention to terminate my membership.
18. I acknowledge that it is my responsibility to notify the Scheme of any changes to the facts, or any changes in my or my dependants' state of health, between the date of signing this application form and the date when my membership commences. If this is not done before my membership commences, waiting periods may apply and/ or future claims or my membership may be rejected.
19. I hereby confirm that I understand the various partnership arrangements (either Designated Service Provider and/ or Preferred Provider) applicable to my option and am aware that co-payments and/ or lower reimbursement rates may apply to the non-use of Fedhealth partners.
20. I declare that this personal statement, whether in my handwriting or not, is complete, true and correct and that I have not concealed, withheld or misstated any material facts.
21. I 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 and managed healthcare services. This includes the collecting and sharing of my personal information with the Scheme's partners and facilities who are essential 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.*

Sanlam Wealth Bonus

Do you have a Sanlam Matrix Premier product? Yes ☐ No ☐

If you answer yes, your I.D and membership number will be shared with Sanlam for the purpose of increasing your current Sanlam Wealth Bonus.

Signed at ..... on this ..... day of ..... 20.....

Signature of principal member .....

Print name ..... Identity number