Liberty Medical Scheme

Declaration Confirming Financial Dependency of Adult Dependant

Intermediary: Aon South Africa (Pty) Ltd
Intermediary Code: 200279

LIFE INVESTMENTS **HEALTH** CORPORATE PROPERTIES ADVICE

Liberty Medical Scheme
Private Bag X3, Century City, 7446
t 0860 000 LMS/567 **f** 021 657 7651
w www.libmed.co.za

Important:

- Proof of eligibility for registration as an adult dependant is required **annually**.
- Please write clearly using capital and block letters.
- All fields need to be completed.
- Adult dependant means a child, biological parent or biological sibling of the Member who is 21 years and older and dependent on the Member.
- Child means a member's natural child, child by virtue of a surrogate motherhood agreement as provided for in the Children's Act (Act 38 of 2005), a stepchild or legally adopted child.
- If your dependant is registered for a date after 1 January, benefits will be pro-rated
- **Please submit completed forms to: newbusiness@libertyhealth.co.za or fax: 021 657 7651.**

SECTION 1 — DETAILS OF MEMBER

Membership number

Member's first name(s)

Member's last name

Member's contact numbers

SECTION 2 – ADULT DEPENDANT'S DETAILS

Title | Initials | Last name

First name(s) (as per ID document)

Marital status: UNMARRIED | MARRIED | DIVORCED | WIDOWED | PARTNER — Gender: M | F

Date of birth: Y Y Y Y M M D D — SA ID number

Relationship to member (For example child. Where your child is not your biological child, please state relationship. For example stepchild, adopted child.)

SECTION 3 – DEPENDENCY DETAIL

Do you maintain this dependant? Y | N

Do you receive any assistance towards the maintenance of this dependant? Y | N

If yes, please provide details

Why is the dependant not able to maintain him/herself?

Does the dependant live permanently in your home? Y | N

If no, please provide details

How much does your dependant earn each month? R

- **If the dependant has an income:** A copy of the most recent payslip/salary advice, commission or other income statement. As a guideline the Scheme uses R3 500 as a threshold level to determine whether or not a dependant is regarded as being dependent. If your dependant's income exceeds this level, registration as a dependant will be terminated and the dependant will have to register as a principal member.
- **If a child is permanently disabled:** A copy of a doctor's disability report (not older than 6 months) to confirm the permanent disability.
- **If a child is a full-time student:** Proof of full-time studies (current proof of registration at a recognised educational institution – student cards won't be accepted).

SECTION 4 – DECLARATION BY MEMBER

I, the undersigned, hereby confirm that:

1. The information provided in this declaration and in any documents submitted in support of this declaration is true, correct and complete and that I have not withheld, concealed or misstated any information;
2. I understand that my membership and/or the registration of my dependant will become null and void or may be terminated should the above statement be found to be incorrect;
3. I will inform the Scheme immediately should any of the detail provided above relating to my dependant change and that my failure to do so may lead to my membership and/or the registration of my dependant being terminated;
4. I understand that, should the Scheme take any of the actions referred in clause 2 or 3 above, all contributions paid in respect of my membership and/or the registration of my dependant, shall be forfeited and that the Scheme shall furthermore be entitled to recover any amounts paid for services rendered from the provider and/or myself.

Signature of Member ____________ Date | Y | Y | Y | Y | M | M | D | D |

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AON
Empower Results®

Contact us on: **0860 tel arc / 0860 835 272,** P.O. Box 1874, Parklands, 2121, www.aon.co.za
FSB number: 20555; CMS number: ORG895

Acknowledgement of appointment

I hereby authorise Aon Hewitt to be my duly appointed Broker with immediate effect.

My ID [ ] and membership number [ ]

I have also been informed of the commission due to Aon Hewitt, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum of R75.00 excl. Vat per month. I have further been issued with a Statutory Notice and Section 13 certificate.

Signed at (town or city) [ ] on yy/mm/dd [ ]

Signature [ ]

Permission to make certain information available to Aon Hewitt

I give consent for the disclosure of information about me.

Membership number [ ]

Medical Scheme [ ] Aon Hewitt Broker Code [ ]

Title [ ] Initials [ ] Surname [ ]

First name(s) (as per identity document) [ ]

ID or passport number [ ]

To clarify this, the following information will be made available:

Personal examples	Benefit examples	Financial examples	Medical examples
Membership number Date of birth ID number Postal and e-mail Address Contact details Physical address Telephone numbers	Plan type Medical Savings Account amounts available Medical Savings Account choice Scheme Rate or Cost Current Medical Savings Account spent Limits Waiting period: details Wellness benefits Self-payment Gap Above Threshold Benefit	Tax certificate and tax reports Banking details Total contribution and breakdown	Chronic indicator Chronic condition PMB Chronic condition details Confirmation of claims paid (excluding amount and paid from where) Claims transaction history Hospital procedures Procedures codes Procedures done in doctor's rooms paid from Hospital Benefit

I hereby also authorise Aon Hewitt and/or Aon to provide me with any products that they consider appropriate to me.

Yes [ ] No [ ]

Signed at (town or city) [ ] on yy/mm/dd [ ]

Signature [ ]

Liberty Medical Scheme
Change of Financial Adviser Form

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Rules:

- This form must be completed in full.
- This form may only be signed by authorised signatories.
- **Individuals:**
  - In the case of individual members, only the principal member may act as the authorised person.
- **Employer groups:**
  - This form must be accompanied by a letter on the letterhead of the employer to confirm this Financial Adviser appointment, and that all affected members are informed and are in agreement with the appointment.
  - Please attach a list with details of affected members (including membership number/ID number and member initials and last name).

1. DETAILS OF NEWLY APPOINTED FINANCIAL ADVISER

Name of Business/Brokerage	Financial Adviser Main code
Aon South Africa (Pty) Ltd	200279
Name of Financial Adviser	**Financial Adviser Commission code**
Aon South Africa (Pty) Ltd	

2. DETAILS OF EMPLOYER GROUP (NOT FOR INDIVIDUAL MEMBERS)

Name of Employer Group	Employer Group code(s)
Name of Signatory	**Designation**

3. DETAILS OF MEMBERS (ONLY FOR INDIVIDUALS)

Membership number	Initials	Last name	Identity number

Important:

1. With receipt of this appointment form, commission payment to the current Financial Adviser will be suspended according to regulation 28(7) of the Medical Schemes Act.
2. The appointment will be effective from the 1st day of the month if received before or on the 15th of that month. If not received by the 15th, it will be implemented on the 1st day of the following month.
3. The Financial Adviser appointment cannot be backdated.
4. This appointment cancels all previous Financial Advisers appointments.

AUTHORISATION

Individuals

I/We, ______________________________ am/are fully authorised to appoint the abovementioned Financial Adviser to act on my/our behalf in all my/our negotiations with Liberty Medical Scheme.

I/We authorise the Scheme to share all membership information pertaining to myself and my registered dependants with the newly appointed Financial Adviser so that he/she may render advice and intermediary services to me/us.

Please advise if all membership information should:
(Please tick applicable box)

Include Claims Information ☐

Exclude Claims Information ☐

Employer Groups

I/We, ______________________________ am/are fully authorised to appoint the above mentioned Financial Adviser to act on behalf of the Employer Group in all the negotiations with Liberty Medical Scheme.

I/We, authorise the appointed Financial Adviser so that he/she may render advice and broker services to the members of the Employer Group.

Signed at ____________________ on this ____________ day of ____________ 20 ______

Signature of Authorised Signatory ☐

The completed form can be sent to Vcommissions via Fax 021 914 3524 or Email commissions@uniquepay.co.za.

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