maxima
APPLICATION FORM

FEDHEALTH

SECTION 1 CHOICE OF OPTION
Choose ONE product option by placing "x" in the appropriate box

- ☐ MAXIMA PLUS
- ☐ MAXIMA EXEC
- ☐ MAXIMA STANDARD
- ☐ MAXIMA BASIS
- ☐ MAXIMA CORE
- ☐ MAXIMA ENTRYZONE
- ☐ MAXIMA STANDARD Elect
- ☐ MAXIMA SAVER*
- ☐ MAXIMA ENTRYSAVER*

* If you have selected Maxima Saver or Maxima EntrySaver please complete section 8 below

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

Preferred name | Initials

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

Tax Number

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

Cellphone number | 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 x – 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 | Preferred name

Cellphone number | E-mail address | 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 Adult Child*

Title | Initials | Relationship to member

Surname

First name/s

Preferred name | Marital status

ID number / passport number

Date of birth d d m m y y y y | Gender M F

E-mail address | Cell

2 Adult Child*

Title | Initials | Relationship to member

Surname

First name/s

Preferred name | Marital status

ID number / passport number

Date of birth d d m m y y y y | Gender M F

E-mail address | Cell

3 Adult Child*

Title | Initials | Relationship to member

Surname

First name/s

Preferred name | Marital status

ID number / passport number

Date of birth d d m m y y y y | Gender M F

E-mail address | Cell

4 Adult Child*

Title | Initials | Relationship to member

Surname

First name/s

Preferred name | Marital status

ID number / passport number

Date of birth d d m m y y y y | Gender M F

E-mail address | 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 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 FP, 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	

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 NOMINATED FP DETAILS FOR MAXIMA SAVER AND MAXIMA ENTRYSAVER OPTIONS ONLY

If you have selected Maxima Saver or Maxima EntrySaver you are required to nominate an FP from the Fedhealth network for yourself and your dependants. Please note that only visits to a nominated FP will be covered on these options. For a list of FP's on the Fedhealth network visit www.fedhealth.co.za, click on member tools and you will find the FP locator button on the right hand side of the page. Alternatively you can phone the Customer Contact Centre on 0860 002 153 for more information.

	MEMBER / DEPENDANT NAME	NOMINATED FP DETAILS		
		NAME	PRACTICE NUMBER	CONTACT DETAILS
Principal member				
Dependant				
Dependant				
Dependant				
Dependant				
Dependant				
Dependant				

SECTION 9 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**

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.

☐ 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 10 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

Customer Contact Centre number:
0860 002 153

Sanlam Reality Application form
for new Fedhealth medical aid members.

Once completed, please submit with your medical aid application form.
Please tick all boxes where applicable.

Personal details

Full names: (As per ID) _____

Preferred name: _____

Surname: _____

Identity number: _____

Sanlam Reality membership

Please select your membership option.

(Refer to our website or call 0860 732 5489 for more information.)

Membership option	Single option		Family option	
Reality Health	R160 pm	☐	R200 pm	☐

Note: By selecting the family option we will automatically add your dependants as per your medical aid.

Money Saver Card:

☐ Add the Money Saver card to my membership

Note: There is no card admin fee for the first three months, thereafter R50 per month will apply. More cards can be ordered for family members.

Sanlam Reality communication options

I prefer to receive communication via the following channels:

Email ☐ SMS ☐ Phone ☐ Mail ☐

I would like to receive information about discounts and special offers available only to members:

Yes ☐ No ☐

Permission to use medical aid information

Sanlam Reality will use your personal information (as supplied by your medical aid scheme) to complete your Sanlam Reality registration. Sanlam Reality will keep your personal and/or health information, as well as the information of your spouse and dependant/s, confidential. However, by signing this form, you agree to the disclosing and use of disclosed information, including that of your spouse and/or dependant/s that you have provided, in that Sanlam Reality may collect, process, store, and share all confidential information, as contained in this application and provided to us after the inception of your Sanlam Reality membership. This information may be used to:

- Administer the Sanlam Reality programme.
- Provide any services that you or your spouse or any dependant/s may require.
- Enable any contracted third party that requires such information to render a service or provide goods to you or your spouse or any dependant/s on your Sanlam Reality membership, but only if such contracted third party agrees to keep the information confidential.
- Enable any other entity within the Sanlam Group, where you or your spouse or your dependant/s have applied for a product, to administer the product.
- Health data may be shared/utilised in order to qualify for specific benefits.

☐ I hereby agree and give permission.

Broker details

Complete this section if an intermediary introduced you to Sanlam Reality.

Surname: _____

First name: _____

Intermediary code: _____

Contact number: _____

Debit order authorisation

☐ I hereby authorise that Sanlam Reality can use the banking details provided for my medical aid claims refunds.

OR

☐ Sanlam Reality may create a debit order instruction based on the information indicated below for the specific amount which will be deducted on the first of every month unless otherwise requested. I undertake to inform Sanlam Reality of any changes to my bank details and authorise Sanlam Reality to verify such details. (Total 'SL' Debit or Real Futures Pty Ltd will reflect on your bank statement for this deduction.)

Debit order information:

Account name: _____

Bank: _____

Bank code: _____

Account number: _____

Account type:

Savings ☐ Transmission ☐ Cheque ☐

Signature:

I hereby confirm that the above information is true and correct. I agree that by joining the Sanlam Reality programme I am bound by Sanlam Reality's rules as set out by the programme. For full T&Cs, visit **www.sanlamreality.co.za**.

Signed: _____

at _____ on _____

Print name: _____

Print name: _____