

# Changes to your medical aid

(To be sent to your wages/salary department)

## SECTION A - Main member required details

Membership number	<input type="text"/>	Date	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Employee number	<input type="text"/>		
Cost code (first six digits)	<input type="text"/>	<b>CHANGE FROM DATE</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Main member surname	<input type="text"/>		
First name	<input type="text"/>	Initials	<input type="text"/>
Identity number	<input type="text"/>	(Certified copy of identity document must be attached.)	
E-mail address (optional)	<input type="text"/>		
Cell phone no. (optional)	<input type="text"/>		

If any of the required information is missing the form cannot be processed.

## SECTION B - Change to main member details only

<b>FROM</b>	<input type="checkbox"/> Single		<b>TO</b>	<input type="checkbox"/> Single
	<input type="checkbox"/> Married			<input type="checkbox"/> Married
<input type="checkbox"/> Divorced	<input type="checkbox"/> Divorced			
<input type="text"/>	Surname	<input type="text"/>	Surname	

Certified copies of certificates must be attached to this form before any of these changes can be made to your medical aid, i.e. marriage certificate, proof of divorce, new ID document in case of surname changes.

## SECTION C - Dependants on your membership card - details and documents required

FROM (Fill in all current details.)				Reason	TO (Fill in all details to show new list.)			
	Surname	First name	Amount			Surname	First name	Amount
Main member					Main member			
Spouse					Spouse			
Child Dep 1					Child Dep 1			
Child Dep 2					Child Dep 2			
Child Dep 3					Child Dep 3			
Child Dep 4					Child Dep 4			
F/D* 1					F/D* 1			
F/D* 2					F/D* 2			
F/D* 3					F/D* 3			
Late joiner penalty					Late joiner penalty			
<b>Total deduction last month</b>			<b>R</b>		<b>Total deduction after change</b>			<b>R</b>

\* Financial dependant (Adult rate. No company subsidy.)

## SECTION C – Dependants on your membership card – details and documents required (continued)

- A. For any new dependant, you must attach a certified copy of his/her ID document before he/she can be added to your medical scheme. (Newborn babies must have a certified copy of the birth certificate.)
- B. If a main member is cancelling membership, proof of membership on spouse's medical scheme must be attached before the member will be removed from the Pick n Pay Medical scheme.
- C. If a main member or dependant has died, a certified copy of the death certificate must be attached to this form before the deduction can be changed.
- D. Waiting periods may apply for any new dependants – please check the rules of the Scheme.
- E. Late joiner penalties may be applied to new dependants – please provide proof of membership to previous medical schemes if you want to avoid these penalties.
- F. For financial dependants an affidavit must be attached indicating that the dependant lives with you and earns less than the State pension per month.
- G. To add a dependant at the "spouse" rate the dependant must be married to the main member or an affidavit must be attached which indicates the permanence of the relationship, i.e. marriage under customary laws.
- H. To pay the child dependant rate the child must be under 21 years old.  
Exceptions are: (i) students at recognised study institutions – proof of this must be attached; or  
(ii) dependants who are mentally and/or physically disabled – a medical report must be attached.  
These exceptional dependants may remain on the Scheme over the age of 25, but will be charged the full adult rate for which there is no company subsidy.

## INFORMATION REQUIRED FOR ANY ADDITIONAL DEPENDANTS

### 1 – Previous medical scheme membership details of your dependants

Name of scheme	<input type="text"/>																
Period of membership from	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table> to <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y										
D	D	M	M	Y	Y	Y	Y										
Name of scheme	<input type="text"/>																
Period of membership from	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table> to <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y										
D	D	M	M	Y	Y	Y	Y										

A certificate of membership of previous schemes is required stating the period of membership and any waiting periods or late joiner penalties.

### 2 – State of health and general information

Have you or your dependant(s) ever been subject to any of the following? Answer questions by writing "YES" or "NO", depending on your circumstances, in the spaces provided.

**NB: HIV/AIDS status should not be disclosed on this form. To enrol confidentially on the HIV/AIDS management programme, call the toll-free line on 0860 767 633 – option 5.**

1. Any disorder of the heart, e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations? 1.
2. High blood pressure or disease of the blood vessels or circulatory disorder, e.g. cramps during exercise, stroke, high cholesterol or hardening of the arteries? 2.
3. Any respiratory or lung disease, e.g. asthma, bronchitis, persistent cough or tuberculosis? 3.
4. Any disorder of the digestive system, gall bladder, pancreas or liver, e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia or anal bleeding? 4.
5. Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis, venereal disease or impotence? 5.
6. Any nervous or mental complaint, e.g. epilepsy, blackouts, anxiety state or depression? 6.
7. Any type of nerve ailments, e.g. loss of sensation, numbness or paralysis, etc.? 7.
8. Ear, nose or throat disorder, e.g. ear discharge, defective vision, deafness or hoarseness? 8.
9. Disorder or disease of skin, muscles, bones, joints, limbs or spine, e.g. psoriasis, arthritis, gout, slipped disc or other back trouble? 9.
10. Diabetes, hormonal imbalance, glandular or metabolic disease, thyroid or blood disorders? 10.
11. Cancer, growth or tumour of any kind? 11.
12. Any other illness, disorder, operation or accident, e.g. fractured nose, breathing disorders, mammary hypertrophy (enlarged breasts with associated side effects) or congenital abnormalities? 12.
13. Are you or your dependants currently undergoing or expecting to undergo any medical, dental or surgical treatment? 13.

## 2 - State of health and general information (continued)

14. Have any exclusions been imposed by any medical scheme on which you or your dependants have been registered? If "YES", please state details. 14.
15. Are you (if female) or any of your dependants pregnant? If "YES", state the expected date of confinement:         15.

**If your answer was "YES" to any of the previous questions, please provide full particulars in the space below. If the space is insufficient, please provide particulars in the form of attachments.**

Question number	Name of patient	Illness or condition	Date and duration of illness or condition	Name of doctor, hospital or institution	Treatment recommended: Likely date and duration of treatment

## Declaration by applicant

I hereby declare that the information is true and correct and agree that any false declaration will make this application illegal (please refer to the original Application for Membership form).

Signature of applicant

Date

## Declaration by salary/wage officer and stamp

The changes to this employee's medical scheme membership have been scrutinised by me and I am not aware of any facts other than those stated, which should be made known to the Scheme.

Checked by: HR/salary/wage officer   
(Please print name)

Signature

Billing code stamp

