



# Change of option form 2019

Broker House Name: Aon South Africa (Pty) Ltd  
Tel No: 0860 835 272  
Broker Code: AON001M16

P.O. Box 1101, Florida Glen, 1708 Call 0860 002 108  
Fax (011) 671 3764 Email optionchanges@bonitas.co.za

If you do not wish to change your option, please do not complete this form. This form must be completed by Bonitas members who would like to change from one option to another. You may only change your option once a year.

## Instructions

- This form must be submitted on or before 31 October 2018 for Persal members or before 30 November 2018 for all other members
- If you are a direct paying member, please email your form to optionchanges@bonitas.co.za or fax it to (011) 671 3764
- We cannot process your application if it is incomplete, incorrect or if you have not attached the correct documents – your form must have an employer stamp in order to be processed (if applicable)
- To access a list of GPs, specialists and hospitals in your area, log in to www.bonitas.co.za
- Please attach proof of identity for you and your dependants to this form (identity document, driving licence or birth certificate).

## Section 1: Details of main member

Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Title:	<input type="text"/>	Surname:	<input type="text"/>
First names:	<input type="text"/>		
Identity number:	<input type="text"/>	Date of birth:	<input type="text"/>
Membership number:	<input type="text"/>	Marital status:	<input type="text"/>
Gender:	<input type="checkbox"/> M <input type="checkbox"/> F	Cellphone:	<input type="text"/>
Telephone (h):	<input type="text"/>	Telephone (w):	<input type="text"/>
Email:	<input type="text"/>		
Postal address:	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	Code:	<input type="text"/>
Street address:	<input type="text"/>		
	<input type="text"/>	Code:	<input type="text"/>

## Section 2: Choosing your option

Please select the option you want to change to (mark with an X). Select one option only.

BonComprehensive    
 BonClassic    
 BonComplete    
 BonSave    
 BonFit    
 Standard    
 Standard Select   
 Primary    
 Primary Select    
 Hospital Standard    
 BonEssential    
 BonEssential Select    
 BonCap

BonCap contributions are income based. Please select the income band that applies to your gross monthly salary.

R0 to R8 030    
 R8 031 to R13 050    
 R13 051 to R17 830    
 R17 831+

**Please note:** If you have selected **BonCap**, you will need to send us proof of your earnings. If you have chosen **Standard Select**, **Primary Select** or **BonCap** you must complete **Section 4**.

## Section 3: Declaration of income

Please complete this section if you have chosen BonCap; if you fail to do so, you will be placed in the highest income band.

Description of income	Main member	Spouse/partner
	R per month	R per month
Salary or wages	<input type="text"/>	<input type="text"/>
Commission and other rewards	<input type="text"/>	<input type="text"/>
Pensions or annuities	<input type="text"/>	<input type="text"/>
Rental income	<input type="text"/>	<input type="text"/>
Trust distributions	<input type="text"/>	<input type="text"/>
Government grants	<input type="text"/>	<input type="text"/>
UIF payments	<input type="text"/>	<input type="text"/>
Interest on investments	<input type="text"/>	<input type="text"/>
Subsidies of any kind	<input type="text"/>	<input type="text"/>
Maintenance	<input type="text"/>	<input type="text"/>
Other income	<input type="text"/>	<input type="text"/>
<b>Total income</b>	<b>R</b>	<b>R</b>

We also require the documents in the table below to be attached to this form for you and your spouse/partner.  
**If the required documents are not submitted with this form, you will be defaulted to the highest income band.**

If you	We need
<b>Earn a monthly salary or salary with commission</b>	Your latest payslip + Your bank statements for the last three months (showing the monthly income you receive)
<b>Get paid weekly/fortnightly wages</b>	Four latest weekly payslips or two latest fortnightly payslips OR A letter from your employer/company confirming your income + Your bank statements for the last three months (showing the monthly/weekly/fortnightly income you receive)
<b>Earn commission only</b>	Proof of earnings OR Your last three commission statements + Your latest IRP5 + Your bank statements for the last three months (showing the monthly income you receive)
<b>Are self-employed</b>	A copy of your latest IT34A (SARS notice of assessment) + A letter from an external auditor/accounting firm confirming your income + Your bank statements for the last three months (showing the monthly income you receive)
<b>Are unemployed</b>	Your UIF statement OR A retrenchment letter or dismissal letter if you were dismissed/retrenched in the past twelve months + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
<b>Are a minor (including children at primary and secondary school)</b>	A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
<b>Are a full-time student (tertiary education)</b>	Proof of registration from your tertiary institution (student card only will not be accepted) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
<b>Are a foreign student</b>	A copy of your passport + Proof of registration from your tertiary institution + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
<b>Are a foreign national (a person living in South Africa who is a citizen of another country)</b>	A copy of your passport + A copy of your work permit + A copy of your contract reflecting your contract period and monthly income + Your bank statements for the last three months (showing the monthly income you receive)
<b>Are temporarily disabled</b>	A copy of your IT34A (SARS notice of assessment) + A full medical report from your doctor + Your disability grant letter OR A letter from the Department of Social Development + Your bank statements for the last three months (showing the monthly income you receive)
<b>Are permanently disabled</b>	A full medical report from your doctor + Your disability grant letter + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid

If you	We need
<b>Earn a Government pension (SASSA)</b>	Your most recent SASSA pension statement OR A copy of an ATM slip confirming your monthly pension OR A copy of a withdrawal slip from a SASSA paypoint confirming your monthly pension OR A SASSA pension income letter (that is not older than six months) + Your bank statements for the last three months (showing the monthly income you receive)
<b>Earn any other pension</b>	A copy of your IT34A (SARS notice of assessment) OR Your most recent pension statement OR A pension income letter (not older than 6 months) + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid

**Please note:** Bank statements submitted must clearly show the money earned being deposited into the account.

**Section 4: GP nomination**

If you choose the **Standard Select**, **Primary Select** or **BonCap** option you must nominate a GP from the Bonitas GP network for each beneficiary.

	Name	Surname	Doctor's name	Practice number	Doctor's contact number
Main member					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

**Section 5: Employer information**

This section must be completed by your employer or pension fund (where applicable).

Name of company representative:

Title of company representative:

Telephone:

Email:

Bonitas paypoint code:

Employer stamp

The above change of option has been noted and approved.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Section 6: Member declaration**

I understand that this written notice to change my option will apply from 1 January 2019. I further understand that I will be responsible for the full payment of the contributions on a monthly basis. I agree to follow the rules of Bonitas Medical Fund. I know that the rules are available at [www.bonitas.co.za](http://www.bonitas.co.za) and will be provided to me upon request.

**Main member's signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**Section 7: Protection of your information**

1. We will keep your information and your dependants' information confidential. We and our administrator have data security measures in place to do this. Personal information refers to information that identifies you or relates specifically to you or your dependants, such as an identity number, name or email address.
2. We have data security measures in place to protect you and your dependants' personal information. This may include access control to restrict the disclosure of personal information to only authorised individuals, confidentiality agreements with service providers and staff members.
3. We will only use your information for the following purposes:
  - Underwriting
  - Assessing and processing medical services claims
  - Fraud prevention and detection
  - Statistical analysis
  - Audit and record-keeping
  - Compliance with legal and regulatory requirements
  - Verifying your identity
  - Certain marketing and related activities that may be applicable from time to time, subject to such rights as you may have in law.
4. We may share your information with the service providers for the purpose of processing it and rendering services to you.
5. You may access the personal information we hold and request us to correct any errors.

**Section 8: Acknowledgement and declaration**

1. I declare that the information contained in this application form, is correct. I also declare that I have the permission of my dependants to disclose personal information about them to Bonitas and will provide written proof of this, if asked.
2. I declare that any false information in this application form or the non-disclosure of any material information will result in my membership being declared null and void.
3. I accept that Bonitas has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation or fraudulent behaviour. If any of my or my dependants' circumstances change after the date of signing this application or the acceptance of my membership, I will promptly notify Bonitas of the changes. I understand that failure to do so may lead to the termination or amendment of the terms and conditions of my membership and Bonitas shall also be entitled to reclaim any amounts, it may have erroneously paid to any service provider on behalf of me or my dependants, from me.
4. I agree that should Bonitas incur any legal costs or expenses to recover any contributions owed by me or any other amount due by me to Bonitas, for any reason; I shall be responsible for such costs and expenses on the attorney/client scale. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any money owed to Bonitas.
5. I understand that it is my responsibility to ensure that the monthly contributions are received by Bonitas. I also understand that if any contributions are unpaid, it may result in me and my dependants being terminated from Bonitas until all arrear contributions have been settled. I also understand that should my membership be suspended or terminated, I will not be entitled to any benefits arising from my membership whatsoever.
6. I will inform Bonitas of any changes to my or my dependants' health or personal status within 30 days of the change as required by Fund Rules.
7. I authorise my and my dependants' healthcare providers to disclose information to Bonitas and its contracted service providers and partners, provided that the information is treated as confidential.
8. I agree to provide Bonitas with any medical or historical information and grant Bonitas access to medical information reasonably required relating to a specific ailment, disease, disorder, condition or disability.
9. I agree that should I be accepted as a member of Bonitas, I shall provide Bonitas with all information including medical information that Bonitas may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Fund Rules.
10. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.
11. I understand that the underwriting conditions will affect my rights and my dependants' rights to benefits if applied.
12. I allow Bonitas to take all reasonable steps to verify information provided by me in this application form and agree to submit proof of identification to Bonitas on demand.
13. I consent to my telephone conversations with the Bonitas call centre being recorded and forming part of Bonitas' records. I also agree that such records will remain the sole property of Bonitas.
14. I declare that the information provided in this document is true and accurate and if accepted will form the basis of my agreement with Bonitas.
15. I hereby confirm that as the main member on Bonitas, I have received permission from my dependants to access and view their healthcare claims made on my membership and deal with all matters relating to the claims on my membership.
16. I hereby authorise the Fund to share my and my dependants' personal and healthcare information with the Fund healthcare management facility, the Fund's administrator or the relevant government authorities for administrative and statistical purposes, provided such information shall be treated as confidential at all times.
17. I understand that it is my responsibility to provide the Fund with notice of my intention to terminate my membership, according to the Fund Rules, in writing by completing the relevant Termination of Membership form.
18. I agree that my and my dependants' personal healthcare data may be shared with third parties for the purpose of membership trend analysis (e.g. employer) and for any other such purposes as may be related to our membership of the Fund. I have read and understood these statements and my permission and the permission of my dependants are given voluntarily. My signature below confirms that I give permission.

Signature of main member: \_\_\_\_\_

Date: \_\_\_\_\_

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