maxima

application form 2014

Real Medical Aid

FEDHEALTH

SECTION 1 CHOICE OF OPTION

Choose ONE product option by placing "x" in the appropriate box

☐ **MAXIMA PLUS** Including OHEB and Savings

☐ **MAXIMA EXEC** Including OHEB and Savings

☐ **MAXIMA STANDARD** Including OHEB and Savings

☐ **MAXIMA BASIS** Including OHEB only

☐ **MAXIMA CORE** Hospital Plan only

☐ **MAXIMA ENTRYZONE** Hospital Plan only

☐ **MAXIMA STANDARD^{net}** Including OHEB and Savings

☐ **MAXIMA SAVER**

☐ **MAXIMA ENTRYSAVER**

I wish to join the scheme from 0 1 m m y y y y

Membership number (administrative use only)

SECTION 2 DETAILS OF PRINCIPAL MEMBER

Surname

Maiden name (if applicable)

Title First name/s

Initials

Gender M F Date of birth d d m m y y y y ID/ passport number

Tax Number

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

Cellular Fax ( )

E-mail address

Postal address

Postal code

Physical address

Postal code

Country

Are you changing your medical scheme due to a change in your employment? Yes No

Have you had previous medical aid cover? Yes No *If yes, please provide details below*

Name of previous medical scheme	Membership number	Date joined	Date left

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on you when applying for membership of any other medical scheme/s? Yes No

PLEASE ☒ – FOR STATISTICAL PURPOSES ONLY Ethnic group Black Coloured Indian White Asian Marital status Single Married Divorced Widowed Common law partner/ spouse

SECTION 3 INTERMEDIARY / FINANCIAL ADVISER

This section must be signed by the broker/ agent/ adviser if applicable

Broker code FSB licence number

Name of brokerage

Name of broker/agent/adviser

Telephone (W) Cellular

Fax

E-mail address

Postal address

Physical address

FINANCIAL ADVISER DECLARATION

1. I hereby acknowledge that I am an accredited Fedhealth Financial Adviser and that I am licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act 37 of 2002.
2. I acknowledge that the applicant has appointed me as his/ her financial adviser and that the applicant is entitled to cancel my services at any time.
3. I confirm that the applicant was provided with my personal details, physical and postal address and telephone number.
4. I acknowledge that a monthly commission of 3% of the total monthly contribution up to a maximum, as legislated from time to time, will be paid to me in terms of the Medical Schemes Act 131 of 1998 (or as amended).
5. I confirm that there has been no material misrepresentation of any fact by me and that in the event of material misconduct or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation or conduct.
6. The applicant is familiar with the information requested in the application form and all the relevant information was provided by the applicant.
7. The advice and assistance given to the applicant was impartial and in the best interest of the applicant.
8. The applicant has personally signed the application form.

Broker's/ agent's/ adviser's signature ………………………………………………………………………………………… Date d d m m y y y y

SECTION 4 DETAILS OF YOUR SPOUSE / PARTNER YOU WISH TO REGISTER

SPOUSE / PARTNER Surname

Maiden name (if applicable)

Title First name/s

Initials

Relationship to principal member Gender M F

ID/ passport/ birth certificate number Date of birth d d m m y y y y

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below*

Name of previous medical scheme	Membership number	Date joined	Date left

Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

SECTION 5 DEPENDANTS YOU WISH TO REGISTER

	1		2	
	Adult	Child*	Adult	Child*
Title		Initials		Initials
Surname				
First name/s				
Relationship to member				
ID number or passport 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
Marital Status				

	3		4	
	Adult	Child*	Adult	Child*
Title		Initials		Initials
Surname				
First name/s				
Relationship to member				
ID number or passport 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
Marital Status				

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

Please note:
Any dependant over the age of 21 must furnish either proof of registration from a full time tertiary institution for the current year or an affidavit confirming residency, marital status, employment status and income. Any dependant, other than your biological children, under the age of 21: 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

SECTION 6 EMPLOYER INFORMATION *This section must be completed by your employer only if employer pays your contribution*

Name of employer

Employee number Employment date d d m m y y y y

Division code Dept. name

Persal number *if applicable* Fedhealth paypoint code

Medical scheme start date 0 1 m m y y y y

We confirm that the applicant is employed by us and commenced employment on the above date

Name of medical scheme/ salary administrator

Designation

Company stamp

Signature ....

Date signed d d m m y y y y

SECTION 7 MEDICAL DETAILS

This section must be completed. Failure to disclose information is fraudulent and may result in membership not being granted or termination of membership without refund of contributions paid.

Have you or any of your dependants sought any advice, been diagnosed with or been treated for any conditions in the last 12 months? If yes, please provide details. Yes | No

Name of beneficiary	Diagnosis	Date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	

If you or any of your dependants are living with HIV/ AIDS and would prefer not to disclose the HIV/ AIDS status on this form in the interest of confidentiality, then please call Aid for AIDS on 0860 100 646 to register on the HIV/ AIDS Disease Management Programme.
Should this space be insufficient, please attach a separate sheet.

SECTION 8 BANK DETAILS OF PRINCIPAL MEMBER *Refund of claims and debit order instruction*

I hereby instruct Fedhealth to electronically collect contributions and to deposit claims refunds, using the information provided below. 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 either of the following two dates for debit order collections.

☐ **25th of the month** **OR** ☐ **First working day of the following month**

☐ 1. USE THIS ACCOUNT FOR ALL TRANSACTIONS

☐ 2. USE THIS ACCOUNT FOR CONTRIBUTION COLLECTIONS ONLY
NB. If you tick this option, then you must complete bank details for claims refunds on the right.

Bank name			
Branch name			
Bank branch code			
Type of account	Cheque	Transmission	Savings
Name of account holder			
Bank account number			

☐ USE THIS ACCOUNT FOR CLAIMS REFUNDS ONLY
NB: If you ticked no. 2 on the left then bank details must be completed here.

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 contribution collections and refunds.

Account/ s holder's signature ………………………………………………………… Date d d m m y y y y

SECTION 9 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. In addition, should I default on payment of any subsequent contributions, 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 month general waiting period, a 12 month waiting period for pre-existing conditions and, if applicable, a late joiner penalty fee.
7. I hereby authorise the Scheme to deduct from my salary or any other available funds via debiting of my bank account, all contributions or any other amounts that may become due by me in terms of the Scheme's rules. 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 is received by the Scheme.
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 and that interest may be charged on all amounts due and owing to the Scheme.
10. I acknowledge that the Scheme may obtain any information regarding myself from any credit bureau, national loans register, South African Fraud Prevention Service or any other agent I have dealt with, with regards to my profile and credit history.
11. I understand that the Scheme may provide written notification, to my e-mail address, failing which, my financial adviser's e-mail address as supplied by my financial adviser, of changes to its rules.
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, and all contributions paid by me shall be forfeited to the Scheme. In such events, the Scheme shall be entitled to reclaim any amounts which they may have paid to me or any person on my or my dependants' behalf under such contracts.
13. Should there be any additional information required by the Scheme which is not received within 7 days, the Scheme will automatically suspend the application.
14. I acknowledge that I am not a member of more than one medical aid.
15. I hereby authorise the Scheme or any of its nominated representatives to 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).
17. I agree to provide the Scheme with 3 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, future claims 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.

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

Signature of principal member ……………………………….................................

Print name ……………………………….................................

Identity number

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

Call Centre number:
0860 002 153