ultimax
APPLICATION FORM

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 2727
Broker Code: AON001M16

FEDHEALTH

SECTION 1 DATE OF JOINING

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

☐ 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 | ID/ passport number

Tax Number

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

Cellphone number | Fax ( )

E-mail address

Postal address

Postal code

Physical address

Postal code

Country

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

Have you 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 you when applying for membership of any other medical scheme/s? Yes No

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

Do you want your membership pack and card: Delivered ☐ Posted ☐ Collected from nearest Medscheme Branch ☐

Delivery Address during working hours (Monday - Friday 08:00AM - 17:00PM):

Postal code

SECTION 3 INTERMEDIARY / FINANCIAL ADVISER

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

Broker code: AON001M16 | FSB licence number: 20555

Name of brokerage: Aon South Africa (Pty) Ltd

Name of broker/agent/adviser

Telephone (W): 0860 835 272 | Cellular

Fax

E-mail address: arc@aon.co.za

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 (POPI) Act as displayed on www.fedhealth.co.za
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.

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

SPOUSE / PARTNER Surname

Maiden name (if applicable)

Title | First name/s

Cellphone number | Initials

Relationship to principal member | Gender M F

ID/ passport/ birth certificate number | Date of birth d d m m y y y y

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? Yes No

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*	3 Adult / Child*	4 Adult / Child*
Title	Initials / Relationship to member	Initials / Relationship to member	Initials / Relationship to member	Initials / Relationship to member
Surname				
First name/s				
Preferred name	Marital status	Marital status	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	d d m m y y y y / Gender M F	d d m m y y y y / Gender M F
E-mail address	Cell	Cell	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 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 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

Name of salary administrator

Designation

Company stamp

Signature ..... Date signed d d m m y y y y

SECTION 7 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	
				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	

If you or any of your dependants are living with HIV/ AIDS and would prefer not to disclose the HIV/ AIDS status on this form in the interest of confidentiality, then please call Aid for AIDS on 0860 100 646 to register on the HIV/ AIDS Disease Management Programme within 90 days of membership. Should this space be insufficient, please attach a separate sheet.

SECTION 8 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 9 BANK DETAILS OF PRINCIPAL MEMBER *Refund of claims and debit order instruction*

I hereby instruct Fedhealth to electronically collect contributions and to deposit refunds, using the information provided below.
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 either of the following two dates for debit order collections.

☐ **25th of the month** **OR** ☐ **First working day of the following 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.

☐ 1. USE THIS ACCOUNT FOR ALL TRANSACTIONS

☐ 2. USE THIS ACCOUNT FOR CONTRIBUTION 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.

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 contribution collections and refunds.

Please note:
Should a 3rd party pay the contribution on your behalf, the following supporting documents are required:
- A copy of the account holder's identity document
- A copy of the account holder's bank statement
- Account holder's letter of authority to the Scheme to deduct contributions on behalf of the member.

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

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SECTION 10 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. In addition, should I default on payment of any subsequent contributions, 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 month general waiting period, a 12 month waiting period for pre-existing conditions and, if applicable, a late joiner penalty fee.
7. I hereby authorise the Scheme to deduct from my salary or any other available funds via debiting of my bank account, all contributions 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 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 e-mail address, failing which, my financial adviser's e-mail address as supplied by my financial adviser, of changes to its rules.
12. 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.
13. Should there be any additional information required by the Scheme which is not received within 7 days, the Scheme will automatically suspend the application.
14. I acknowledge that I am not a member of more than one Medical Scheme.
15. I hereby authorise the Scheme or any of its nominated representatives to verify and confirm my bank details.
16. 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).
17. I agree to provide the Scheme with 3 months' written notice to inform Fedhealth of my intention to terminate my membership.
18. 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, future claims may be rejected.
19. 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.
20. 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.
21. 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 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 Reality Access

Fedhealth members receive FREE Sanlam Reality Access membership – a value-added offering that provides you with R3 000 cover for your pets in case of an accident through PetSure, as well as up to R5 million worth of travel insurance through Travel Insurance Consultants (TIC). Your Sanlam Reality Access membership is automatically activated and terminated with your Fedhealth membership. For more information about Sanlam Reality Access you can visit fedhealth.co.za/Sanlam-reality-access/

Please note:

- Once your Sanlam Reality Access membership is activated, you will receive monthly communication from Sanlam Reality.
- You can cancel your Sanlam Reality Access membership at any time without any effect on your Fedhealth membership. Simply email info@sanlamreality.co.za
- In order to offer, activate and maintain your Sanlam Reality Access membership, Fedhealth will supply your personal information to Sanlam Reality, but not your healthcare information.

By signing this section, you agree to the declaration above and give Fedhealth your consent to activate your Sanlam Reality Access membership.

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

Signature of principal member ……

Print name …… Identity number

Please mail completed form to:
Fedhealth Medical Scheme
Private Bag X3045
Randburg 2125

Or fax to:
Fedhealth Membership
Fax No: 011 671 3647

Or e-mail to:
update@fedhealth.co.za

Customer Contact Centre number:
0860 002 153

Broker House: Aon South Africa (Pty) Ltd
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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 that the commission due to Aon, payable by the medical scheme as part of my monthly contribution, 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).

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