



# MEMBER RECORD AMENDMENT / DEPENDANT REGISTRATION

MEDIMED MEDICAL SCHEME  
 CALL CENTRE (041) 395 4474  
 E-MAIL ADDRESS [medimed@providence.co.za](mailto:medimed@providence.co.za)

P.O. Box 1672 7 Lutman Road  
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 6001 Port Elizabeth  
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ADMINISTERED BY PROVIDENCE HEALTHCARE RISK MANAGERS.

## INSTRUCTIONS

- CHANGE OF ADDRESS / CONTACT DETAILS  
*Complete Sections 1, 2, 6, 7*
- CHANGE OF BANK DETAILS  
*Complete Sections 1, 3, 6,7*
- TERMINATION OF DEPENDANT MEMBERSHIP  
*Complete Sections 1, 4, 6,7*

- REGISTRATION OF BIRTHS  
*Complete Sections 1, 5, 6,7  
Attach copy of Birth Certificate*
- REGISTRATION OF ADULT AND CHILD DEPENDANTS  
*Complete Sections 1, 5, 6,7,8  
Attach copy Identity Document /  
Birth Certificate / Marriage certificate /  
Proof of previous membership /  
Student Registration*

- Sections 1, 6 and 7 **must always** be completed
- Please complete in block letters.
- Complete blocks from left to right, one letter/number per block.
- Registration and amendments are subject to the rules of the Scheme.
- The Scheme must be notified within 30 days from date of change.
- Should you have any queries, please contact our customer care department.

## SECTION 1 | PRINCIPAL MEMBER DETAILS

Title	Initials	Surname
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
		Membership Number
		<input style="width: 100%;" type="text"/>

## SECTION 2 | CHANGE OF ADDRESS / CONTACT DETAILS

Telephone Number (Work) <input style="width: 100%;" type="text"/>	Physical Address <input style="width: 100%; height: 40px;" type="text"/> <input style="width: 100%; height: 40px;" type="text"/> <input style="width: 100%; height: 40px;" type="text"/>
Telephone Number (Home) <input style="width: 100%;" type="text"/>	Postal Address <input style="width: 100%; height: 40px;" type="text"/>
Cellular Number <input style="width: 100%;" type="text"/>	
Fax Number <input style="width: 100%;" type="text"/>	
E-mail address <input style="width: 100%;" type="text"/>	

## SECTION 3 | CHANGE OF BANK DETAILS

### APPLICATION FOR ELECTRONIC TRANSFER OF FUNDS

I hereby instruct Medimed Medical Scheme to electronically collect contributions or to deposit refunds into my bank account. I understand that credit card accounts may not be used for these transactions. I also irrevocably authorise Medimed Medical Scheme to reverse any erroneous transaction and/or to rectify any incorrect electronic transfer of funds without prior notice.

I declare that contributions due to Medimed Medical Scheme will be paid MONTHLY and in advance should I become a private member. Failure to do so will result in my membership being suspended or terminated as per the Medimed Scheme Rules.

Signature: ..... Date: .....

PLEASE TICK (MORE THAN ONE OPTION CAN BE SELECTED)

<input type="checkbox"/>	USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS
<input type="checkbox"/>	USE THIS ACCOUNT FOR CLAIMS & SAVINGS REFUNDS

<b>BANK DATE STAMP REQUIRED</b>	BANK NAME	<input style="width: 100%;" type="text"/>
	BRANCH NAME	<input style="width: 100%;" type="text"/>
	ACCOUNT HOLDER NAME	<input style="width: 100%;" type="text"/>
	BANK ACCOUNT NUMBER	<input style="width: 100%;" type="text"/>
	BRANCH CODE	<input style="width: 100%;" type="text"/>
	TYPE OF ACCOUNT	CURRENT <input type="checkbox"/> CHEQUE <input type="checkbox"/> SAVINGS <input type="checkbox"/> TRANSMISSION <input type="checkbox"/>

**NOTE :For a cheque account, please attach an original cancelled cheque**

## SECTION 4 | TERMINATION OF DEPENDANT REGISTRATION

Name	<input style="width: 100%;" type="text"/>	Date of Birth	<input style="width: 100%;" type="text"/>
Relationship	<input style="width: 100%;" type="text"/> Female Male	Date of Termination	<input style="width: 100%;" type="text"/>
Reason	<input style="width: 100%;" type="text"/>		

  

Name	<input style="width: 100%;" type="text"/>	Date of Birth	<input style="width: 100%;" type="text"/>
Relationship	<input style="width: 100%;" type="text"/> Female Male	Date of Termination	<input style="width: 100%;" type="text"/>
Reason	<input style="width: 100%;" type="text"/>		

  

Name	<input style="width: 100%;" type="text"/>	Date of Birth	<input style="width: 100%;" type="text"/>
Relationship	<input style="width: 100%;" type="text"/> Female Male	Date of Termination	<input style="width: 100%;" type="text"/>
Reason	<input style="width: 100%;" type="text"/>		

## SECTION 5 | REGISTRATION OF SPOUSE / PARTNER / ADDITIONAL ADULT OR CHILD DEPENDANT

Relationship to member	<input style="width: 100%;" type="text"/>		
First Name	<input style="width: 100%;" type="text"/>	Date of Birth	<input style="width: 100%;" type="text"/>
Surname	<input style="width: 100%;" type="text"/> Female Male	Date Effective	<input style="width: 100%;" type="text"/>
Marital Status	<input style="width: 100%;" type="text"/>	Date of Marriage	<input style="width: 100%;" type="text"/>

  

Relationship to member	<input style="width: 100%;" type="text"/>		
First Name	<input style="width: 100%;" type="text"/>	Date of Birth	<input style="width: 100%;" type="text"/>
Surname	<input style="width: 100%;" type="text"/> Female Male	Date Effective	<input style="width: 100%;" type="text"/>
Marital Status	<input style="width: 100%;" type="text"/>	Date of Marriage	<input style="width: 100%;" type="text"/>

  

Relationship to member	<input style="width: 100%;" type="text"/>		
First Name	<input style="width: 100%;" type="text"/>	Date of Birth	<input style="width: 100%;" type="text"/>
Surname	<input style="width: 100%;" type="text"/> Female Male	Date Effective	<input style="width: 100%;" type="text"/>
Marital Status	<input style="width: 100%;" type="text"/>	Date of Marriage	<input style="width: 100%;" type="text"/>

**PLEASE ANSWER THE FOLLOWING COMPULSORY QUESTIONS - Mark the appropriate block with an "X"  
(not compulsory for registration of a newborn baby)**

1. Does the dependant receive a monthly income?

YES  NO If yes, complete the following:

Monthly salary. State name of employer \_\_\_\_\_ R \_\_\_\_\_  
 Pension - state whether old age, military or disability \_\_\_\_\_ R \_\_\_\_\_  
 Pension - state other than above, including an annuity \_\_\_\_\_ R \_\_\_\_\_  
 \_\_\_\_\_ TOTAL R \_\_\_\_\_

2. Is the dependent entirely reliant on you for maintenance and support?

YES  NO Give reasons \_\_\_\_\_

3. Does the dependant live with you?

YES NO

Give reasons and attach a certified affidavit \_\_\_\_\_

Indicate length of stay \_\_\_\_\_

4. Is the dependent a student?

YES NO

If yes, state whether full time, part time, name of academic institution and expected period of study. Also attach proof of student registration. \_\_\_\_\_

\_\_\_\_\_

5. Has the dependant been a beneficiary of any medical scheme before this application?

YES NO

If yes, provide Name of Scheme \_\_\_\_\_ Membership Number \_\_\_\_\_

Date Joined \_\_\_\_\_ Date left \_\_\_\_\_

Reason membership terminated \_\_\_\_\_

**Please attach a copy of a membership certificate, reflecting join and exit dates.  
Please note that a copy of a medical aid card is not sufficient.**

If no, provide reason. \_\_\_\_\_

(PLEASE COMPLETE SECTION 8)  
(not compulsory for registration of a newborn baby)

**SECTION 6 | EMPLOYER TO COMPLETE AND SIGN**

Company Name

\_\_\_\_\_

Scheme Join Date

y y y y m m d d

Payroll Number

\_\_\_\_\_

Date of Employment

y y y y m m d d

Date of Benefit

y y y y m m d d

Total current contribution R \_\_\_\_\_

Total new contribution R \_\_\_\_\_

Arrears (if applicable) R \_\_\_\_\_

We confirm that the applicant is employed by us and commenced employment on the above mentioned date. Contributions are being deducted according to the Scheme's rules  
**All sections of the application form have been completed.**

Employer's Telephone Number

c o d e \_\_\_\_\_

Employer's Fax Number

c o d e \_\_\_\_\_

Employer's E-mail Address

\_\_\_\_\_

Name of Medical Aid/Salary Administrator

\_\_\_\_\_

Designation

\_\_\_\_\_



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

y y y y m m d d

**SECTION 7 | DECLARATION BY PRINCIPAL MEMBER**

**I DECLARE THAT TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT**

Date y y y y m m d d

Principle Member's signature \_\_\_\_\_

**SECTION 8 | MEDICAL HISTORY (not compulsory for registration of a newborn baby)**

Patient Name

**CONDITION INFORMATION**

Has your dependant ever experienced or been treated for, or is currently suffering from any of the following conditions?  
*If Yes, Please tick the appropriate block or specify the conditions*

**1. Cardiovascular and or Blood disorders**

Chest Pain (Angina)     Valve defect     Rheumatic heart disease     Heart attack  
 Murmurs     Hypertension (Blood pressure)     Arrhythmia     Hypercholesterolcemia  
 Anemia     Leukemia

Other, Specify

**2. Respiratory problems (Lungs or breathing)**

Difficulty in breathing     Shortness of breath     Persistent cough     Asthma  
 Croup     Tuberculosis     Bronchitis     Pneumonia  
 Coughing up blood

Other, Specify

**3. Ear, Nose & Throat**

Hearing/speech impairment     Ear Infections     Sinus problems     Allergic rhinitis

Other, Specify

**4. Kidney / Urinary System**

Blood in urine     Kidney infections     Prostate conditions     Kidney failure  
 Kidney stones     Congenital urinary conditions     Recurrent urinary tract infections

Other, Specify

**5. Gynaecological**

Ovarian cysts     Endometriosis     Abnormal pap smears     Fibroid  
 Enlarged uterus     Menstrual disorders     Pregnant at present

Other, Specify

**6. Glandular/ Endocrine**

Diabetes Mellitus     Addison's disease     Cushing's syndrome     Growth disorders  
 Disorders of the pituitary gland     Hypo/hyperactive thyroid gland

Other, Specify

**7. Neurological (Nervous system)**

Paralysis     Stroke     Epilepsy     Migraine  
 Brain or spinal cord disorder     Multiple sclerosis

Other, Specify

**8. Gastrointestinal**

Malena Stools (Bleeding)     Ulcers     Jaundice     Change in bowel habits  
 Pancreatic disorders     Colitis     Gall Stones/Cholecystitis     Pancreatic disorders  
 Irritable bowel syndrome

Other, Specify

**9. Musculoskeletal**

Joint or spine condition, including Rheumatoid/Osteo-arthritis     Neck or Back problems  
 Recurrent back pain     Ankylosing Spondylitis     Osteoporosis

Other,Specify

**10. Lumps or Growths**

Benign tumours     Malignant tumours     Lymph cancer  
 Leukemia     Melanoma

Other, Specify

**11. Emotional / Psychological**

Anxiety     Depression     Schizophrenia     Attention deficit disorder  
 Anorexia     Anorexia or any other eating disorders     Alzheimers disease     Bi-polar disorders

Other, Specify

**12. Eyes**

Glaucoma     Blindness     Impaired vision     Retinitis  
 Conjunctivitis     Macular degeneration     Cataract

Other, Specify

Has your dependant had, or is he/she currently undergoing or anticipating any specialist dentist treatment? **Y or N**  
 (E.g. Orthodontic treatment or impacted wisdom teeth)

Does your dependant have any congenital, hereditary or physical disability? **Y or N**

Does your dependant participate in any hazardous sports or pursuits e.g. mountain climbing, paragliding? **Y or N**

Are you aware of any other conditions which may not have been specified on this form? **Y or N**  
 If the answer is 'Yes', please supply details on Page 5.

