Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1009

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CONTINUATION OF MEMBERSHIP FORM

PLEASE USE BLACK INK TO COMPLETE ALL SECTIONS, AND RETURN AS SOON AS POSSIBLE TO ENSURE SPEEDY REGISTRATION. PLEASE INDICATE YOUR REASON FOR CONTINUING MEMBERSHIP BY TICKING THE APPROPRIATE BOX:

Continuing as: ☐ Individual ☐ Group ☐ Widow(er) ☐ Orphan

Please indicate your option by ticking the appropriate box:

MEDICAL FUND OPTIONS: ☐ Primary Care ☐ Savings Care ☐ Affordable Care ☐ Full Benefit

FOR INTERNAL USE ONLY

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Employer group: ☐☐☐☐☐☐☐☐☐☐☐

SECTION 1 PERSONAL DETAILS

Title: ____________________ Surname: ____________________

First names: ____________________

Membership number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Identity number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Postal address: ____________________

____________________ Postal code: ____________________

Physical address: ____________________

____________________ Postal code: ____________________

Email address: ____________________ Occupation: ____________________

Tel (H): ( ) ____________________ Tel (W): ( ) ____________________

Cell: ____________________ Date of birth: ____________________

SECTION 2 TO BE COMPLETED BY THE PRINCIPAL MEMBER'S / WIDOW(ER'S) EMPLOYER (IF APPLICABLE)

Date joined Fund: DD / MM / YYYY Date of benefit: DD / MM / YYYY

Income category: ____________________

Member's share of contribution: ____________________ Employer's share of contribution: ____________________

Total monthly contribution: ____________________ Payroll/persal number: ____________________

Employer/Account number: ____________________

NB: Proof of income/salary slip to be submitted with this form

Company/division: ____________________ Name: ____________________

Account no: ____________________ Designation: ____________________

Email: ____________________ Telephone: ( ) ____________________

Date: DD / MM / YYYY

We confirm that the applicant is employed/or is the widow(er) and that contributions are being deducted in accordance with the applicant's income and eligible dependants, in terms of the appropriate contribution table. Any further changes to the employee's/widow(er)'s status will be advised to the Fund within seven days.

____
SIGNATURE OF EMPLOYER

OFFICIAL STAMP OF EMPLOYER

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Broker Code: 1009

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SECTION 3 DEPENDANT'S DETAILS

Relationship codes:

S = Spouse C = Child O = Other

P = Parent LP = Life Partner

Gender codes:

M = Male

F = Female

Dependant code: 01 Full name:______________________
Date of birth: DD / MM / YYYY Date joined Fund: DD / MM / YYYY
Gender: ☐ Relationship: ☐
Identity number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Dependant code: 02 Full name:______________________
Date of birth: DD / MM / YYYY Date joined Fund: DD / MM / YYYY
Gender: ☐ Relationship: ☐
Identity number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Dependant code: 03 Full name:______________________
Date of birth: DD / MM / YYYY Date joined Fund: DD / MM / YYYY
Gender: ☐ Relationship: ☐
Identity number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Dependant code: 04 Full name:______________________
Date of birth: DD / MM / YYYY Date joined Fund: DD / MM / YYYY
Gender: ☐ Relationship: ☐
Identity number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

SECTION 4 MEDICAL HISTORY OF PRINCIPAL MEMBER AND REGISTERED DEPENDANTS

To match the correct dependant code with the codes below, please refer to Section 3.

IMPORTANT: Please submit proof and date of treatment of pre-existing health conditions of principal member and all dependants. This means a sickness or condition for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months preceding application. Please ask your treating doctor to help you to provide the relevant ICD-10 code for your condition.

Please provide full details for any of the conditions below in the space provided and attach relevant medical reports to this form:

	Condition	Mark one		Dependant number (Mark with X where applicable)					ICD- 10 code	Date of last treatment
1	Any disorder of the heart (eg, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	Y	N	00	01	02	03	04		
2	High blood pressure or disease of the blood vessels or circulatory disorder (eg, cramp during exercise, stroke, high cholesterol, hardening of arteries)?	Y	N	00	01	02	03	04		
3	Any respiratory or lung disease (eg, asthma, bronchitis, persistent cough, tuberculosis?	Y	N	00	01	02	03	04		
4	Any disorder of the digestive system, gall bladder, pancreas or liver (eg, actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, anal bleeding, haemorrhoids or jaundice)?	Y	N	00	01	02	03	04		

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SECTION 4 MEDICAL HISTORY OF PRINCIPAL MEMBER AND REGISTERED DEPENDANTS (CONTINUED)

		Mark one		Dependant number (Mark with X where applicable)					ICD- 10 code	Date of last treatment
5	Disease or disorder of the kidneys, bladder or reproductive organs (eg, albumin in urine, kidney stones, prostatitis, venereal diseases, infertility or impotence)?	Y	N	00	01	02	03	04		
6	Any nervous or mental complaint (eg, epilepsy, blackouts, anxiety or depression)?	Y	N	00	01	02	03	04		
7	Any type of nerve ailment (eg, loss of sensation, numbness or paralysis)?	Y	N	00	01	02	03	04		
8	Ear, eye, nose or throat disorder (eg, discharge, defective vision)?	Y	N	00	01	02	03	04		
9	Disorder or disease of skin, muscles, bones, joints, limbs, spine (eg, psoriasis, arthritis, gout, slipped disc or other back trouble)?	Y	N	00	01	02	03	04		
10	Diabetes, hormonal imbalance, glandular or metabolic diseases, thyroid or blood disorders?	Y	N	00	01	02	03	04		
11	Cancer, growth, tumour of any kind?	Y	N	00	01	02	03	04		
12	Any other illness, disorder, operation, disability or accident (eg, fractured nose, breathing disorers, mammary hypertrophy [enlarged breasts with associated side-effects], AIDS, congenital abnormalities, etc)?	Y	N	00	01	02	03	04		
13	Are you pregnant? State expected date of confinement.	Y	N	00	01	02	03	04		
14	Are you or your dependants currently undergoing or expecting to undergo any medical, dental or surgical treatment?	Y	N	00	01	02	03	04		
15	Have you or your dependants received any medical, dental or surgical treatment?	Y	N	00	01	02	03	04		
16	Have any exclusions been imposed on yourself or your dependants by any medical scheme on which you have been registered? If YES, please state details below.	Y	N	00	01	02	03	04		

17 Please give any other relevant information: ______________________________

____

____

DISCLAIMER: I will inform the Fund Fund of any changes in my health status or the health of my dependant/s within 30 days of the change occuring from the date of application and within 90 days of the activation date.

SECTION 5 LATE SPOUSE'S DETAILS

Name: ______________________________ Surname: ______________________________

Membership number: | | | | | | | | | | | | | |

Identity number: | | | | | | | | | | | | | |

Employer: ______________________________

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1009

SECTION 6 — INCOME DECLARATION AND BANKING DETAILS (FOR REFUND PURPOSES AND DEBIT ORDER AUTHORITY)

A) Banking details

Bank:______________________________

Branch: ______________________________

Branch code: ______________________________

Type of account: ______________________________

Account number: ______________________________

B) Contribution payments

I hereby authorise that the monthly contribution, as raised by the Sizwe Medical Fund, may be withdrawn from the abovementioned account on the 1st of each month for the current month's membership contributions. This payment will represent the full monthly contribution payable to the Fund. If I am a Direct Paying Member, I understand that my contributions are collected monthly in advance. I further understand that if payment is not made to the Fund on the 1st of each month, then my membership can be terminated with immediate effect and all benefits derived from the Fund will cease. I hereby declare that the information in this application is true and correct and I agree that any false declaration could render my application null and void.

C) Income declaration (compulsory for all members)

I hereby declare that my monthly income is R__________________ per month.
(Substantiating proof of income must be attached and must be resubmitted to the Fund on an annual basis.)

NOTE: If the account holder is not the principal member of the Fund, the principal member agrees to refund monies being paid into the above account and both Sizwe Medical Fund and its administrator, Sechaba Medical Solutions, are not held responsible for this money once paid.

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Tel No: 0860 835 272
Broker Code: 1009

Date of first payment: D D / M M / Y Y Y Y

Signature: ______________________ Date: D D / M M / Y Y Y Y

SECTION 7 — ESSENTIAL DOCUMENTS (COMPULSORY)

Please provide the following documentation with your application	Are the relevant documents attached?			
Copy of ID for yourself and your dependants	YES		NO	
Birth certificates of children (where ID is not available)	YES		NO	
Clinic cards for newborn babies (within 30 days of birth to avoid waiting periods)	YES		NO	
Documentary proof in the case of adopted/foster children	YES		NO	
Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting periods)	YES		NO	
Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable)	YES		NO	
Membership certificates with termination dates from previous medical aids, for member and dependants (where applicable)	YES		NO	
Written confirmation that claimant is a member of the Unemployment Insurance Fund (if unemployed)	YES		NO	
Proof of taxable income (ie, pay slip, SARS IT34 form, etc)	YES		NO	

SECTION 7 ESSENTIAL DOCUMENTS (COMPULSORY) (CONTINUED)

Please provide the following documentation with your application	**Are the relevant documents attached?**			
Proof of study for dependant/s from the age of 21 years, or affidavit for financially dependent dependant/s, or doctor's letter for mentally or physically disabled children	**YES**		**NO**	
Either an original cancelled cheque (for a cheque account) or an original bank statement (for a transmission or savings account) so that claims can be paid directly into your bank account.	**YES**		**NO**	

PLEASE ENSURE THIS SECTION IS COMPLETED IN FULL AND ALL NECESSARY DOCUMENTS ARE ATTACHED WITH YOUR APPLICATION. FAILURE TO SUBMIT THE RELEVANT DOCUMENTS WILL DELAY THE PROCESSING OF YOUR MEMBERSHIP APPLICATION.

6th Floor, 56 von Wielligh Street, Johannesburg **PO Box 260709, Excom, 2028**

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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 South Africa (Pty) Ltd 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, 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 South Africa (Pty) Ltd

I give consent for the disclosure of information about me.

Membership number [ ]

Medical Scheme [ ] Aon 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 South Africa (Pty) Ltd to provide me with any products that they consider appropriate to me.

Yes [ ] No [ ]

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

Signature [ ]