Medimed
Managing your healthcare security

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MEMBER RECORD AMENDMENT/ DEPENDANT REGISTRATION

INSTRUCTIONS

☐ **CHANGE OF ADDRESS / CONTACT DETAILS:** *Complete Sections 1, 2 & 8*

☐ **TERMINATION OF DEPENDANT MEMBERSHIP:** *Complete Sections 1, 2, 3, *5B & 8 (*Not applicable for private members)*

☐ **REGISTRATION OF BIRTHS:** *Complete Sections 1, 2, 4, *5B, **6 & 8 (*5B not applicable for private members, **6 for Essential Members only)*
Attach copy of Birth Certificate

☐ **REGISTRATION OF ADULT AND CHILD DEPENDANTS:** *Complete Sections 1, 2, 4, *5B, **6, 7 & 8*
*(*5B not applicable for private members, **6 for Essential Members only)*
Attach copy Identity Document / Birth Certificate / Marriage certificate / Proof of previous membership / Student Registration / Affidavit should any dependants surname differ from principle member surname

- **Sections 1, 2, 6 and 7 *must always be completed for adding of a dependant.***
- **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 30 days in advance of effective date of change.
- Should you have any queries, please contact our customer care department.

SECTION 1: PRINCIPAL MEMBER DETAILS

Title | Initials | Surname | Medical Aid Number

SECTION 2: CHANGE OF ADDRESS / CONTACT DETAILS

Telephone Number (Work) code

Telephone Number (Home) code

Cellphone Number

E-mail Address

Physical Address

Street Number / Street Name
Suburb
City
Province / State
Code

Postal Address ☐ Same as Physical

Street Number / Street Name
Suburb
City
Province / State
Code

Medical Aid Number:

SECTION 3: TERMINATION OF DEPENDANT REGISTRATION

Name | Date of Birth (Y Y Y Y M M D D)
Relationship | **Gender:** M F | Date of Termination (Y Y Y Y M M D D)
Reason

Name | Date of Birth (Y Y Y Y M M D D)
Relationship | **Gender:** M F | Date of Termination (Y Y Y Y M M D D)
Reason

Name | Date of Birth (Y Y Y Y M M D D)
Relationship | **Gender:** M F | Date of Termination (Y Y Y Y M M D D)
Reason

SECTION 4: REGISTRATION OF SPOUSE / PARTNER / ADDITIONAL ADULT OR CHILD DEPENDANT

Note: If the dependant is 18 and older kindly complete the consent section.

D1

First Names | Surname | Relationship

Date of Birth (Y Y Y Y M M D D) | **Gender:** M F

Identity Number/ Passport Number

Cellphone Number | Effective Date: (Y Y Y Y M M D D)

Physical Address
Street Number / Street Name
Suburb
City
Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: **R**

Adult Dependant Consent Section: *You give permission to make information available to the third party/family member specified below.*

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: (Y Y Y Y M M D D)

D2

First Names | Surname | Relationship

Date of Birth (Y Y Y Y M M D D) | **Gender:** M F

Identity Number/ Passport Number

Cellphone Number | Effective Date: (Y Y Y Y M M D D)

Physical Address
Street Number / Street Name
Suburb
City
Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: **R**

Medical Aid Number:

Adult Dependant Consent Section: *You give permission to make information available to the third party/family member specified below.*

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: Y Y Y Y M M D D

D3

First Names | Surname | Relationship

Date of Birth Y Y Y Y M M D D

Gender: M F

Identity Number/ Passport Number

Cellphone Number | Effective Date: Y Y Y Y M M D D

Physical Address

Street Number / Street Name

Suburb

City

Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: **R**

Adult Dependant Consent Section: *You give permission to make information available to the third party/family member specified below.*

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: Y Y Y Y M M D D

D4

First Names | Surname | Relationship

Date of Birth Y Y Y Y M M D D

Gender: M F

Identity Number/ Passport Number

Cellphone Number | Effective Date: Y Y Y Y M M D D

Physical Address

Street Number / Street Name

Suburb

City

Province / State | Code

If your dependant is your child and is 21 years and older, or your parent, are they:

Married: YES NO

Financially dependant on you? YES NO

Does your dependant earn an income? YES NO

Monthly Income: **R**

Adult Dependant Consent Section: *You give permission to make information available to the third party/family member specified below.*

Title | Initials | First Names | Surname

Identity / Passport Number | Contact Number

Please select one option by placing an "X" in the appropriate box: All consent | Updating details | Financial info | Clinical info | None

Relationship | Signature: | Date: Y Y Y Y M M D D

Medical Aid Number:

SECTION 5: INCOME & EMPLOYER SECTION

Private Member ☐ *If ticked Private Member, please complete SECTION 5A and *marked fields in SECTION 5B*

SECTION 5A: PRIVATE MEMBER TO COMPLETE

The rules of the Scheme refer to "income" as: The total gross monthly earning from all sources. If a spouse or partner is registered as a dependent on the Scheme, then "income" is the higher of member or spouse/partner's income.

Important notice: Declaring income lower than your actual income is fraud. This will result in the immediate cancellation of your membership and you will not be able to join the Scheme again.

Monthly earnings in the highest income category? YES ☐ NO ☐ *If yes, not required to submit supporting documentation.*

If your income is lower than the highest bracket, we will require the following documentation:

- A copy of your latest IT 34 (Mandatory)
- Latest payslip with IRPS or
- Letter from your company or employer confirming your monthly income
- And 3 months bank statements

SECTION 5B: EMPLOYER TO COMPLETE AND SIGN

Employer

Paypoint

Tax Number*

Basic Salary* R

Scheme Join Date (Y Y Y Y M M D D)

Clock/Payroll Number

Date of Employment (Y Y Y Y M M D D)

Date of Benefit (Y Y Y Y M M D D)

Number of Subsidised Dependants: Spouse ☐ Children ☐ Adult Dependents ☐

We confirm that the applicant is employed by us and commenced employment on the above date. Contributions are being deducted according to the selected MEDIMED Rules. **All sections of the application form have been completed and signed.**

Employer's Telephone Number (code)

Employer's E-mail Address

Name of Medical Scheme/ Salary Administrator

Designation

COMPANY STAMP REQUIRED

Signature:

Date: (Y Y Y Y M M D D)

SECTION 6: GP SELECTION FOR NEW DEPENDANTS ON ESSENTIAL OPTION

Dependant:	Doctor Selection:	Doctor Practice Number:

Medical Aid Number:

SECTION 7: MEDICAL HISTORY (not compulsory for registration of a newborn baby)

Patient Name

CONDITION INFORMATION

Please indicate if you or any dependant in this application have experienced any of the below medical incidents within the 12-month period prior to your application for membership. ***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
- ☐ Hypercholestrolcemia
- ☐ Anemia
- ☐ Leukemia

Other, Specify

2. Respiratory problems (Lungs or breathing)

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

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)

- ☐ Brain or spinal cord disorder
- ☐ Multiple sclerosis

Other, Specify

Medical Aid Number:

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
- ☐ Conjuntivitis
- ☐ Macular degeneration
- ☐ Cataract

Other, Specify

Has your dependant had, or is he/she currently undergoing or anticipating any specialist dentist treatment? ☐ YES ☐ NO
(E.g. Orthodontic treatment or impacted wisdom teeth)

Does your dependant have any congenital, hereditary or physical disability? ☐ YES ☐ NO

Does your dependant participate in any hazardous sports or pursuits (e.g. mountain climbing, paragliding?) ☐ YES ☐ NO

Are you aware of any other conditions which may not have been specified on this form? ☐ YES ☐ NO
If the answer is 'Yes', please supply details on the reverse.

Medical Aid Number:

SECTION 7: MEDICAL HISTORY *(Continued)*

If you answered "yes", to any of the previous questions, please provide full details by completing this schedule.

Question Answered	Diagnosis	Date of Onset	Condition resolved?	Name of current medicine	Further treatment expected	Date of last symptoms	Prognosis	Name and contact number of treating GP, dentist or specialist
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		
		YYYYMMDD	YES NO			YYYYMMDD		

SECTION 8: DECLARATION BY PRINCIPAL MEMBER

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND CORRECT

Principal Member's Signature: ____________ Date: YYYYMMDD