fedhealth member

APPLICATION FORM

FEDHEALTH

EMAIL TO:
update@fedhealth.co.za

OR 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

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 10.

maxiFED

☐ maxima **EXEC** ☐ maxima **PLUS**

flexiFED

☐ flexiFED 1* ☐ flexiFED 2* ☐ flexiFED 3* ☐ flexiFED 4

flexiFED NETWORK CHOICE

☐ **GRID*** ☐ **ELECT***

* Please also complete Section 9 for nomination of a Fedhealth network GP (General Practitioner).

flexiFED CHOICE OF DAY-TO-DAY

☐ SUPERCHARGED HOSPITAL PLAN

☐ SUPERCHARGED SAVINGS PLAN*

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

☐ SUPERCHARGED FLEXIBLE SAVINGS PLAN*

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

Twelve months: Yes ☐

Members can select shorter repayment periods
Shorter period:

Select between 1 – 12 months <12 ☐ months

*When you select either the Supercharged Savings Plan or the Supercharged flexible Savings Plan, you accept the terms and conditions of MediVault and acknowledge the debt of the pre-determination Wallet activation amount transfer as defined in the flexiFED brochure or pro-rated amount based on the calculation of the option amended.

I wish to join the scheme from 0 1 m m y y y y

I choose: ☐ **Contribution collection in ADVANCE** ☐ **Contribution collection in ARREARS**

SECTION 2 DETAILS OF PRINCIPAL MEMBER

Surname

Maiden name (if applicable)

Title First name/s

Preferred name Initials

Gender M F Date of birth d d m m y y y y Nationality

ID number Passport number, if no ID

Country of origin of passport

Income Tax Number

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

Cellphone number Fax ( )

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 x – 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: 21110

FSCA number: 8625

Name of brokerage: BS CONSULTING

Name of broker/agent/adviser: bradley sayers

Telephone (W):

Cellular: 0829558957

Fax:

Email address: bradley.say@gmail.com

Postal address:

Physical address:

FINANCIAL ADVISER DECLARATION

1. 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.
2. 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.
3. I confirm that the applicant was provided with my personal details, physical and postal address and telephone number.
4. 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).
5. 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.
6. The applicant is familiar with the information requested in the application form and all the relevant information was provided by the applicant.
7. The applicant is familiar with the information relating to the Protection of Personal Information Act (POPIA) as displayed on www.fedhealth.co.za and;

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

1. Personal Information — Yes / No
2. Benefits — Yes / No
3. Financial Information — Yes / No
4. Medical Information — Yes / No
5. Fund Documents — Yes / No

Member signature: .....

(Member must sign acknowledgment on Broker section.)

Date: d d m m y y y y

8. The advice and assistance given to the applicant was impartial and in the best interest of the applicant.
9. The applicant has personally signed the application form.
10. 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:

Maiden name (if applicable):

Title: First name/s: Preferred name:

Cellphone number: Email address: Initials:

Relationship to principal member: Gender: M / F Date of birth: d d m m y y y y

ID number: Nationality:

Income Tax Number: Passport number, if no ID:

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 ☐ 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		
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 21 or 27 if a full-time student*

	3 Adult ☐ Child* ☐	4 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		
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 21 or 27 if a full-time student*

Please note:

- Any dependant turning 21, and dependants over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- 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

Employee number

Employment date d d m m y y y y

Division code

Dept. name

Persal number *if applicable*

Fedhealth paypoint code

Medical scheme start date 0 1 m m y y y y

We confirm that the applicant is employed by us and commenced employment on the above date

Company stamp

Name of salary administrator

Designation

Monthly salary of myFED applicant

Signature .....

Date signed d d m m y y y y

SECTION 7 BANK DETAILS OF PRINCIPAL MEMBER *Refund of claims and debit order instruction*

I hereby instruct Fedhealth to electronically collect contributions and MediVault 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** ☐ **20th 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 MediVault instalment collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT. Any arrear collection will include ARR with previous abbreviates.

☐ 1. USE THIS ACCOUNT FOR ALL COLLECTIONS INCLUDING MEDIVAULT 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 MEDIVAULT 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.

Please note:
Should a third party pay the contribution and/or MediVault 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.

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

SECTION 8 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 without refund of contributions paid.

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

Name of beneficiary	Diagnosis	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	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	

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

SECTION 9 NOMINATED GP DETAILS

If you have selected flexiFED 1, flexiFED 1Elect, flexiFED 2, flexiFED 2GRID, flexiFED 2Elect, flexiFED 3, flexiFED 3GRID, flexiFED 3Elect, flexiFED 4GRID, flexiFED 4Elect 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, 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.

	MEMBER / DEPENDANT NAME	NOMINATED GP DETAILS		
		NAME	PRACTICE NUMBER	CONTACT DETAILS
Principal member		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.

SECTION 10 INCOME VERIFICATION FOR THE MYFED OPTION

Please tick appropriate box

Highest household income per month
☐ R1 – R6 251
☐ R6 252 – R8 550
☐ R8 551 – R10 219
☐ R10 220 – R12 622
☐ R12 623 – R14 426>
☐ R14 427 – >

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 11 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 12 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 MediVault 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 the Payroll on behalf of the Scheme, to deduct from my salary or any other available funds via debiting of my bank account, all contributions, instalments arrears or any other amounts that may become due by me in terms of the Scheme's rules. 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 and that interest may be charged on all amounts due and owing to the Scheme.
10. I acknowledge that the Scheme may obtain any information regarding myself from any credit bureau, national loans register, South African Fraud Prevention Service or any other agent I have dealt with, with regards to my profile and credit history.
11. I understand that the Scheme may provide written notification, to my email address, or SMS failing which, my financial adviser's email address as supplied by my financial adviser, of changes to its rules.
12. 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 received.
13. 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, and all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me or any person on my or my dependants' behalf under such contracts.
14. 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.
15. I acknowledge that I am not a member of more than one Medical Scheme.
16. I hereby authorise the Scheme or any of its nominated representatives to verify and confirm my bank details.
17. 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).
18. I agree to provide the Scheme with 3 (three) months' written notice to inform Fedhealth of my intention to terminate my membership.
19. 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.
20. 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.
21. 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.
22. 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

fedhealth member

RECORD AMENDMENT FORM 2023

FEDHEALTH

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

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

☐ **Change of address / contact details**
Sections 1, 2, 8 and 9 must be completed

☐ **Change of bank details**
Sections 1, 3, 8 and 9 must be completed

☐ **Change of marital status**
Sections 1, 4, 8 and 9 must be completed

☐ **Termination of dependant membership**
Sections 1, 5, 8 and 9 must be completed

☐ **Registration of:** • **Births and adoptions** • **Additional adult and child dependants**
Sections 1, 6, 7, 8 and 9 must be completed

☐ **Change of MediVault bank details**
Sections 1, 3, 8 and 9 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
Country Of Origin 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 MediVault 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** ☐ **20th 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 MediVault instalment collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT any arrear collection will include ARR with previous abbreviates.

☐ 1. USE THIS ACCOUNT FOR ALL TRANSACTIONS INCLUDING MEDIVAULT REPAYMENTS

☐ 2. USE THIS ACCOUNT FOR ALL COLLECTIONS ONLY
NB. If you tick this option, then 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 then bank details must be completed here.

☐ USE THIS ACCOUNT FOR MEDIVAULT 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.

Please note:
Should a third party pay the contribution/and MediVault Instalment on your behalf, the following supporting documents are required, certified by a commissioner of oaths and not older than three months:
- The account holder's identity document
- The 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.

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

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

Income Tax Number

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

If none, passport number, | Nationality

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	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 1Elect, flexiFED 2, flexiFED 2Grid, flexiFED 2Elect, flexiFED 3, flexiFED 3Grid, flexiFED 3Elect, myFED members are required to nominate 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 21 or 27 if a full time student.*

Please note:

- Any dependant turning 21, and over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- 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 6 REGISTRATION OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT *Continued*

2 Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname

Relationship to principal member | Gender M F

Income Tax Number

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

If none, passport number, | Nationality

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	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

flexi**FED 1**, flexi**FED 1**^{Elect}, flexi**FED 2**, flexi**FED 2**^{GRID}, flexi**FED 2**^{Elect}, flexi**FED 3**, flexi**FED 3**^{GRID}, flexi**FED 3**^{Elect}, my**FED members are required to nominate 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** my**FED 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 21 or 27 if a full time student.*

Please note:

- Any dependant turning 21, and over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- 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.

3 Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname

Relationship to principal member | Gender M F

Income Tax Number

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

If none, passport number, | Nationality

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	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 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 to nominate 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 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 21 or 27 if a full time student.*

Please note:

- Any dependant turning 21, and over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- 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 SOUGHT ANY ADVICE, 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	

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	

SECTION 7 MEDICAL DETAILS *Continued*

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

Name of beneficiary	Expected delivery date	Attending doctor

8. Are there any other conditions or symptoms 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 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

Vault Instalment (if applicable): R

Name of salary administrator

Designation

Company stamp

Signature .....

Date signed d d m m y y y y

SECTION 9 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 : d d m m y y y y

newborn registration form

It is very important that you submit this form to Fedhealth within 30 days of your baby's date of birth. Failure to do this may result in underwriting being applied. Please note a newborn baby is defined as a child of the main member or spouse born into the Scheme.

Email completed form to newborn@fedhealth.co.za

SECTION 1 DETAILS OF PRINCIPAL MEMBER

First name/s: _____ Initials and surname: _____

Membership no: _____

SECTION 2 REGISTRATION OF NEWBORN BABY

Date of birth: _____ Gender: _____

Initials: _____ First name/s: _____ Surname: _____

ID/passport number: (Refer to the Birth Certificate) _____

A notification of birth (received from the hospital) or a copy of the birth certificate is required

flexiFED 4^{GRID}, flexiFED 4^{Elect},flexiFED 3, flexiFED 3^{GRID}, flexiFED 3^{Elect}, flexiFED 2, flexiFED 2^{GRID}, flexiFED 2^{Elect}, flexiFED 1, flexiFED 1^{Elect} and myFED members are required to nominate up to two GPs (General Practitioners) 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 DETAILS		
Name	Practice number	Contact details
1.	1.	1.
2.	2.	2.

flexiFED members, please refer to the SuperCharged Savings and Supercharged Flexible Savings powered by MediVault in your brouchure regarding family size.

SECTION 3 EMPLOYER INFORMATION

Name of employer: _____ Division code: _____

Department name: _____ Fedhealth paypoint code: _____

Employee number: _____ Dependants subsidised: yes | no

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

Designation: _____ _____

Signature: _____ Date signed: d d m m y y y y

COMPANY STAMP

SECTION 4 DECLARATION BY PRINCIPAL MEMBER

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 personal information 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 d d m m y y y y

FEDHEALTH