


<p>This check list is for HR practitioners to check and ensure all the information is on the application form and all the documents that are required have been attached. It will further assist in the processing of applications and minimise delays in activation of the employees new medical scheme.</p> <p><b>The Employee Must Sign Off On The Check List.</b></p>			
<p><b>CHECKLIST FOR APPLICATIONS</b></p>		<p>Are the relevant documents attached?</p>	
<p>Please provide the following documentation with the application</p>			
<p>Please read and answer all the questions</p>			
Is an affidavit attached if registering a common law spouse or partner?	Yes	No	
Is the application signed and stamped by Transnet HR practitioner(this is to confirm that you are an employee of Transnet).?	Yes	No	
You understand that the completed applications must be scanned to transnetapps@aon.co.za or faxed to 086 726 7146?	Yes	No	
Have you answered all the questions?	Yes	No	
Are all the Birth Certificates of Children where ID is not yet available attached?	Yes	No	
Do you understand that you should not resign until you accepted at the new medical scheme?	Yes	No	
Do you understand that you have to give your existing medical scheme there notice period?	Yes	No	
Have you attached the Documentary proof in case of adopted/foster child?	Yes	No	
Have you allocated your commencement date?	Yes	No	
Have you allocated your date of employment?	Yes	No	
Have you completed the section for your banking details for the medical scheme to refund you for claims?	Yes	No	
Have you selected your option?	Yes	No	
Have you signed and dated the declaration?	Yes	No	
Have you signed on all the applicable sections?	Yes	No	
Are all the ID Documents for yourself and all your dependants attached?	Yes	No	
Have you allocated your ID number and SAP number on the application?	Yes	No	
If you altered your application, did you sign next to the alteration?	Yes	No	
If you answered yes to any questions - have you given an explanation to the questions?	Yes	No	
Is your Marriage certificate attached if you regisstering a spouse?	Yes	No	
Have you attached the Membership certificates with termination dates from your previous medical schemes?	Yes	No	
Have you allocated contact details in order to be contacted?	Yes	No	
Have you given your full Postal address with postal codes?	Yes	No	
Have you attached Proof(payslip) of your taxable income, (Income Band Options only)?	Yes	No	
Have you specified your Business Unit clearly on the application?	Yes	No	
Do you fully understand that your application will not be processed until a fully completed application is received by the medical scheme with all the supporting documents?	Yes	No	
Employee Full Name & Surname:			
Date:			
Employee Signature:			

# fedhealth member

## APPLICATION FORM

**FEDHEALTH**

Sanlam healthcare partner

EMAIL TO:  
newapps@fedhealth.co.zaOR MAIL COMPLETED FORM TO:  
Fedhealth Medical Scheme  
Private Bag X3045  
Randburg  
2125**SECTION 1 CHOICE OF OPTION**

Choose ONE product option by placing "x" in the appropriate box

**maxiFED**☐ maxima EXEC☐ maxima PLUS**myFED**☐ myFED\*

• If your contribution is paid by your employer, please also complete section 6.

• If your contribution is not paid by your employer, please also complete section 11.

\* Please also complete Section 10 for nomination of a Fedhealth network GP (General Practitioner).

Broker House: Aon South Africa (Pty) Ltd

Tel No: 0860 100 404

Broker Code: AON001M17

**flexiFED**☐ flexiFED 1\*☐ flexiFED 2\*☐ flexiFED 3\*☐ flexiFED 4☐ flexiFED 1<sup>Elect</sup>☐ flexiFED 2<sup>Elect</sup>☐ flexiFED 3<sup>Elect</sup>☐ flexiFED 4<sup>Elect</sup>☐ flexiFED 2<sup>GRID</sup>☐ flexiFED 3<sup>GRID</sup>☐ flexiFED 4<sup>GRID</sup>

\* Please also complete Section 10 for nomination of a Fedhealth network GP (General Practitioner).

**flexiFED CHOICE OF DAY-TO-DAY**☐ HOSPITAL PLAN☐ FEDHEALTH SAVINGS PLAN

I choose to select this option according to the recommended activation as per the flexiFED brochure and understand that this may be pro-rated as per my membership join date.

☐ FEDHEALTH BACKUP SAVINGS PLAN

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

• I do not want to activate an amount now ☐• I would like to activate the following amount:  
(Minimum R600)R • I would like to activate my full Fedhealth Savings benefit ☐

Repayments are calculated at a maximum of 12 equal instalments based on the amount activated. I understand that the chosen amount may be pro-rated as per my membership join date:

• I wish to repay my Fedhealth Savings over 12 months ☐• I wish to repay my Fedhealth Savings over  number of months\*

\*This can be anything from 1 - 11 months

I wish to join the scheme from I choose: ☐ Contribution collection in ADVANCE\*☐ Contribution collection in ARREARS\*

\* Advance: you will have access to benefits once contributions received

\* Arrears: a minimum of 1 month general waiting period will apply

**SECTION 2 DETAILS OF PRINCIPAL MEMBER**

Surname

Maiden name  
(if applicable)

Title

First name/s

Preferred name

Initials

Gender

☐ M ☐ F

Date of birth

Nationality

ID number

Passport number, if no ID

Country of issue  
of passport

Income Tax Number

Telephone (H)

Telephone (W)

Cellphone number

Email address

Postal address

Postal code

Physical address

Postal code

Country

## SECTION 2 DETAILS OF PRINCIPAL MEMBER (CONTINUED)

You can find your e-card on the Fedhealth Member App and the Fedhealth WhatsApp Service.

Have you had previous medical aid cover? ☐ Yes ☐ No

Are you changing your medical scheme due to a change in your employment? ☐ Yes ☐ No

*If yes, please provide details below*

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

PLEASE ☒ – FOR STATISTICAL PURPOSES ONLY Ethnic group ☐ Black ☐ Coloured ☐ Indian ☐ White ☐ Asian Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common law partner/ spouse

## SECTION 3 INTERMEDIARY / FINANCIAL ADVISER

*This section must be signed by the broker/ agent/ adviser if applicable*

Broker code	<input type="text"/>	FSCA number	<input type="text"/>
Name of brokerage	<input type="text"/>		
Name of broker/agent/adviser	<input type="text"/>		
Telephone (W)	<input type="text"/>	Cellular	<input type="text"/>
Email address	<input type="text"/>		
Postal address	<input type="text"/>		
Physical address	<input type="text"/>		

### FINANCIAL ADVISER DECLARATION

- I hereby acknowledge that I am an accredited Fedhealth Financial Adviser and that I am licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act 37 of 2002.
- I acknowledge that the applicant has appointed me as his/ her financial adviser and that the applicant is entitled to cancel my services at any time.
- I confirm that the applicant was provided with my personal details, physical and postal address and telephone number.
- I acknowledge that a monthly commission of 3% of the total monthly contribution up to a maximum, as legislated from time to time, will be paid to me in terms of the Medical Schemes Act 131 of 1998 (or as amended).
- I confirm that there has been no material misrepresentation of any fact by me and that in the event of material misconduct or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation or conduct.
- The applicant is familiar with the information requested in the application form and all the relevant information was provided by the applicant.
- The applicant is familiar with the information relating to the Protection of Personal Information Act (POPIA) as displayed on [www.fedhealth.co.za](http://www.fedhealth.co.za) and;

7.1. I, the Member give consent for the Financial Advisor to have access to my data relating to:

- Personal Information
- Benefits
- Financial Information
- Medical Information
- Fund Documents

**Broker House: Aon South Africa (Pty) Ltd**

**Tel No: 0860 100 404**

**Broker Code: AON001M17**

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

Member signature: .....

*(Member must sign acknowledgment on Broker section.)*

Date  d  d  m  m  y  y  y  y

- The advice and assistance given to the applicant was impartial and in the best interest of the applicant.
- The applicant has personally signed the application form.
- I acknowledge that a member must complete a broker note in the event of a member account transfer from a company exclusive broker appointment to an individual membership account.

Broker's/ agent's/ adviser's signature .....

Date  d  d  m  m  y  y  y  y

## SECTION 4 DETAILS OF YOUR SPOUSE / PARTNER YOU WISH TO REGISTER

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

SPOUSE / PARTNER Surname	<input type="text"/>		
Maiden name (if applicable)	<input type="text"/>		
Title	<input type="text"/>	First name/s	<input type="text"/>
Cellphone number	<input type="text"/>	Email address	<input type="text"/>
Relationship to principal member	<input type="text"/>	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
ID number	<input type="text"/>	Date of birth	<input type="text"/> d <input type="text"/> d <input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y
Country of issue of passport	<input type="text"/>		
Passport number, if no ID	<input type="text"/>	Income Tax Number	<input type="text"/>

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

## SECTION 5 DEPENDANTS YOU WISH TO REGISTER

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

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

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

\* 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 EMPLOYER INFORMATION

*This section must be completed by your employer only if employer pays your contribution*

Name of employer	<input type="text"/>		
Employee number	<input type="text"/>	Employment date	<input type="text"/> d <input type="text"/> d <input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y
Division code	<input type="text"/>	Dept. name	<input type="text"/>
Persal number <i>if applicable</i>	<input type="text"/>	Fedhealth paypoint code	<input type="text"/>
Medical scheme start date	<input type="text"/> 0 <input type="text"/> 1 <input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y		
We confirm that the applicant is employed by us and commenced employment on the above date			
Name of salary administrator	<input type="text"/>		
Designation	<input type="text"/>		
Monthly salary of myFED applicant	<input type="text"/>		
Signature .....		Date signed <input type="text"/> d <input type="text"/> d <input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y	

Company stamp

## SECTION 7

## 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 abbreviations.

*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 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 ☐ Hearing Disability ☐ Intellectual Disability ☐ Mental Disability  
(Please tick the applicable box) ☐ Physical Disability ☐ Speech Disability ☐ Vision Disability

Nature of Disability ☐ Temporary ☐ Permanent  
(Please tick the applicable box)

Limitation ☐ Mild ☐ Moderate ☐ Severe  
(Please tick the applicable box)

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 MEDICAL DETAILS

**This section must be completed. Failure to disclose information is fraudulent and may result in membership not being granted or termination of membership resulting in claims reversal and refund of payments after debt recovery.**

Have you or any of your dependants sought any advice, been diagnosed with or been treated for any conditions in the last 12 months? If yes, please provide details.

Yes	No
-----	----

[illegible]

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

## SECTION 10 NOMINATED GP DETAILS

If you have selected flexiFED 1, flexiFED 1<sup>Elect</sup>, flexiFED 2, flexiFED 2<sup>GRID</sup>, flexiFED 2<sup>Elect</sup>, flexiFED 3, flexiFED 3<sup>GRID</sup>, flexiFED 3<sup>Elect</sup>, flexiFED 4<sup>GRID</sup>, flexiFED 4<sup>Elect</sup> and myFED you are required to nominate a General Practitioner (GP) from the Fedhealth network for yourself and your 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](http://www.fedhealth.co.za), click on Locate a Provider. Alternatively you can phone the Customer Contact Centre on 0860 002 153 for more information. You may nominate up to 2 GPs per beneficiary.

[illegible]

## SECTION 11 INCOME VERIFICATION FOR THE MYFED OPTION

Please tick appropriate box

Highest household income per month

- ☐ R1 – R11 063  
☐ R11 064 - R15 617  
☐ R15 618 - R21 651  
☐ R21 652 + >

Income is considered as the income of the highest earner per household. Income to declare includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (this includes self-employment and informal employment), pension and annuity proceeds, interest earned on active and passive investments, rental income from leasing properties and distributions received from a trust. Members will be required to declare income on an annual basis at the beginning of the new Benefit Year.

**Please note:**

**Should you declare income lower than your actual income, it will be considered fraud and will lead to the immediate cancellation of your membership.**

**What you are required to do:**

Complete the Income Verification Form and attach all relevant proof of income and other supporting documents requested in each section to avoid any administrative delays.

## SECTION 12 THIRD PARTY POWER OF AUTHORITY

Should you want to give permission to a third party to act on your behalf, when you are unable to, please complete a separate Third Party Power of Authority Consent form.

## SECTION 13 DECLARATION & TERMS AND CONDITIONS

### 13.1 DECLARATION BY PRINCIPAL MEMBER

- I, the undersigned hereby apply for membership of Fedhealth Medical Scheme (the Scheme) and also nominate my dependants as specified.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- I acknowledge that the Scheme may obtain any information regarding myself from any credit bureau, national loans register, South African Fraud Prevention Services, or any other agent I have dealt with in an event of nonpayment, debt collection or fraudulent activity.
- 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.
- I understand that should there be any outstanding debt my account will be suspended from the date of default and no claims will be paid thereafter until a payment arrangement is reached and payment received.
- 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.
- 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.
- I acknowledge that I am not a member of more than one Medical Scheme.
- I hereby authorise the Scheme or any of its nominated representatives to verify and confirm my bank details.
- 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.
- I agree to provide the Scheme with 3 (three) months' written notice to inform Fedhealth of my intention to terminate my membership.
- 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.
- 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.
- 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.
- 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](http://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.

Broker House: Aon South Africa (Pty) Ltd

Tel No: 0860 100 404

Broker Code: AON001M17

## 13.2 FEDHEALTH SAVINGS TERMS &amp; CONDITIONS

These are the terms and conditions that will apply to the activation and use of your Fedhealth Savings, which is available to all active Members of the Scheme who are on the flexiFED range.

The maximum, interest free, loan amount that is available in your Fedhealth Savings, has been pre-determined by the Scheme in line with your selected benefit option and family size or composition. You can decide how much of the total amount available in your Fedhealth Savings you choose to activate, at any time during the benefit year, also known as the Fedhealth Backup Savings. The maximum repayment period for the amount activated will be 12 months. Should you choose to select the Savings Plan repayment amount, a pre-determined amount will be activated. Please consult the Scheme brochure.

**General Provisions**

- a) The Fedhealth Savings is available annually as per the Scheme benefit year, which runs from 1 January to 31 December. Only Fedhealth Backup Savings Plan can be accessed any time of the year.
- b) The Fedhealth Savings will be prorated for a member joining the Scheme during the benefit year unless predetermined rules are defined for a Participating Paypoint.
- c) The minimum amount which may be activated from the Fedhealth Savings is R600.

**Eligibility Criteria**

- a) The Fedhealth Savings is available to all members on options which offer this benefit. Members automatically accept the terms and conditions upon joining a flexiFED option.
- b) To qualify for the Fedhealth Savings Benefit the member must be in good standing with the Scheme and over the age of 18 years.
- c) Suspended and terminated members will not be allowed to activate any amounts from their Fedhealth Savings, nor will suspended members be able to select the Fedhealth Savings Plan.
- d) The legal guardian of a member younger than 18 years of age can apply for the benefit on behalf of the minor member.
- e) The Fedhealth Savings is only available to active beneficiaries of the Scheme.

**Fedhealth Savings Conditions**

- a) When a member joins a flexiFED option they automatically accept the terms and conditions for Fedhealth Savings.
- b) The Fedhealth Savings is provided by the Scheme, in terms of the Scheme Rules, more particularly Rule 19.13 (which empowers the Board to grant repayable loans to members) and Section 30 (b) of the Medical Schemes Act 131 of 1998.
- c) The loan amount in the Fedhealth Savings will only be available up to a maximum as specified on the applicable option or company rule for a Participating Paypoint.
- d) The loan will not attract any interest (i.e. it will be an interest free loan).
- e) Any portion of the Fedhealth Savings not activated during a benefit year will not carry over to the next year.
- f) The maximum loan amount available in the Fedhealth Savings may only be utilised once during a benefit year. Repayment of the loan will not result in the loan becoming available again. (i.e. the Fedhealth Savings facility will not be based on a revolving credit basis).
- g) The loan is **only** activated once the member instructs the Scheme to activate an amount from the Fedhealth Savings.

**Fedhealth Savings Activation**

- a) The member activates the Fedhealth Savings Benefit by utilising the various platforms available to members. When a member selects the Fedhealth Savings Plan, the annual pre-determined amount will be automatically activated on the 1st January annually.
- b) Subject to the provisions under General Provisions above, members on the Fedhealth Backup Savings Plan are not restricted in terms of the number of activations in a benefit year.
- c) Any amount held in the Fedhealth Savings account will not earn any interest.
- d) A five (5) day cooling off period will be allowed for the purpose of cancelling the activation.

**Fedhealth Savings Utilisation**

- a) The amount activated can only be accessed by submitting a valid claim to the Scheme.
- b) The amount available will **only** be utilised once the member's Medical Savings Account has been exhausted.
- c) All payments made for the benefit of the member or the member's dependants will only be for the funding of relevant healthcare services and will be made directly by the Scheme to the healthcare provider, medical facility or refunded to the member.
- d) The member and his/her dependants will have access to the amount available during any waiting periods (if applicable).
- e) Any amount left over at year end will carry over in the following year. This amount will not earn any interest.

**Repayment of the Activated amount**

- a) Repayments of the loan/s are in arrears and will commence on the debit order date selected following an instruction by the member to activate an amount from the Fedhealth Savings before the tenth (10th) of the month. Any transfers after the tenth (10th) will become due in the following month.
- b) If the Fedhealth Savings Plan is selected during a benefit year, the pre-determined activation will be pro-rated to ensure repayments are completed by the end of January of the following year (applicable to new members only).
- c) Repayment of the loan payment by debit order is compulsory, therefore bank details must be provided, refer to section 7 of the application form.
- d) The debit order deduction will be done on the selected day of the month except where it falls on a public holiday - in which case it will be collected on the day before or after, depending on the circumstances.
- e) Each and every loan activated must be repaid over a maximum 12 month period. The repayment term for that loan cannot be amended after the event.
- f) You may select a repayment period less than 12 months.
- g) Your debit order repayment amount will be adjusted with any subsequent loan activations. The Fedhealth Savings Plan collection will remain the same, on condition that the previous year's instalment is fully paid up and no additional funds are accessed or activated during the year.
- h) A single debit order will be deducted from the member's account for contributions as well as the Fedhealth Savings, with the following reference: FDHSUBVLT<member number>, unless a member belongs to a Non-Participating Paypoint Group that only pays for contributions and not the Fedhealth Savings instalment. In this case, a separate debit order deduction will occur with the following reference: FDHVLTLT<member number>.
- i) The member may make additional repayments at any time, but it will not reduce the monthly instalment; only the period of indebtedness.
- j) The member will receive a monthly statement reflecting the total Fedhealth Savings Benefit, Fedhealth Savings Benefit used and Fedhealth Savings Benefit available.
- k) The statement will also reflect the detail of the Fedhealth Savings Benefit used and repayments thereof.
- l) If a member belongs to a Participating Paypoint Group, the repayment will be collected from the Participating Paypoint Group. The member still needs to provide their banking details for collection to ensure continued collection if the member no longer belongs to the Participating Paypoint Group.
- m) The member remains ultimately responsible for the repayment of the loan.

**Dependant Termination**

- a) If a dependant is terminated off the membership, the amount available in the Fedhealth Savings will be recalculated according to the new family size and composition.
- b) If, at the time of termination of the dependant, the member has activated an amount greater than the recalculated Fedhealth Savings amount, no further activations will be allowed, however the member will still be required to repay all amounts activated.
- c) If the member has not utilised more than the recalculated Fedhealth Savings Benefit, the recalculated Fedhealth Savings Benefit will be allocated as the new limit. The new available balance will be the recalculated Benefit minus the amounts activated during the benefit year.

**Option Change during the Benefit Year**

- a) Where there is an option upgrade that takes place during the benefit year, to an option which also offers the Fedhealth Savings Benefit, the Benefit will be recalculated according to the new benefit option.
- b) If a member downgrades to an option with a lower Benefit available and at the time of downgrading the member has activated an amount greater than the lower Benefit, no further transfers will be allowed, however the member will still be required to repay all amounts activated.
- c) If a member downgrades to an option with a lower Benefit available and at the time of downgrading the member has not utilised more than the lower Benefit, the lower Benefit will become the member's new limit. The new available balance will be the lower Benefit minus any amounts during the benefit year.
- d) If the member moves to a Fedhealth option where the Benefit is not available, the member will be required to still repay the utilised amount for the remainder of the repayment period. Any unused credits will be offset with any debt outstanding or refunded to the member on request.

**Repayment on Termination**

- a) Any outstanding loan amount owed by the member on termination of membership will be offset against any credit balances (including Fedhealth Savings balances) due to the member.
- b) Any remaining loan balance outstanding must be repaid to the Scheme by the first (1st) of the month following termination.
- c) Any amount left after all debt has been settled, will be refunded to the member.



## 13.2 FEDHEALTH SAVINGS TERMS &amp; CONDITIONS (CONTINUED)

**Repayment on Estate Late and Continuation Membership**

- a) Any outstanding loan amount owed by the deceased member cannot become the responsibility of the new member (continuation of the surviving spouse/dependant) and needs to follow the Death Administration process as defined in Estate Act, 66 of 1965 (as amended).
- b) The new member must comply with the Eligibility Criteria set out above.
- c) When a new member joins a flexiFED option they automatically accept the terms and conditions for Fedhealth Savings.

**Repayment on Beneficiary Swop Membership**

- a) Members requesting a Beneficiary Swop from being the member to becoming a dependant must pay all outstanding loan balances owed before the transaction will be approved.
- b) The new member must comply with the Eligibility Criteria set out above.
- c) The new member automatically accept the terms and conditions on joining a flexiFED option before activating a amount.
- d) The benefit on the new membership will only be activated after a period of 30 (thirty) days from the date of the new membership becoming active, provided that all outstanding amounts were settled by the dependant on the previous benefit.

**Debt Collection Process**

- a) Any outstanding loan amount for an active or terminated member will not be written off and will be pursued through debt collection.
- b) Deferred instalments will not be allowed and will result in full membership suspension and no claims will be paid until the member is in good standing, and the Scheme's debt collection process will follow.
- c) A member who continues to default on the loan instalment debt will be offset with the available Fedhealth Savings credits and no further access will be allowed to the unused Benefit. Any outstanding instalments will result in full membership suspension.
- d) Members will be liable to pay for all fees associated with the collection of outstanding debts.

I consent to my Financial Adviser / Broker activating the Wallet on my membership. I acknowledge that the Financial Adviser / Broker is acting on my behalf and I agree not to hold the Scheme liable for acting on the instructions of my Financial Adviser / Broker.

Yes

No

## Parental/guardian Declaration (Complete if principal member is a minor)

Parent of member (full name)	<input type="text"/>	Relation	<input type="text"/>
Parent of member's Identity Number	<input type="text"/>		
Guardian of member (full name)	<input type="text"/>	Relation	<input type="text"/>
Guardian of member's Identity Number	<input type="text"/>		
Parent/Guardian cellphone number	<input type="text" value="(       )"/>	Relation	<input type="text"/>
Parent/Guardian cellphone number	<input type="text" value="(       )"/>	Relation	<input type="text"/>
Parent/Guardian email address	<input type="text"/>	Relation	<input type="text"/>

If parent or guardian is completing this application form on behalf of a minor, please provide certified copies of Parent's/Guardian's Identity Document

I/We ..... Full Name ..... Member/Parent/Guardian,  
the undersigned, do hereby declare that I/We have read and understood the declaration and terms and conditions as contained in this section.

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

Signature of principal member/parent/guardian .....

Print name .....

Identity number

## DECLARATION BY PRINCIPAL MEMBER

I/We ..... Full Name ..... Member, the undersigned,  
do hereby declare that I/We have read and understood the declaration and terms and conditions as contained in this section.

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

Signature of principal member .....

Print name .....

Identity number

Broker House: Aon South Africa (Pty) Ltd

Tel No: 0860 100 404

Broker Code: AON001M17



# Benefits of appointing Aon South Africa Healthcare as your intermediary

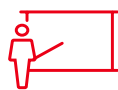
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## Our philosophy is to:



### Guide:

our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.



### Educate:

our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.



### Protect:

the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

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  - **Member letter** - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - **Guidance letter** - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Client Assistance Programme**
  - We are delighted to offer you access to a range of essential services at absolutely no charge. The Aon Client Wellbeing Programme is a telephonic, online, and structured e-mail support program (excluding in-person or video sessions). The following services are available through our third- party service provider, LifeAssist:
    - Structured Telephonic Counselling
    - Telephonic Trauma Support
    - Financial Wellbeing Coaching
    - Legal Advisory Services
    - Health and Wellness Services (professional advice from a dietician and a biokineticist)
- **General Updates:**
  - Ad-hoc updates pertaining to Medical schemes industry and providers specific updates.

## Cost of appointing Aon

We are pleased to inform you that there is no additional fee charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products, we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

## For more information, contact Aon South Africa:

0860 100 404 | [arc@aon.co.za](mailto:arc@aon.co.za) | [www.aon.co.za](http://www.aon.co.za)

## Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to [www.aon.co.za](http://www.aon.co.za)

<http://www.facebook.com/Aonhealthcare>  
Click "Like" on our page (Aon healthcare)

[http://twitter.com/Aon\\_SouthAfrica](http://twitter.com/Aon_SouthAfrica)  
Click "follow" on our profile

## Aon Employee Benefits – Healthcare

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<http://www.aon.co.za/disclaimer>

On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at <http://www.aon.co.za/terms-of-trade> or will be sent to you upon request.

[Privacy Notice](#)

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FSP number: 20555; CMS number: ORG895  
Follow our [website link](#) for further information on Aon's processing of your personal information

## Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: \_\_\_\_\_ and membership number: \_\_\_\_\_

Signed at (Town or City): \_\_\_\_\_ on yy/mm/dd: \_\_\_\_\_

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus Value Added Tax (VAT).

**Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.**

I give consent for the disclosure of information about me.

Membership number: \_\_\_\_\_ ID or passport number: \_\_\_\_\_

Title: \_\_\_\_\_ Initials: \_\_\_\_\_ Surname: \_\_\_\_\_

First name(s) (as per identity document): \_\_\_\_\_

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
<ul style="list-style-type: none"><li>* Name and Surname</li><li>* Membership number</li><li>* Date of birth</li><li>* ID number</li><li>* Postal Address</li><li>* Physical address</li><li>* E-mail Address</li><li>* Telephone numbers</li><li>* Cellular Number</li><li>* Number of dependents</li></ul>	<ul style="list-style-type: none"><li>* Plan type</li><li>* Medical Savings Account (MSA)</li><li>* Balance Medical Scheme benefits</li><li>* Spent for the year Accumulated</li><li>* Medical scheme Savings Account</li><li>* Medical Savings Carry over from previous year</li><li>* MSA reimbursement, Scheme Rate or cost</li><li>* Self-payment Gap</li><li>* Above Threshold Benefit</li><li>* Waiting period details</li><li>* Late joiner penalty indicator</li><li>* Wellness benefits</li></ul>	<ul style="list-style-type: none"><li>* Total Contribution</li><li>* Contribution breakdown</li></ul>	<ul style="list-style-type: none"><li>* Chronic Indicator/confirmation (Yes/No)</li><li>* In Hospital Indicator/confirmation (Yes/No)</li><li>* Confirmation of claims paid and from what benefit</li><li>* Claims transaction history</li><li>* Procedures done in doctor's rooms paid from Hospital Benefit</li></ul>



By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): \_\_\_\_\_ on yy/mm/dd: \_\_\_\_\_

Signature: \_\_\_\_\_

**ATTENTION:**

**TO WHOM IT MAY CONCERN**

**TENDERING OF RESIGNATION OF TRANSMED MEMBERSHIP**

DATE:                    \_\_\_\_/\_\_\_\_/\_\_\_\_

SURNAME:                    \_\_\_\_\_

FULL NAMES:                    \_\_\_\_\_

MEMBERSHIP NUMBER: \_\_\_\_\_

ID NUMBER:                    \_\_\_\_\_

CONTACT NUMBERS:                    \_\_\_\_\_

E-MAIL ADDRESS:                    \_\_\_\_\_

I would like to tender my resignation from the **TRANSMED Medical Scheme** effective immediately.

Since the rules of the scheme state I have to give **A ONE MONTH CALANDER NOTICE**, my last day on **TRANSMED Medical Scheme** will be: \_\_\_\_/\_\_\_\_/\_\_\_\_

Kind regards

\_\_\_\_\_

Signature

**PLEASE EMAIL THIS RESIGNATION TO ENQUIRIES@TRANSMED.CO.ZA  
BUT ATTACH THE COPY TO YOUR NEW APPLICATION.**

**ATTENTION:**  
**TO WHOM IT MAY CONCERN**  
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DATE:                    \_\_\_\_/\_\_\_\_/\_\_\_\_

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ID NUMBER:                    \_\_\_\_\_

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I would like to tender my resignation from the \_\_\_\_\_  
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Since the rules of the scheme state I have to give \_\_\_\_\_ days' notice, my last day on  
\_\_\_\_\_ Medical

Scheme will be: \_\_\_\_/\_\_\_\_/\_\_\_\_

Kind regards

\_\_\_\_\_  
Signature

**PLEASE SEND TO YOUR MEDICAL SCHEME BUT ATTACH A COPY  
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# Benefits of appointing Aon South Africa Healthcare as your intermediary

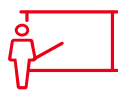
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## Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to [www.aon.co.za](http://www.aon.co.za)

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Click "Like" on our page (Aon healthcare)

 [http://twitter.com/Aon\\_SouthAfrica](http://twitter.com/Aon_SouthAfrica)  
Click "follow" on our profile

## Aon Employee Benefits – Healthcare

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Signed at (Town or City): \_\_\_\_\_ on yy/mm/dd: \_\_\_\_\_

Signature: \_\_\_\_\_

Broker House Name: Aon South Africa (Pty) Ltd  
Broker House Code:1004785125  
Broker Code:1020031108