fedhealth member

RECORD AMENDMENT FORM

FEDHEALTH

PLEASE MAIL COMPLETED FORM TO:
Fedhealth Medical Scheme
Private Bag X3045
Randburg
2125

E-MAIL TO:
update@fedhealth.co.za

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 100 404
Broker Code: AON001M16

☐ **Change of address / contact details**
Sections 1, 2, 8 and 9 must be completed

☐ **Change of bank details**
Sections 1, 3, 8 and 9 must be completed

☐ **Change of marital status**
Sections 1, 4, 8 and 9 must be completed

☐ **Termination of dependant membership**
Sections 1, 5, 8 and 9 must be completed

☐ **Registration of:** • **Births and adoptions** • **Additional adult and child dependants**
Sections 1, 6, 7, 8 and 9 must be completed

☐ **Change of MediVault bank details**
Sections 1, 3, 8 and 9 must be completed

SECTION 1 DETAILS OF PRINCIPAL MEMBER

First name/s | Initials
Surname | Preferred name
Membership no.
ID number | Passport number, if no ID
Nationality | Country of issue of Passport
Income Tax Number

SECTION 2 CHANGE OF ADDRESS / CONTACT DETAILS

Telephone (H) ( ) | Telephone (W) ( )
Cellular | Fax ( )
E-mail address
Postal address
Postal code
Physical address
Postal code

SECTION 3 BANK DETAILS OF PRINCIPAL MEMBER

Refund of claims and debit order instruction

I hereby instruct Fedhealth to electronically collect contributions and MediVault instalments as a single debit order and to deposit refunds, using the information provided below (Direct Paying Members only). Should the collection date fall on a public holiday, the Scheme reserves the right to collect prior to or after the holiday. 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 from the following dates for debit order collections:

☐ **1st of the month** ☐ **5th of the month** **OR** ☐ **25th of the 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. The debit order collection description will have the following prefix before your membership number for **current** contribution collecitons: FDHSUBS, for **arrear** contribution collections: FDHARR and a MediVault instalment collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT any arrear collection will include ARR with previous abbreviates.

☐ 1. USE THIS ACCOUNT FOR ALL TRANSACTIONS INCLUDING MEDIVAULT REPAYMENTS
☐ 2. USE THIS ACCOUNT FOR ALL 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.
☐ USE THIS ACCOUNT FOR MEDIVAULT DEDUCTIONS ONLY

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 collections and refunds.

Account/ s holder's signature .....

Date d d m m y y y y

SECTION 3 BANK DETAILS OF PRINCIPAL MEMBER *Continued* *Refund of claims and debit order instruction*

3rd Party Payor

Should a third party pay the contribution and/or MediVault instalment on your behalf, the following supporting documents are required, certified by a commissioner of oaths and not older than three months:

- Account holder's identity document
- Account holder's bank statement
- Account holder's letter of authority to the Scheme to deduct contributions on behalf of the member. This also needs to include the relationship of the account holder to the principal member as well as a physical address, and where an individual, their Income Tax Number.

3rd Party Details

Surname

Title | First name/s

Physical address

Relationship to principal member | Nationality

ID number | Passport number, if no ID

Country of issue

Income Tax Number | Company registration number

SECTION 4 CHANGE OF MARITAL STATUS

Marital status: Single | Married | Divorced | Widowed | Common law partner/ spouse

Date of marriage : d d m m y y y y

Surname:

myFED members:
Please note that if you pay your own contributions and you add a spouse/ partner, you will be required to complete an Income Verification Form.

SECTION 5 TERMINATION OF BENEFICIARY REGISTRATION DUE TO DEATH, DIVORCE, CHILD SELF SUPPORTING ETC.

Please attach certified copy of death certificate if termination is due to death

Full name/s as reflected on your membership card	Date of birth	Deletion date (last day of the month)
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y
	d d m m y y y y	d d m m y y y y

Reason for termination

SECTION 6 REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT

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* ☐

Title | Initials | First name/s

Preferred name

Surname

Relationship to principal member

ID number | Date of birth d d m m y y y y

If none, passport number, | Nationality

Country of issue of passport | Income Tax Number

Cell | E-mail address

If adult, is the dependant financially dependent on the principal member? Yes | No

Does the dependant receive an income, e.g. pension, salary? Yes | No | If yes, what is the monthly income? R

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? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes | No

SECTION 6 REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT *Continued*

flexiFED 1, flexiFED 1Elect, flexiFED 2, flexiFED 2Grid, flexiFED 2Elect, flexiFED 3, flexiFED 3Grid, flexiFED 3Elect, myFED members are required to nominate a GP (General Practitioner) from the Fedhealth network for themselves and their dependants. Please note that only visits to a nominated GP will be covered on these options. For a list of GPs on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the GP locator button on the page. For a list of GPs on the myFED GP network, please contact the Customer Contact Centre on 0860 002 153.

NOMINATED GP (GENERAL PRACTITIONER) DETAILS		
Name	Practice number	Contact details
1.	1.	1.
2.	2.	2.

**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.

2

Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname | Gender M F

Relationship to principal member

ID number | Date of birth d d m m y y y y

If none, passport number, | Nationality

Country of issue of passport | Income Tax Number

Cell | E-mail address

If adult, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No | If yes, what is the monthly income? R

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? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes No

flexiFED 1, flexiFED 1Elect, flexiFED 2, flexiFED 2GRID, flexiFED 2Elect, flexiFED 3, flexiFED 3GRID, flexiFED 3Elect, myFED members are required to nominate a GP (General Practitioner) from the Fedhealth network for themselves and their dependants. Please note that only visits to a nominated GP will be covered on these options. For a list of GPs on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the GP locator button on the page. For a list of GPs on the myFED GP network, please contact the Customer Contact Centre on 0860 002 153.

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- 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.

3

Adult ☐ Child* ☐

Title | Initials | First name/s

Preferred name

Surname | Gender M F

Relationship to principal member

ID number | Date of birth d d m m y y y y

SECTION 6 REGISTRATION/ UPDATE OF SPOUSE/ PARTNER/ ADDITIONAL ADULT OR CHILD DEPENDANT *Continued*

If none, passport number, | Nationality

Country of issue of passport | Income Tax Number

Cell | E-mail address

If adult, is the dependant financially dependent on the principal member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No If yes, what is the monthly income? R

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? Please provide full details to avoid possible Late Joiner Penalties. Should this space be insufficient, please attach a separate sheet Yes No

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NOMINATED GP (GENERAL PRACTITIONER) DETAILS		
Name	Practice number	Contact details
1.	1.	1.
2.	2.	2.

**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 7 MEDICAL DETAILS

It is compulsory to answer each question. Failure to disclose information is fraudulent and may result in membership not being granted, or termination of membership without refund of contributions paid.

HAVE ANY OF THE DEPENDANTS INDICATED IN SECTION 6 SOUGHT ANY ADVICE, BEEN DIAGNOSED WITH, OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS IN THE PAST 12 MONTHS?

1. A chronic illness? (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and/ or thyroid disorders). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and 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	

2. Gastro intestinal disorder? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and/ or a spastic colon). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and 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	

3. Muscle, bone, skin or nerve illnesses or disorders? (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and 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	

4. Urinary or genital disorders? (e.g. kidney stones, prostates, endometriosis, ovarian cysts, menstrual disorders). If yes, please provide details. Yes No

Name of beneficiary	Diagnosis and 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	

SECTION 7 MEDICAL DETAILS *Continued*

5. Ear, nose or throat disorders? (e.g. Glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics). If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and 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	

6. Blood disorders, immune deficiency state, HIV/AIDS, cancer etc? If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and 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	

7. Are you or any of your dependants pregnant? If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and 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	

8. Are there any other conditions not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months? If yes, please provide details. Yes / No

Name of beneficiary	Diagnosis and 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	

SECTION 8 EMPLOYER INFORMATION *This section must be completed by your employer only if employer pays your contribution*

Name of employer

Division code

Dept. name

Fedhealth Paypoint code

Employee number

Dependant/s subsidised Yes / No

Persal number *if applicable*

The above details have been noted and contributions will be adjusted in terms of the scheme rules on and include arrears, if applicable. d d m m y y y y

Total current contribution: R

Total new contribution: R

Arrears (if applicable): R

Vault Instalment (if applicable): R

Name of salary administrator

Designation

Company stamp

Signature .....

Date signed d d m m y y y y

SECTION 9 DECLARATION BY PRINCIPAL MEMBER *This section must be completed*

I declare that to the best of my knowledge the information provided above is true and correct. 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 PI with the Scheme's partners and facilities who are essentail 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.*

Signature of principal member: .....

Date : d d m m y y y y

Contact us on: 0860 100 404, P.O. Box 78367, Sandton, 2146, www.aon.co.za
FSP number: 20555; CMS number: ORG895
Follow our website link for further information on Aon's processing of your personal information

Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: _____ and membership number: _____

Signed at (Town or City): _____ on yy/mm/dd: _____

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly 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).

Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.

I give consent for the disclosure of information about me.

Membership number: _____ ID or passport number: _____

Title: _____ Initials: _____ Surname: _____

First name(s) (as per identity document): _____

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
* Name and Surname * Membership number * Date of birth * ID number * Postal Address * Physical address * E-mail Address * Telephone numbers * Cellular Number * Number of dependents	* Plan type * Medical Savings Account (MSA) * Balance Medical Scheme benefits * Spent for the year Accumulated * Medical scheme Savings Account * Medical Savings Carry over from previous year * MSA reimbursement, Scheme Rate or cost * Self-payment Gap * Above Threshold Benefit * Waiting period details * Late joiner penalty indicator * Wellness benefits	* Total Contribution * Contribution breakdown	* Chronic Indicator/ confirmation (Yes/No) * In Hospital Indicator/ confirmation (Yes/No) * Confirmation of claims paid and from what benefit * Claims transaction history * Procedures done in doctor's rooms paid from Hospital Benefit

By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd ("Aon") to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it's reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): _____ on yy/mm/dd: _____

Signature: _____

Benefits of appointing

Aon South Africa Healthcare as your intermediary

Aon Healthcare is committed to providing you with exceptional service at every interaction. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

Our philosophy is to:

Guide:
our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.

Educate:
our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.

Protect:
the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end renewal, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to member letters providing updates on the following:
  - Alert - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
  - Member letter - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - Guidance letter - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Ad-Hoc Alerts:**
  - Ad-hoc updates pertaining to Medical schemes industry or providers specific updates.

Cost of appointing Aon

We are pleased to inform you that there is **no additional fee** charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission 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). In terms of Primary Care Insurance products we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to **www.aon.co.za**

http://www.facebook.com/Aonhealthcare
Click "Like" on our page (Aon healthcare)

http://twitter.com/Aon_SouthAfrica
Click "follow" on our profile

Aon Employee Benefits – Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

Disclaimer:

Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.