Pick n Pay
Medical scheme

Changes to your membership

(To be sent to your wages/salary department)

PLEASE COMPLETE IN BLOCK LETTERS.

Section A: Main member details

Membership number | Date (DD/MM/YYYY)

Employee number | **Change from date** (DD/MM/YYYY)

Cost code (first six digits) | Tax reference number

Title | Initials

Surname

First names

ID/Passport number (certified copy of ID/passport must be attached)

Race ☐ African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other
☐ Do not wish to disclose

Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

Contact number

Email address

PLEASE NOTE: If any of the required information is missing, the form cannot be processed.

Section B: Change to main member details only

FROM		TO	
☐	Single	☐	Single
☐	Married	☐	Married
☐	Divorced	☐	Divorced
	Surname		Surname

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

Section C: Beneficiaries on your membership card – details and documents required

FROM (fill in all current details)					TO (fill in all details to show new list)			
	Surname	First name	Amount	Reason		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			

Section C: Beneficiaries on your membership card – details and documents required (continued)

FROM (fill in all current details)					TO (fill in all details to show new list)			
	Surname	First name	Amount	Reason		Surname	First name	Amount
F/D* 1					F/D* 1			
F/D* 2					F/D* 2			
F/D* 3					F/D* 3			
Late joiner penalty					Late joiner penalty			
Total deduction last month R					**Total deduction after change** R			

*Financial dependant (adult contribution rate)

Notes:

1. For any new dependant, please attach a certified copy of his/her ID document before he/she can be added to your medical scheme. (In the case of newborn babies, please provide a certified copy of the birth certificate.)
2. If a main member is cancelling his/her membership, proof of membership on his/her spouse's medical scheme must be attached before he/she will be removed from the Pick n Pay Medical Scheme.
3. If a main member or dependant has died, a certified copy of the death certificate must be attached to this form before your monthly contribution can be changed.
4. Waiting periods may apply for any new dependants – please check the rules of the Scheme.
5. Late joiner penalties may be applied to new dependants – please provide proof of membership of previous medical schemes if you want to avoid these penalties.
6. For financial dependants, an affidavit must be attached indicating that the dependant is financially dependent on you.
7. To add a spouse as a dependant, the dependant must be married to the main member or an affidavit must be attached that indicates the permanence of the relationship, i.e. marriage under customary law/partner/common-law spouse.
8. To pay the child dependant contribution rate, the child must be under 21 years old.

   Exceptions are: (i) students at accredited learning institutions – proof of this must be attached; or
   (ii) dependants who are mentally and/or physically disabled – a medical report must be attached.

   These dependants may remain on the Scheme over the age of 25, but will be charged the full adult contribution rate.

INFORMATION REQUIRED FOR ANY ADDITIONAL DEPENDANTS

1. Previous medical scheme membership details of your dependants

Name of medical scheme _____

Period of membership from _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

Name of medical scheme _____

Period of membership from _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

Certificates of membership of previous medical schemes are 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 dependants received diagnosis, treatment or care for any of the following in the last 12 months? Please answer questions on page 3 by writing **'YES'** or **'NO'**, depending on your circumstances, in the spaces provided.

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

INFORMATION REQUIRED FOR ANY ADDITIONAL DEPENDANTS (CONTINUED)

2. State of health and general information (continued)

1. Any disorder of the heart, e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations? ☐
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? ☐
3. Any respiratory or lung disease, e.g. asthma, bronchitis, persistent cough or tuberculosis? ☐
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? ☐
5. Disease or disorder of kidneys, bladder or reproductive organs, e.g. albumin in urine, kidney stones, prostatitis, venereal disease or impotence? ☐
6. Any nervous or mental complaint, e.g. epilepsy, blackouts, anxiety state or depression? ☐
7. Any type of nerve ailments, e.g. loss of sensation, numbness or paralysis? ☐
8. Ear, nose or throat disorder, e.g. ear discharge, defective vision, deafness or hoarseness? ☐
9. Disorder or disease of skin, muscles, bones, joints, limbs or spine, e.g. psoriasis, arthritis, gout, slipped disc or other back trouble? ☐
10. Diabetes, hormonal imbalance, glandular or metabolic disease, thyroid or blood disorders? ☐
11. Cancer, growth or tumour of any kind? ☐
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? ☐
13. Are you or your dependants currently undergoing or expecting to undergo any medical, dental or surgical treatment? ☐
14. Have any exclusions been imposed by any medical scheme on which your dependants have been registered? ☐
15. Are any of your dependants pregnant? ☐
    If **'YES'**, please state the expected date of confinement: ☐ (DD/MM/YYYY)

If your answer was 'YES' to any of the questions above, please provide full particulars in the space below. If the space is insufficient, 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

Section D: Declaration by the applicant

I authorise and give consent to PICK N PAY MEDICAL SCHEME and its Administrator to share my personal information, including health information, and that of my dependants, with any entity (including an entity forming part of Momentum Metropolitan Holdings and its subsidiaries) with whom I and/or my dependants have a contractual relationship or have applied to for a product or service. This personal information will be processed and/or used for further processing in order to administer the products or services.

I NAME AND SURNAME OF MEMBER

hereby give my consent to PICK N PAY MEDICAL SCHEME's Administrator for me to receive direct marketing of complementary products and services offered by Momentum Metropolitan Holdings Limited and its subsidiaries by means of electronic communication.

☐ **Tick here if you do not wish to receive any direct marketing.**

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 Main Member Application Form).

Signature of applicant

Date DD/MM/YYYY

Section E: Declaration by the 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 that should be made known to the Scheme.

Checked by:

HR/salary/wage officer PLEASE PRINT NAME

Signature

Date DD/MM/YYYY

Billing code stamp

10/2023