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

MEDSHIELD medical scheme

ACTIVE SWOPPING (Change of Principal Member)

Email: newapplication@medshield.co.za

This form needs to be completed in the event that the current Principal Member becomes the dependant, and his/her spouse becomes the Principal Member. No termination of beneficiaries are allowed during the swopping of membership process.

Please complete in black ink. All sections to be completed in full. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with an X where necessary. All relevant sections must be signed.
Swopping of membership is subject to Scheme approval.

Broker Code:

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 document copy(ies) for all beneficiaries (e.g. ID/birth certificate/passport)	
Student certificate (child dependant age 21-27 that is studying or turning 21 in the next 3 months)	
Stamped bank statement or stamped confirmation letter from the bank or copy of cancelled cheque and signed letter of authority for 3rd Parties	
ID copy(ies) of the nominated 3rd Party(ies) Consent (To whom we may provide specified information)	

SECTION A — TO BE COMPLETED BY CURRENT PRINCIPAL MEMBER

Membership Number:

Member ID Number:

Member Name:

Member Surname:

I hereby resign as the Principal Member and request that my spouse /partner take over the rights and responsibilities of my membership.

Provide reasons for the request: _____

_____

_____

_____

_____

Date:

SECTION B TO BE COMPLETED BY NEW PRINCIPAL MEMBER

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

Please provide at least one email address

Personal Email Address:	
Business Email Address:	
Telephone Number (W):	
Telephone Number (H):	
Cell Number:	
Fax Number:	

Please complete for statistical purposes. If you do not wish to disclose your 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 DEPENDANTS DETAILS (Must be Active Beneficiaries on Existing Membership)

Dependants (attach copies of ID or birth certificate)

Dependant 1

Name of Dependant:				
Surname: (If Different to Principal Member)				
ID Number:				
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	

Please complete for statistical purposes. If you do not wish to disclose your 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:						
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	

Please complete for statistical purposes. If you do not wish to disclose your 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:						
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	

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

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

Dependant 4

Name of Dependant:						
Surname: (If Different to Principal Member)						
ID Number:						
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	

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

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

Dependant 5

Name of Dependant:					
Surname: (If Different to Principal Member)					
ID Number:					
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	

Please complete for statistical purposes. If you do not wish to disclose your 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 BANK DETAILS OF NEW PRINCIPAL MEMBER

I hereby authorise Medshield Medical Scheme to deduct monthly contributions and/or pay refunds to the following bank account.
A stamped bank statement, cancelled cheque 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, a stamped bank statement, cancelled cheque or a stamped confirmation letter from the bank together with a signed letter of authorisation from the account holder must accompany this form. For Companies/Groups a signed letter of authorisation needs to be on a company letterhead.

NB: If contributions are not deducted by PERSAL or your employer, payment via debit order is the preferred method for the collection of contribution payment.

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 ☐
Name of Account Holder:			
Bank Account Number:			
Date:			

Signature of Account Holder: _____

SECTION E EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date:

COMPANY STAMP

Tick this box if no Company Stamp is available ☐

By selecting this box you confirm that the Employer has granted approval ☐

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 F CONSENT (Consent for Medshield Medical Scheme to process personal information)

The Scheme understands that your personal information and that of your dependants is important to you. 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.**

I, the Principal Member, _____ (Name & Surname),

ID number _____, do hereby:

Please read the items of consent below carefully. All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

☐ Give permission, with the consent of my dependants, that Medshield Medical Scheme may collect, process, store and share our personal information, including health information with the Scheme's contracted service providers to perform their functions for the administration and/or managed care of my membership which include the assessment and processing of my application, eligibility, underwriting, risk assessment, assessment and payment of claims, the provision of managed healthcare services, assessments of non-disclosures, validation and allocation of benefits, reporting to statutory bodies, fraud prevention and detection, member surveys and communication, collection and refund of contributions, members portions and savings and credit reporting.

☐ Authorise Medshield Medical Scheme to obtain from any doctor, medical professional, or any other person who may be in possession of, or may hereafter acquire, any information concerning my or any of my dependants' health, whether such information relates to the past or future, to disclose such information to the Scheme and it's contracted third parties and agree that this request shall remain in force after my / their death, as well as prior thereto.

☐ Confirm that I am duly authorised to apply for membership and to act for those for whom I am applying for under the age of 18 in any matter relating to this application and the administration of our Medshield membership.

☐ I hereby acknowledge and declare that as the Principal Member of the Scheme, to the extent that it may be required by law, that I have received the necessary consent from my dependant(s) over the age of 18 to 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.

☐ Consent that all conversations between me, or any of my dependant(s), and the Scheme or its contracted service providers may be recorded.

☐ Acknowledge that my and my dependants' personal information, shall be retained as part of the records of the Scheme for as long as it is required by the Scheme for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of the applicable law. Medshield Medical Scheme are required to collect and keep personal information in terms of the allowable statutory limits.

☐ 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. 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.

☐ Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Planner, if any, who is an accredited Medical Aid Broker of my choice.

☐ Consent to receive Scheme communication as it pertains to my membership and any information from the Scheme which could enhance my benefits, health and the management of my health.

☐ I have the right to request my personal information and that of my dependant(s), which is in the possession of Medshield Medical Scheme, provided that I furnish adequate identification and written consent from my dependant(s) over the age of 18.

☐ I have the right to request Medshield Medical Scheme where necessary, to correct, or delete my, or any of my dependant(s), personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.

☐ I shall inform the Scheme of any changes relating to my or any of my dependant(s) personal information within 30 days of the change, as required by the Scheme rules, as it may impact the administration of my membership and communication from the Scheme.

☐ I agree that should I have a complaint relating to the processing of my and my dependant(s) personal information, I will refer it to the Scheme to resolve. If I am not satisfied with the outcome of the complaint, I may refer the complaint to the Information Regulator.

Principal Member Signature: _____ Date: _____

SECTION G MEMBER DECLARATION

All boxes must be ticked as confirmation that you have read, understood and agree with the terms as stated.

Please read the declarations below carefully.

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.

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 pre-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 14 days of the Member Declaration sign date, in order to avoid your application being rejected due to it being stale.

SECTION H 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	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

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	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

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	DD/MM/YYYY	DD/MM/YYYY
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Financial Information: (Banking details, contributions, tax certificate)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N	DD/MM/YYYY	DD/MM/YYYY
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N	DD/MM/YYYY	DD/MM/YYYY
Request changes and updates on my behalf	Y	N	DD/MM/YYYY	DD/MM/YYYY

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: _____

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.