company
APPLICATION FORM

FEDHEALTH

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

OR FAX TO:
Fedhealth Membership
Fax No: 011 671 3647

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

SECTION 1 : INTERMEDIARY This section MUST be signed by the broker / agent

Broker code | FSB licence number

Name of brokerage/ broker/ agent

Telephone number (W) ( ) | Cell

E-mail address

Broker's / agent's signature ..... Date d d m m y y y y

SECTION 2 : EMPLOYER DETAILS

Company name

Legal entity

Company registration number

Contact person

Title | Initials | First name

Surname

ID number | Gender M F

Business postal address

Postal c o d e

Business street address

Postal c o d e

Telephone (W) ( ) | Fax ( )

E-mail address

Position in company

Type of business

COIDA (workmen's compensation) registration number / /

Additional contact person

Title | Initials | First name

Surname

ID number | Gender M F

Telephone (W) ( ) | Fax ( )

E-mail address

SECTION 3 : CHOICE OF SCHEME OPTION *Submit a completed enrolment form for each member that indicates the option they have selected*

Starting date for the company d d m m y y y y

Do you require your billing to reflect the subsidy amounts? yes no

If yes, please provide information below

Principal member subsidised? yes no

If yes, value of subsidy R

Dependants subsidised? yes no

If yes, value of subsidy R

Total number of subsidised dependants

Total number of non-subsidised dependants

SECTION 4 : BANKING DETAILS FOR CONTRIBUTION PAYMENTS

I hereby instruct Medscheme on behalf of Fedhealth Medical Scheme, to electronically collect contributions via Debit Order

OR the company to pay via EFT

The company bank details are as follows:

Name of account holder

Name of financial institution

Branch code

Branch name

Account number

Account type Current Savings Transmission

Please attach a copy of a letter of confirmation from your bank or a bank statement.

OFFICIAL BANK ACCOUNT SIGNATORIES

Name and Surname

Designation

Name and Surname

Designation

Authorised signatory/ies

Dates d d m m y y y y d d m m y y y y

SECTION 5 : COMPANY'S PREVIOUS AND CURRENT MEDICAL SCHEME INFORMATION

Name of current medical scheme

Date joined d d m m y y y y

Date to be terminated d d m m y y y y

Name of previous medical scheme

Date joined d d m m y y y y

Date terminated d d m m y y y y

SECTION 6 : YOUR EMPLOYEE BASE

Number of employees that your company employs

Number of employees that Fedhealth Medical Scheme will cover

Is membership of a medical fund compulsory for all employees in the company within a specific group? Yes No

If yes, define the group .....

Will the company offer any other scheme membership to employees? Yes No

If yes, name of scheme

SECTION 7 : TERMS AND CONDITIONS

1. The Rules of Fedhealth Medical Scheme (referred to as Fedhealth), as amended from time to time shall bind Fedhealth Medical Scheme, the employer and the employee (the member).

2. The person signing this application on behalf of the employer warrants that he/ she is duly authorised to do so and acknowledges that he/ she has received a set of Fedhealth rules and that he/ she has read them prior to signing this application.

3. Please note the following:

   3.1 If membership is compulsory, then all eligible employees must join.
   3.2 The employer will submit application forms for all eligible employees and their dependants to become members.
   3.3 If the employer does not pay the monthly contributions and any other amounts due to Fedhealth in respect of any member, Fedhealth shall have the right to suspend/ terminate the member's membership within its sole discretion.
   3.4 Fedhealth shall send monthly statements to the employer/ member stating all amounts due and owing to Fedhealth.
   3.5 The employer/ member shall pay all amounts owing in full and ensure that payment reaches Fedhealth Medical Scheme by no later than the third day of the month in which the amount is due.
   3.6 Fedhealth requires the employer to pay contributions and any other amounts due to Fedhealth by ACB or any form of electronic fund transfer that Fedhealth may in its discretion determine.
   3.7 Fedhealth shall not be liable for the payment of any benefits should:
      3.7.1 The employer/ member fail to comply with any of the employer/ member's obligations.
      3.7.2 Any contribution, part of a contribution, or any other amount be in arrears.
   3.8 The employer is the agent of the member in respect of all obligations arising from the agreement.
   3.9 The employer shall notify Fedhealth within 30 (thirty) days of any change of address or material change in a member's circumstances. Fedhealth shall not be held liable should the employer fail to give notice and should a member be prejudiced in any way. The employer indemnifies and holds Fedhealth harmless against any loss or damage that may be suffered by a member in this regard.

4. The employer warrants that it has an agreement with all the members granting the employer the right to receive and pay over all amounts due to Fedhealth from such member's remuneration.

5. The employer shall have the right to terminate the employer's group membership of Fedhealth by giving no less than 3 (three) calendar months' prior written notice of termination to Fedhealth.

6. A binding agreement shall only come into being once an authorised Fedhealth signatory has signed the company enrolment form.

7. The employer bears the responsibility to ensure that all contributions are collected and paid over to Fedhealth in respect of retired employees who are members. Furthermore, the employer agrees to pay over all amounts owing by ex-employees or retired employees in respect of any outstanding contributions, or amounts paid to service providers (where amounts were advanced by Fedhealth). On termination of the employer's group membership of Fedhealth, the employer shall ensure that the membership of all employees, ex-employees and retired employees of the employer's group scheme are terminated simultaneously. The employer shall indemnify and hold Fedhealth harmless against any loss or damage which Fedhealth may suffer as a result of the employer failing to notify or comply in this regard.

Signed for and on behalf of the employer/ individual: I/ we warrant that I am/ we are properly authorised to bind the employer.

Name and surname		
Designation		
Name and surname		
Designation		
Authorised signatory/ies		
Dates	d d m m y y y y	d d m m y y y y

Company Stamp