Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1343

TopMed tm

TopMed Medical Scheme
PO Box 1462, Durban, 4000
Client Services: 0860 00 21 58
Website: www.topmed.co.za

AMENDMENT FORM

To be completed for the following amendments

- Change of address
- Change of contact details
- Change of banking details
- Addition of dependant
- Removal of dependant

(A) DETAILS OF THE MEMBER

Surname

Full Name(s)

Membership Number

(B) CHANGE OF ADDRESS

Postal Address

Postal Code

Physical Address

Postal Code

(C) CHANGE OF CONTACT DETAILS

Email Address

Telephone (home)

Telephone (work)

Cellphone Number

Initial here

D DEBIT/CREDIT ORDER INSTRUCTION

Member Name

Member/Group Number ID Number

Telephone Number

Postal Address

Postal Code

TO WHOM IT MAY CONCERN

Debit Credit

The details of my/our bank account is/are as follows:

Name of Account Holder

Name of Bank

Branch Name Branch Code

Account Number

Account Type: Current / Savings / Transmission

PLEASE NOTE THAT CREDIT CARD TRANSACTIONS ARE NOT ALLOWED AGAINST YOUR MEDICAL AID CONTRIBUTIONS AND REFUNDS.

I/We hereby instruct and authorise you to debit/credit amounts which may be due to/by me/us to the debit/credit of my/our account with the abovementioned bank, or any other bank to which I/we may transfer my/our account.

I/We understand that the debit/credit transfers hereby authorised will be processed by computer through a system known as ACB Magnetic Tape Service and I/we also understand that no advice of the debit/credit will be provided by my/our bank, but details of each debit/credit will be printed on my/our statement or on any accompanying voucher.

I/We agree to pay any bank charges relating to the debit order instruction.

I/We understand that Billing advices and details will be supplied in the normal way and that the debit/credit will be actioned at least ten days after the date of Statement to/from my/our account.

This authority may be cancelled by me/us by giving thirty days written notice, sent by prepaid registered post, but I/we understand that I/we shall not be entitled to any refund amounts which have been withdrawn while this authority was in force if such amounts were legally owing by me/us.

SIGNATURE OF ACCOUNT HOLDER (MANDATORY) ______________________ DATE D D M M Y Y Y Y

SIGNATURE OF PRINCIPAL MEMBER (MANDATORY) ______________________ DATE D D M M Y Y Y Y

SIGNATURE OF GROUP / EMPLOYER (WHERE APPLICABLE) ______________________ DATE D D M M Y Y Y Y

SIGNATURE OF BROKER / INTERMEDIARY (WHERE APPLICABLE) ______________________ DATE D D M M Y Y Y Y

PLEASE NOTE: Changes to your banking details will only be processed upon receipt of a valid copy of your identity document attached to this application.

You will receive your Billing statement and details as usual and the debit order will be actioned at least ten days after the date of statement. If for some reason you do not agree with the statement and do not want the Debit Order actioned, kindly telephone us on **0860 00 21 58** so that alternate arrangements can be made.

GROUP STAMP

Aon South Africa (Pty) Ltd
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(E) ADDITION OF DEPENDANT

Start Date D D M M Y Y Y Y

Please complete section J (UNDERWRITING QUESTIONS) in full for all additional dependants.
In the case of newborns within 30 days of birth, please attach a copy of ID Document or Birth Certificate.

Full Name(s)	**Surname**	**Gender M / F**	**ID Number (compulsory)**	**Relationship** (spouse, son, partner*, etc)

- All newborns must be registered within 30 days after birth as a dependent of the Principal Insured Person.
- **Proof of Student Registration must be attached for all dependent children aged 21-24 years.**
- **Copies of ID documents/birth certificates must be attached for all dependants.**

I hereby declare that the insured persons with different surnames, are related to me as:

Biological child ☐ Adopted child * ☐
Step child ☐ Married to Principal Insured ☐
Foster child * ☐ Partner ** ☐

Please note:
***** Foster/Adopted child - proof of legal guardianship is required.

** Partner - a person with whom the Member has a committed and serious relationship simliar to that of a marriage in which there is mutual, financial and emotional support and a shared household, irrespective of the gender of either party.

(F) REMOVAL OF DEPENDANT

Surname Initials
Full Name(s) (including any names or nicknames)
ID No. of Dependant Date of Resignation D D M M Y Y Y Y
Reason

Surname Initials
Full Name(s) (including any names or nicknames)
ID No. of Dependant Date of Resignation D D M M Y Y Y Y
Reason

(H) DECLARATION BY MEMBER

I hereby declare that the information in this document, whether it is in my own handwriting or not, is complete and correct.

Signature (Main Member)
Date D D - M M - 2 0 Y Y

(I) TO BE COMPLETED BY EMPLOYER IF MEMBER HAS COMPLETED SECTIONS E AND F

Name of Employer
Group Number

Total current contribution R
Total new contribution R
Arrears (if applicable) R

Signature (Employer)
Company Stamp
Date D D - M M - 2 0 Y Y

Initial here

(J) UNDERWRITING QUESTIONS

In order to add a Dependant to your membership, please complete the questionnaire below:

PLEASE ANSWER YES ☑ OR NO ☒ TO EVERY QUESTION FOR EVERY BENEFICIARY.

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High Blood Pressure, High Cholesterol or lipids, Ischaemic Heart Disease, heart failure, Angina, Stroke (CVA) or Peripheral Vascular Disease						
2	Obstructive Lung Disease (Asthma, Emphysema or C.O.A.D)						
3	Diabetes (Insulin or Non-insulin Dependant Diabetes Mellitus)						
4	Hypo or Hyperthyroidism						
5	Arthritis (i.e. Osteo, Rheumatoid Arthritis or Gout) - all related musculoskeletal conditions						
6	Osteoporosis						
7	Gastro Oesophageal Reflux Disease (G.O.R.D/heartburn) or stomach/duodenal ulcers (please circle)						
8	Immune Deficiency status (i.e. HIV/AIDS*, immunoglobulin deficiencies)						
9	Anaemia or abnormalities of clotting mechanism						
10	Hormone Replacement Therapy, Endometriosis or ovarian cysts						
11	Depression and/or anxiety disorders						
12	Any nervous or mental complaint (e.g. Epilepsy, blackouts, paralysis or headaches)						
13	Glaucoma, cataracts or any other disorders of the eye						
14	Parkinson's Disease or Multiple Sclerosis (please circle)						
15	Hyperplasia of prostate (BPH) or Prostatism						
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)						
17	Urinary tract infection or calculi (stones)						
18	Back or neck related condition (lumbago, sciatica, injury, spasm, etc)						
19	Are you pregnant? If so, how many weeks?						
20	Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure for the following 12 months?						
21	Are you on any medication at present?						
22	Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical aid claim within the next 12 months?						
23	Skin conditions/disorders (e.g Acne, Eczema, Psoriasis, etc)						
24	Ear, nose or throat disorders (e.g. ear discharge, recurrent Tonsillitis)						
25	Infectious diseases (e.g. Tuberculosis, Shingles, Measles, etc)						
26	Malignant neoplasms (cancer, growths or malignant tumours)						
27	Benign neoplasms (non-malignant tumours/growths)						
28	Specialised dentistry/maxillo-facial treatment						
29	Have you had or are you expecting to have plastic or reconstructive surgery?						
30	Do you or your dependants take chronic medication?						

* Should you be HIV positive and do not wish to disclose this on your application form, please note that once you have received your membership (Contract) number, we require you to please fax confirmation of your HIV/AIDS status to our HIV/AIDS Department on **0860 448 2273**. Please note that this may result in you receiving a second card from the Scheme depending on whether your application will require underwriting as per current legislation.

IF YOU HAVE ANSWERED 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS BELOW. FAILURE TO DISCLOSE ANY PRE-EXISTING CONDITIONS COULD RESULT IN BENEFITS BEING LIMITED, EXCLUDED AND/OR MEMBERSHIP BEING TERMINATED.

Question No.	Nature and duration of complaint and full details of treatment being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment?

NB: Failure to disclose any pre-exisinting conditions could result in benefits being limited, excluded and/or membership being terminated.

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Aon South Africa (Pty) Ltd
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TopMed tm

Registration No. 1422

BROKER APPOINTMENT

- This form must be completed in full
- This form may only be signed by authorised members. In the case of individual members, only the principal member may act as the authorised person
- Compulsory employer groups: this form must be accompanied by a letter on the letterhead of the employer to confirm this broker appointment.
- Non-compulsory employer groups: Please attach a list with details to this form if there is not sufficient space provided at point 3.

1. DETAILS OF NEW BROKER

Name of Broker House: Aon South Africa (Pty) Ltd

Broker House Code: 1343

Name of Broker: Aon South Africa (Pty) Ltd

Broker Code:

2. DETAILS OF EMPLOYER (not for individual members)

Name of Employer

Employer Group Code

Name of Authorised Person

Designation

3. DETAILS OF MEMBER (only for individuals and non-compulsory employer groups)

Membership Number	Initials	Surname	Identity Number

4. AUTHORISATION

I, ______________________, am fully authorised to appoint the abovementioned broker to act on behalf of me/us in all my/our negotiations with TopMed. I am aware that the broker will have access to my/our membership information.

Signature

Date D D - M M - 2 0 Y Y

RULES

1. With receipt of this appointment form, commission payment to the current broker will be suspended according to regulation 28(7) of the Act of Medical Schemes. This appointment will only come into effect 30 days after the current broker was notified of this appointment.
2. The broker appointment cannot be backdated.

Trustees: Jerry van Vuuren (Chairman); Jan Burger; Nick Byrne; Alistair Dry; Callie Du Plessis; Martyn Evers; Martin Neethling; Jakobus Viljoen Principal Officer: Barbara Duffy

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 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 ______________