Broker House: Aon South Africa (Pty) Ltd
Broker Code: AON104
Tel No: 0860 100 404

MEDSHIELD medical scheme

NEW MEMBERSHIP - BENEFICIARY CONTINUATION

Email: newapplication@medshield.co.za

This form needs to be completed by an active beneficiary on Medshield Medical Scheme who wish to continue in his/her own capacity with/without the dependants currently registered on the same membership. This application is subject to Scheme approval.

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary. All sections must be completed.

Selection of Benefit Option: _____

Broker Code:

Previous membership number:

This form needs to be submitted to the Scheme by the 14th of the month for a join date of the following month.

Start Date of Membership:

DOCUMENT CHECKLIST

In order to avoid rejection of your application please provide the following documents:	Please Tick
ID copy(ies) for all beneficiaries (e.g. ID/birth certificate/passport)	☐
Student(s)-(child dependant age 21-27 that is studying or turning 21 in the next 3 months): Proof of registration at a recognised tertiary institution	☐
Additional documents for Special Dependants (foster/adopted children, niece, nephew, sibling, grandchild): **Adopted/Foster Child:** • Legal documentation of adoption or foster arrangement	☐
A parent or grandparent of the Principal Member: • Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent • Proof of income such as payslip, bank statement, or proof of pension	☐ ☐
A grandchild, niece, nephew or sibling: • Certified affidavit from Principal Member and parent(s) confirming residency, employment, and income of child and both parents • Proof of income if dependant is employed	☐ ☐
Stamped bank statement or stamped confirmation letter from the bank. If contributions are paid by a third party, the required documents as per the bank detail section, should be attached to this form	☐
Death certificate of current Principal Member (applicable only if surviving dependants are continuing in own capacity)	☐
ID copy(ies) of the nominated 3rd Party(ies) Consent (to whom we may provide specified information)	☐

SECTION A — TO BE COMPLETED BY THE CURRENT PRINCIPAL MEMBER

Membership Number:

Member ID number:

Member Name:

Member Surname:

I hereby request to terminate the following dependant(s) from my membership as they are seeking to continue their Medshield membership in their own capacity

Medshield is an Authorised Financial Services Provider (FSP 51381)

Dependant 1 First Name/s:	
Dependant 1 Surname:	
Termination Efective Date:	

Dependant 2 First Name/s:	
Dependant 2 Surname:	
Termination Efective Date:	

Dependant 3 First Name/s:	
Dependant 3 Surname:	
Termination Efective Date:	

Principal Member Signature: _____ Date:

SECTION B TO BE COMPLETED BY NEW PRINCIPAL MEMBER (Attach copy of ID document)

Title:		Initials:	
First Name/s:			
Surname:			
ID/Passport Number:			
Date of Birth:			
Postal Address:			
Postal Code:			
Residential Address:			

Please provide at least one email address

Personal Email Address:	
Business Email Address:	
Cell Number:	
Fax Number:	
Tax Number:	

Please complete for marketing purposes:

Gender: (Mark with an X)	M		F		Marital Status:	Single	Married	Divorced	Widowed

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African		Caucasian/ White		Coloured		Indian		Asian		Other
I do not wish to disclose:											

SECTION C DEPENDANT DETAILS ON NEW MEMBERSHIP (Must be beneficiaries from previous membership)

Spouse or Partner:	Spouse		Life Partner		Divorced Spouse		
Title:		Initials:					
First Name/s:							
Surname:							
Previous Surname:							
ID/Passport Number:							
Date of Birth:							
Country of Residence:							
Dependant Email Address:							
Dependant Telephone Number (W):							
Dependant Cell Number:							

Please complete for marketing purposes:

Gender: (Mark with an X)	M		F		Marital Status:	Single	Married	Divorced	Widowed

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

For special dependants (e.g. parents, foster/adopted children, niece, nephew, grandchild, parents) please attach the following:

Adopted/Foster Child:

- Legal documentation of adoption or foster arrangement.

A parent or grandparent of the Principal Member:

- Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent.
- Proof of income such as payslip, bank statement, or proof of pension.

A grandchild, niece, nephew or sibling:

- Certified affidavit from Principal Member and parent(s) confirming residency, employment, and income of child and both parents.
- Proof of income if dependant is employed.

If the dependant is classified as a student and falls within the age range of 21 to 27 or will reach the age of 21 in the next three months, student proof in the form of a stamped or signed letter, on a letterhead from the accredited institution for tertiary education for the current year must accompany this form.

Include copies of the dependants' ID, birth certificate or passport.

Acceptance of dependants will be in accordance with the Rules of the Scheme.

Dependant 1

Name of Dependant:					
Surname: (If Different to Principal Member)					
ID Number / Passport number for non-South African Citizens:					
Date of Birth:					
Dependant Email Address:					
Dependant Cell Number:					
Relationship to Principal Member:					
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 2

Name of Dependant:				
Surname: (If Different to Principal Member)				
ID Number / Passport number for non-South African Citizens:				
Date of Birth:				
Dependant Email Address:				
Dependant Cell Number:				
Relationship to Principal Member:				
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y / N

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 3

Name of Dependant:				
Surname: (If Different to Principal Member)				
ID Number / Passport number for non-South African Citizens:				
Date of Birth:				
Dependant Email Address:				
Dependant Cell Number:				
Relationship to Principal Member:				
Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y / N

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

SECTION D FAMILY PRACTITIONER (FP) NOMINATION – MediPhila, MediCurve, MediValue Compact and MediPlus Compact

If you have selected MediPhila, MediCurve or one of the Compact options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP). If you do not nominate a FP as per the criteria listed per option below, your application form will not be processed by the Scheme.

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediCurve: Each Beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

MediValue Compact and MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where a FP was nominated from the FP Network & Day-to-Day benefit is depleted the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION E BANK DETAILS OF PRINCIPAL MEMBER

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account(s).

A stamped bank statement (Not older than 3 months) or a stamped confirmation letter from the bank in the name of the Principal Member is required. Should contributions be paid by a 3rd party, the following supporting documents are required:

Account in the name of an Individual other than the Principal member (for example, spouse, parent, child etc.):

- ID Copy of the Principal Member or copy of passport for non-SA citizens
- ID Copy of the account holder or copy of passport for non-SA citizens
- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the account holder.
- Signed letter of authority from the account holder which include the details of the member(s)

Account in the name of a Company:

- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the Company
- Signed letter of authority on a Company letterhead including the details of the member(s)
- ID Copies of each signatory who has authority to sign on behalf of the company
- Copy of Company Registration Certificate

Trust Account:

- Copy of a stamped bank statement (not older than 3 months) or a stamped confirmation letter from the bank in the name of the Trust
- Signed letter of authority including the details of the member(s)
- ID Copies of each trustee
- Copy of Trust Resolution showing the trustees

Select relevant box with a tick:
To be completed by the Account Holder

Select Account Holder:

Principal Member	☐	**Company**	☐
Trust	☐	**Individual other than Principal Member** (for example spouse, parent, child etc.)	☐

Account Holder Title:	
Account Holder First Name(s):	
Account Holder Initial(s):	
Account Holder Surname:	
Account Holder Date of Birth:	
Account Holder ID Number:	
Account Holder Passport Number (for non-SA citizens):	
Country of Issue:	
Account Holder Tax number (SARS):	
Registered Company Name (if the account is in the name of a company):	
Company Registration Number:	
Account Holder Residential Address:	
Postal Code:	
Account Holder Postal Address:	
Postal Code:	

Mark relevant box with an X:

Use this account for: **Contributions only** ☐ **Contributions and Claim Refunds** ☐

Bank Name:			
Branch Name:			
Branch Code:			
Type of Account: (Mark with an X)	Current ☐	Transmission ☐	Savings ☐
Bank Account Number:			

Mark relevant box with an X:

Direct paying members have the option to select from the following dates for debit order collections:

- 1st of the month ☐
- 5th of the month ☐
- 25th of the month ☐
- 27th of the month ☐

In the event that you do not specify a preferred date, the Scheme will automatically set your debit order collection to the 1st of the month.

Use this account for: **Refunds only** ☐

Bank Name:			
Branch Name:			
Branch Code:			
Type of Account: (Mark with an X)	Current ☐	Transmission ☐	Savings ☐
Bank Account Number:			

I _____ (account holder's full name) the undersigned, declare that:
I understand that Medshield will rely upon the facts set out herein for the accurate loading of bank details. I understand and accept that should any details contained herein prove to be incorrect, or should I fail to inform Medshield of any subsequent change to the bank details, Medshield will not be held responsible. I also agree that I am the account holder of the bank details provided and I hereby authorise Medshield to electronically collect monthly contributions and/or pay refunds to the above bank via the Elektropay system using the information provided. I also irrevocably authorise Medshield to reverse any erroneous transaction and/or rectify any electronic transfer of funds error without prior notice.

I hereby authorise Medshield Medical Scheme, or any of its nominated representatives, to verify the bank details as stipulated on this form. ☐

Give consent that Medshield Medical Scheme, may collect, process, store and share our personal information with the Scheme's respective Service Providers including South African Revenue Services. This information includes, but is not limited to details such as, name, surname or registered name (in the cases of companies and trusts), identity numbers, registration number, tax number, addresses and other details which could include financial information and banking details. ☐

SECTION F EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:	
Paypoint Code:	
Employee Payroll No.:	
Employment Date:	

☐

COMPANY STAMP

If no Company Stamp is available, please mark this block with an X.

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section E have been completed:

Employer's Email Address:	
Employer's Representative's Name:	
Employer's Representative's Designation:	
Date:	

Employer's Representative's Signature: _____

SECTION G — CONSENT (Consent for Medshield Medical Scheme to process personal information)

The Scheme understands that your personal information and that of your dependants is important. Medshield undertakes to keep this information confidential and shall take all reasonable steps to comply with the provisions of legislation protecting your personal information.
We require your consent to obtain, process and disseminate your personal information so we can provide you with the services stipulated in our contractual agreement, as detailed for your chosen benefit option and in compliance with the Medical Schemes Act 131/1998. These services include but is not limited to:

a. Treatment Authorisations;
b. Claims Assessment;
c. Claims Payment;
d. Communication;
e. Disease Management; and
f. Wellness Initiatives.

While your consent is voluntary, it is a requirement for the administration of your Medshield membership. **If you object to the processing of your personal information, the Scheme will not be able to activate and service your membership.**

Please carefully read and consent to the items listed below
I hereby consent, with the permission of my dependants, that the Scheme may collect, use, process, retain and share my and my dependant's personal information for the purpose of providing medical scheme benefits, managed healthcare services and medical scheme specific value adds. This includes the collecting and sharing of my personal information with the Scheme's partners and facilities who are essential to the administration and ongoing membership process.

You can access more details on the Protection of your Personal and Health Information on the Medshield website www.medshield.co.za. When you accept these terms and conditions you will allow us to provide your family with the full range of our Medshield services.

(1) I hereby acknowledge and declare that as the Principal Member of the Scheme, I have received the necessary consent from my dependant(s) and act on their behalf in any matter relating to this application and the administration of our Medshield Membership and to access and view their healthcare claims.
(2) Confirm that if I (Principal Member) am part of a group membership by virtue of employment, I grant permission to Medshield Medical Scheme to share information relating to my membership with my employer and my employer's appointed broker This will be limited to information that is relevant to my application, collection of contributions and information that is required for the ongoing servicing of my membership, but will not include any health information unless I have given Medshield permission to do so.
(3) Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Advisor/ Broker, if any, who is an accredited Medical Aid Broker of my choice.

Principal Member Signature: _____ Date: _____

SECTION H — MEMBER DECLARATION

Please carefully read and agree to the declarations below.

1. I the undersigned, hereby apply to be admitted as a member of Medshield Medical Scheme (hereafter referred to as "the Scheme") and agree that my dependants and I shall abide by its Rules as amended from time to time which are available on Medshield's website www.medshield.co.za
2. I understand that the Scheme's brochures are a summarised version and do not supersede the rules of the Scheme.
3. I acknowledge that I have familiarised myself with the benefits covered on my benefit option of choice and that I may only change my benefit option during year-end for an effective date of 01 January.
4. I am aware of the fact that on joining the Scheme during the course of a calendar year, the maximum benefits to which I may be entitled shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular calendar year.

5. I certify that all the information given is true and correct, whether completed by me or on my behalf, and acknowledge that non-disclosure of any information by me, or my dependants, relevant to the assessment of this application, shall render any contracts to which this application relates null and void, effective from date of registration. In such event, the Scheme will have the right to offset applicable costs against contributions paid and refund the difference, if any.

6. I understand that should a period greater than three (3-month) lapse since contributions were paid to Medshield, that my membership will not be reinstated and that I have to re-apply subject to full underwriting.

7. I undertake to give notice to the Scheme to terminate my membership in accordance with the Rules of the Scheme.

8. Furthermore, I understand and agree that I will be liable for any legal cost incurred in the recovery of any amount owing to the Scheme and should there be any outstanding money owed to the Scheme, the Scheme has the right to terminate my membership, and list my details with a credit bureau.

If applicable:

9. I hereby authorise my employer to deduct, from my salary, any amount I may lawfully owe to the Scheme and to pay over such amounts to the Scheme.

If applicable:

10. As a government employee, I acknowledge that the Scheme will strictly adhere to Persal policies and procedures.

11. Notwithstanding point 9 and 10, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by the Scheme.

If applicable:

12. As a direct paying member, I acknowledge that monthly contributions are payable in advance via debit order and in accordance with the Rules of the Scheme.

13. I hereby authorise the Scheme, or any of its nominated representatives, to verify my bank details, as well as my and my dependants' identities, and any other information that I provided in this application form.

14. I acknowledge and agree that it's my responsibility to advise the Scheme in writing of any change in banking details. The Scheme will not be liable should an incorrect account be credited under any circumstances.

15. The Scheme may give any notice in terms of its Rules to me at my domicilium citandi et executandi or by any agreed electronic means unless otherwise notified. Any notice given to me by prepaid registered post at my domicilium citandi et executandi or by any agreed electronic means shall be deemed to have been received by me on the 7th day after the date of posting.

16. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No. 131 of 1998:
- a 3 (three) month general waiting period in respect of all benefits;
- a maximum 12 (twelve) month exclusion in respect of a re-existing condition;
- a late joiner contribution penalty.

17. I agree to inform the Scheme of any deterioration or change in my state of health or in that of my dependant(s) before the commencement date of membership, or the date of acceptance of this application form by the Scheme, or the date of receipt of the first subscription, whichever date is the latest shall entitle Medshield to reconsider the application and propose new terms of admission.

18. It is illegal to be a member of more than one medical scheme at the same time. I acknowledge that it is my responsibility to resign from my existing medical scheme and agree that neither me, nor any of my dependants, will be registered on both Medshield and another medical scheme simultaneously.

19. I hereby acknowledge that I have read and understood the content of this application form. I declare that all information provided on this form, to the best of my knowledge is true and accurate.

Signed at: _____ Date: _____

Principal Member Signature: _____

NB: Medshield Medical Scheme requires that your application form be submitted to the Scheme within 30 calendar days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

SECTION I THIRD PARTY CONSENT (To allow disclosure of information to a third party)

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words.
Mark with a tick where required. All sections must be completed.

ABOUT THE INFORMATION WE PROVIDE TO THE THIRD PARTY

This section needs to be completed if you want to nominate someone to manage your medical aid membership on your behalf. For instance your financial adviser/broker or a family member or a friend who you trust to administer your membership. We call this giving a Third Party Consent by nominating them on this form, which provides us with your approval that the Scheme may share specific personal information and/or discuss your membership with the specific Third Party you nominated below.

Additonally, please specify what type of information may be accessed by your financial adviser, employer representative and/or nominated Third Party, and for how long (if no date is specified, the consent will be in effect from the signature date until you revoke the consent in writing).

PRINCIPAL MEMBER DETAILS (attach copy of ID)

Membership Number:			
Title:		Initials:	
Principal Member Name/s:			
Principal Member Surname:			
Principal Member ID number:			
E-mail Address:			

FINANCIAL ADVISER/BROKER (If applicable)

Your Financial Adviser/Broker	
Broker code:	
Financial Adviser/Brokerage Name:	
Financial Adviser Email address:	
Financial Adviser Telephone Number (W):	

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my Financial Adviser/Broker as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N		
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N		
Financial Information: (Banking details, contributions, tax certificate)	Y	N		
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N		
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N		
Request changes and updates on my behalf	Y	N		

EMPLOYER REPRESENTATIVE (If applicable)

Your employer representative (if you form part of a group membership by virtue of employment) ☐

Company Name:	
Employer Representative Name and Surname:	
Employer Representative Email address:	
Employer Representative Telephone Number (W):	

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my employer representative as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N		
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N		
Financial Information: (Banking details, contributions, tax certificate)	Y	N		
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N		
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N		
Request changes and updates on my behalf	Y	N		

THIRD PARTY NOMINEE (Another adult that you choose to administer your membership on your behalf.

DOCUMENT CHECKLIST

For third party nomination and consent, please attach the below documents	Please Tick
ID copy(ies) of Principal Member and/or person giving consent	☐
ID copy(ies) of your nominated Third Party	☐

Third Party Nominee 1 ☐

Relationship to Principal Member:				
Title:		Initials:		
First Name/s:				
Surname:				
ID Number:				
Date of Birth:				
Email Address:				
Telephone Number (W):				
Telephone Number (H):				
Cell Number:				
Gender: (Mark with an X)	M ☐	F ☐		

I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my nominated Third Party as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N		
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N		
Financial Information: (Banking details, contributions, tax certificate)	Y	N		
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N		
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N		
Request changes and updates on my behalf	Y	N		

Third Party Nominee 2 ☐

Relationship to Principal Member:			
Title:		Initials:	
First Name/s:			
Surname:			
ID Number:			
Date of Birth:			
Email Address:			
Telephone Number (W):			
Telephone Number (H):			
Cell Number:			
Gender: (Mark with an X)	M ☐	F ☐	

YOUR LEGAL DECLARATION

1. I acknowledge and understand that this document authorises Medshield Medical Scheme and its outsourced providers to disclose and/or distribute the above information to the nominated third party(s)/employer representative/financial adviser, if any indicated herein.
2. I agree that by making this information available, Medshield Medical Scheme and its outsourced providers accepts no liability whatsoever for any loss, including direct, indirect and consequential loss, that may arise from the use of this information other than where it is due to, or attributable to, gross negligence or fraudulent conduct by the Scheme.
3. I understand that the consent provided to Third Party(s) will be in force during the specified time periods. If I have not specified the dates, the consent will be in effect from the signature date below until I revoke the consent in writing.
4. Confirm that if I am part of a group membership by virtue of employment, the consent granted to my employer representative will cease when my employment with the company comes to an end. I hereby agree to inform Medshield Medical Scheme immediately of any employment changes.
5. The consent granted to my financial adviser (if applicable) will become null and void in the event that I appoint a new financial adviser.
6. This consent will become null and void in the event of the death of a member or person providing consent, and a new consent form should be completed by the appointed executor of the deceased estate.
7. I may choose to change or revoke my consent at any time by informing the Scheme in writing.

Signed at: _____ Date: _____

Signature of Person Giving Consent: _____

Name of Person Giving Consent: _____

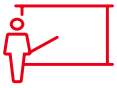
Benefits of appointing

Aon South Africa Healthcare as your intermediary

Across Aon, we are united in our passion to provide you with the insights and support to make Better Decisions around all aspects of your holistic wellbeing, medical scheme, gap cover and primary care insurance. 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 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 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.
  - **Client Assistance Programme** - We are delighted to offer you access to a range of essential services at absolutely no charge. The Aon Client Wellbeing Programme is a telephonic, online, and structured e-mail support program (excluding in-person or video sessions). The following services are available through our third- party service provider, LifeAssist:
    - Structured Telephonic Counselling
    - Telephonic Trauma Support
    - Financial Wellbeing Coaching
    - Legal Advisory Services
    - Health and Wellness Services (professional advice from a dietician and a biokineticist)
- **General Updates:**
  - Ad-hoc updates pertaining to Medical schemes industry and 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.

For more information, contact Aon South Africa:

0860 100 404 | arc@aon.co.za | www.aon.co.za

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.

http://www.aon.co.za/disclaimer
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Privacy Notice

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Disclaimer:

The Benefits and contributions are subject to approval by the council for medical schemes. 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.

21 February 2024 | V1 | CH

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: _____

Aon South Africa (Pty) Ltd, an Authorised Financial Services Provider, FSP # 20555