Continuation form

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

OR MAIL COMPLETED FORM TO:
Fedhealth Membership
Private Bag X3045
Randburg
2125

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

Current Membership no. _____ (NB: this will change)

Change effective from 0 1 m m y y y y

Change of principal member ☐

Subject to Scheme approval only

Supporting documents required:

Signed and dated request from principal member stating reason for the change.

Should the member be part of an emloyer group, the request needs to have employer approval and a company stamp affixed.

The details of the existing Intermediary/Financial Advisor will remain in place. Should there be a change in Advisor, a new letter of appointment will need to be attached.

Death of principal member ☐

Supporting documents required:

A copy of death certificate

The details of the existing Intermediary/Financial Advisor will remain in place. Should there be a change in Advisor, a new letter of appointment will need to be attached.

Immigration of principal member ☐

Supporting documents required:

Signed and dated request from principal member stating date of departure and destination and a copy of the flight detail. Should the member be part of an emloyer group, the request needs to have employer approval and a company stamp affixed.

The details of the existing Intermediary/Financial Advisor will remain in place. Should there be a change in Advisor, a new letter of appointment will need to be attached.

Member move from Group to Direct Paying Member (DPM) status (employment change) ☐

Note:

Member and broker are required to complete section 2

SECTION 1 DETAILS OF PRINCIPAL MEMBER

Surname

Title | First name/s

Preferred name

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

SECTION 2 BROKER APPOINTMENT

I, the member, appoint:

Name of Broker

Broker code as my healthcare broker. I understand that this appointment will remain in force until cancelled by myself

Member signature ..... Date signed d d m m y y y y

I, the Broker hereby agree to maintain the appointment signed at ..... on this ..... day of ..... 20.....

Name of Brokerage ..... Broker code.....

Signature of Broker ..... Name of Broker .....

SECTION 3 ADDRESS / CONTACT DETAILS

Telephone (H) ( ) | Telephone (W) ( )

Cellular | Fax ( )

E-mail address

Postal address

Postal code

Physical address

Postal code

SECTION 4 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 collections: 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 COLLECTIONS INCLUDING MEDIVAULT INSTALMENTS AND REFUNDS

☐ 2. USE THIS ACCOUNT FOR ALL COLLECTIONS ONLY
NB: If you tick this option, 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, 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

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 5 CONFIRMATION OF EXISTING BENEFICIARIES TO REMAIN ON MEMBERSHIP

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* ☐	2 Adult ☐ Child* ☐
Title / Initials / Relationship to member		
Surname		
First name/s		
Preferred name / Marital status		
ID number / passport number		
Nationality		
Country of issue of passport		
Income Tax Number		
Date of birth / Gender (M F)	d d m m y y y y	d d m m y y y y
Email address / Cell		

** Child dependant = the member's dependent child up to the age of 21 or 27 if a full-time student*

SECTION 5 CONFIRMATION OF EXISTING BENEFICIARIES TO REMAIN ON MEMBERSHIP (CONTINUED)

	3 Adult ☐ Child* ☐	4 Adult ☐ Child* ☐
Title	Initials / Relationship to member	Initials / Relationship to member
Surname		
First name/s		
Preferred name	Marital status	Marital status
ID number / passport number		
Nationality		
Country of issue of passport		
Income Tax Number		
Date of birth	d d m m y y y y Gender M F	d d m m y y y y Gender M F
Email address	Cell	Cell

** 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 dependants over the age of 21, must furnish either proof of registration from a full-time tertiary institution for the current year or an affidavit.
- For any dependant, other than your biological children, please supply 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.
- For adult dependants, please supply an affidavit confirming residency, marital status, employment status and income.

SECTION 6 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 | 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

Name of salary administrator

Designation

Company stamp

Signature .....

Date signed d d m m y y y y

SECTION 7 FLEXIFED MEMBERS ONLY - MEDIVAULT DETAILS

Should you choose to activate MediVault and transfer funds into your Wallet on your new membership, complete a new MediVault Application form and refer to the MediVault benefit in your brochure

SECTION 8 DECLARATION BY PRINCIPAL MEMBER

1. I, the undersigned hereby apply for membership of Fedhealth Medical Scheme (the Scheme) and also nominate my dependants as specified.
2. I hereby undertake to observe and carry out the provisions of the Medical Schemes Act 131 of 1998 (the Act) and of the rules of the Scheme as amended from time to time.
3. I agree that the Scheme shall not be bound in any way by any representations or undertakings made or given by any person or agent which is in contradiction with the registered rules of the Scheme.
4. I further agree that the commencement of my membership and the liability of the Scheme as a result of this application is conditional upon the first contribution being paid and received by the Scheme, as well as the MediVault instalment. In addition, should I default on payment of any subsequent contributions or instalments, and fail to remedy such default within the time periods allowed in the rules, any benefits paid by the Scheme on my behalf after the receipt of my last contribution shall be reversed and payment of these claims shall be for my account.
5. I hereby authorise and request any doctor or medical professional person, or any other person who may be in possession of, or may hereafter acquire, any information concerning my/ the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my/ their deaths, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of, or arising out of the disclosure of any test results or medical information.
6. I accept any penalties/ waiting periods that may be applied in accordance with the Act. I understand that these waiting periods may include a 3 (three) month general waiting period, a 12 (twelve) month waiting period for pre-existing conditions and, if applicable, a late joiner penalty fee.
7. I hereby authorise my employee and/or Payroll of my company to deduct from my salary or any other available funds and/or via debiting of my bank account, all contributions, instalments, arrears, or any other amounts that I may owe to the Scheme as per the rules and agreement selected. In the event of arrears, I will be responsible for any legal costs that may arise in the recovery thereof.
8. It is my sole responsibility as a member to ensure that the monthly contribution, instalments and any amounts that may become due by me in terms of the Scheme rules, is received by the Scheme.

SECTION 8 DECLARATION BY PRINCIPAL MEMBER (CONTINUED)

9. I hereby acknowledge that any credit extended by the Scheme to myself or my dependants whilst a member of the Scheme will become payable in full on termination of my membership.
10. I understand and agree to receive written notifications, SMS and other communication to the email address and/or cell number provided by me or my financial advisor. This communication may include changes to the rules of the Scheme as amended from time to time.
11. I understand that should there be any outstanding debt, my account will be suspended and no claims will be paid until payment agreement is reached and payment received.
12. I acknowledge that non-disclosure of any information by myself or my dependants relevant to the assessment of this application shall render any contracts to which this application relates null and void.
13. Should there be any additional information required by the Scheme which is not received within 7 (seven) days, the Scheme will automatically suspend the application.
14. I acknowledge that I am not a member of more than one Medical Scheme.
15. I hereby authorise the Scheme or any of its nominated representatives to verify and confirm my bank details.
16. I acknowledge that a monthly commission of 3% of my total monthly contribution up to a maximum, as legislated from time to time, will be paid to the financial adviser in terms of the Medical Schemes Act 131 of 1998 (or as amended), only if an advisor/ broker is appointed.
17. I agree to provide the Scheme with 3 (three) months' written notice to inform Fedhealth of my intention to terminate my membership.
18. I acknowledge that it is my responsibility to notify the Scheme of any changes to the facts, or any changes in my or my dependants' state of health, between the date of signing this application form and the date when my membership commences. If this is not done before my membership commences, waiting periods may apply and/ or future claims or my membership may be rejected.
19. I hereby confirm that I understand the various partnership arrangements (either Designated Service Provider and/ or Preferred Provider) applicable to my option and am aware that co-payments and/ or lower reimbursement rates may apply to the non-use of Fedhealth partners.
20. I declare that this personal statement, whether in my handwriting or not, is complete, true and correct and that I have not concealed, withheld or misstated any material facts.
21. I 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 and managed healthcare services. This includes the collecting and sharing of my personal information with the Scheme's partners and facilities who are essential 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.*

Sanlam Wealth Bonus

Do you have a Sanlam Matrix Premier product? Yes ☐ No ☐

If you answer yes, your I.D and membership number will be shared with Sanlam for the purpose of increasing your current Sanlam Wealth Bonus.

Signed at …….. on this …….. day of …….. 20.....

Signature of principal member …….....

Print name ……..... Identity number

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.