SIZWE MEDICAL FUND
Caring for the health of the nation

APPLICATION TO REGISTER A DEPENDANT

SECTION 1 TO BE COMPLETED BY MEMBER

Principal member's name: ____________________

Principal member's address: ____________________

____________________ Postal code: __________

Medical aid number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Payroll/persal number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

SECTION 2 DETAILS OF DEPENDANT TO BE REGISTERED

NOTES:

1. For registration of child dependants, please attach relevant documents (eg, adoption papers, birth certificates, clinic cards, etc).
2. For registration of adult dependants, please attach relevant documents (eg, previous medical scheme certificates with termination dates, affidavits indicating how long you have been living together, IDs, marriage certificates, lobola agreements, etc).
3. Child dependants who are under 24 years and employed cannot be registered on the medical aid if their income exceeds the social pension amount per month.
4. A parent of the member who is still employed (ie, not yet on pension) and whose income exceeds the social pension amount, does not qualify to be registered as an adult dependant, but should be registered as a principal member.

Dependant's surname: ____________________ First names: ____________________

(If there is a difference between the surname of the child and the main member, please state reason.)

____

Relationship to principal member: ____________________ ID no of dependant: ____________________

Date of birth: D D / M M / Y Y Y Y Date joining Fund: D D / M M / Y Y Y Y

Marital status: __________ Date of marriage: D D / M M / Y Y Y Y Gender: [ ] Male [ ] Female

1. Is the dependant in receipt of an income? [ ] Yes [ ] No

Monthly salary: R ____________________

State name of employer: ____________________

Pension (old age, military or disability): R ____________________

Pension (other than above, including an annuity): R ____________________

Other (eg, interest and/or dividends on investments): R ____________________

Total: R ____________________

2. Is the dependant entirely dependent on you for maintenance and support? [ ] Yes [ ] No

If yes, give details: ____________________

3. Does the dependant reside with you? [ ] Yes [ ] No

If no, give address details: ____________________

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SECTION 3 MEDICAL DETAILS OF DEPENDANT TO BE REGISTERED

IMPORTANT: Please submit proof and date of treatment of pre-existing health conditions of dependant.
This means an illness or condition for which medical advice, diagnosis, care of treatment was recommended or received.
Please ask your treating doctor to help you provide the relevant ICD-10 Code.

Has the dependant ever suffered from any of the following (if "YES" state full details of each instance in the schedule below):			ICD-10 Code	Initialled by principal member
1. Any disorder of the heart, (eg, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	Y	N		
2. High blood pressure or disease of the blood vessels or circulatory disorder (eg, cramps during exercise, stroke, high cholesterol, hardening of arteries)?	Y	N		
3. Any respiratory or lung disease (eg, asthma, bronchitis, persistent cough or tuberculosis)?	Y	N		
4. Any disorder of the digestive system, gall bladder, pancreas or liver (eg, actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, anal bleeding, haemorrhoids or jaundice)?	Y	N		
5. Disease or disorder of the kidney, bladder or reproductive organs (eg, albumin in urine, kidney stones, prostatitis, venereal diseases, infertility or impotence)?	Y	N		
6. Any nervous or mental complaint (eg, epilepsy, blackouts, anxiety state or depression)?	Y	N		
7. Any type of nerve ailment (eg, loss of sensation, numbness or paralysis)?	Y	N		
8. Ear, eye, nose or throat disorder (eg, discharge, defective vision)?	Y	N		
9. Disorder or disease of skin, muscles, bones, joints, limbs, spine (eg, psoriasis, arthritis, gout, slipped disc or other back trouble)?	Y	N		
10. Diabetes, hormonal imbalance, glandular or metabolic diseases, thyroid or blood disorders?	Y	N		
11. Cancer, growth, tumour of any kind?	Y	N		
12. Any other illness, disorder, operation, disability or accident (eg, fractured nose, breathing disorders, mammary hypertrophy (enlarged breasts with associated side-effects, AIDS, congenital abnormalities, etc)?	Y	N		
13. Is the dependant, pregnant? State the expected date of confinement: ____________	Y	N		
14. Is the dependant currently undergoing or expecting to undergo any medical, dental or surgical treatment?	Y	N		
15. Has the dependant received any medical, dental or surgical treatment in the last 12 months?	Y	N		
16. Have any exclusions been imposed by any medical scheme on the dependant? If "YES", please state details: ____________	Y	N		
17. Please provide any other relevant information: ____________				

Question number	Name of patient	Nature and duration of complaint and full details of treatment being or expected to be received. NB: Please specify chronic medication	Name and telephone number of attending doctor or hospital

IMPORTANT: Failure to disclose all relevant and/or correct information may adversely affect the benefits available to you and your family.

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Waiting period	Yes / No	From	DD/MM/YY	To	DD/MM/YY
Reason					
Condition-specific waiting period	Yes / No	From	DD/MM/YY	To	DD/MM/YY
Reason					

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			Number of years subject to penalty	Penalty imposed (please tick)	
Current age		years			
Less: creditable coverage		years	1-4 years	5%	
= Number of years not covered		years	5-14 years	25%	
Less: qualifying age		years	15-24 years	50%	
Years subject to penalty		years	25+ years	75%	

Vetted by (name): ______________________

Signature (supervisor): ______________________ Date: DD / MM / YYYY

Processed by (name): ______________________

Signature: ______________________ Date: DD / MM / YYYY

SECTION 4 PREVIOUS MEDICAL SCHEMES

Please give full details of your dependant's membership of any previous medical scheme(s) during the past two years (list the most recent first) and provide proof by attaching your certificate/s of membership.

Name of scheme: ______________________

Membership number: | | | | | | | | | | | | | |

Membership from: DD / MM / YYYY To: DD / MM / YYYY

Reason for termination: ______________________

Name of scheme: ______________________

Membership number: | | | | | | | | | | | | | |

Membership from: DD / MM / YYYY To: DD / MM / YYYY

Reason for termination: ______________________

SECTION 5 TO BE COMPLETED BY PRINCIPAL MEMBER'S EMPLOYER

Date principal member joined scheme: DD / MM / YYYY

Principal member's date of benefit: DD / MM / YYYY

Subsidised dependants: ☐ Non-subsidised adult dependants: ☐

We confirm that contributions are being deducted in accordance with the applicant's income and the eligible dependants, in terms of the appropriate contribution table. Any further changes to the employee's status will be advised to the fund within 30 days.

EMPLOYER'S STAMP

Company/division: ______________________

Name: ______________________

Designation: ______________________ Email: ______________________

Date: DD / MM / YYYY Telephone: ( ) ______________________

Signature of employer official: ______________________ Date: DD / MM / YYYY

SECTION 6 DECLARATION BY PRINCIPAL MEMBER

I hereby declare that the information in this declaration is true and correct and agree that any false declaration will render my application null and void.

Signature of principal member: ______________________________ Date: D D / M M / Y Y Y Y

SECTION 7 ESSENTIAL DOCUMENTS

	Are the relevant documents attached?	
Copy of dependant's ID:	Yes ☐	No ☐
Birth certificate of child (where ID is not available):	Yes ☐	No ☐
Clinic card for newborn baby (within 30 days of birth to avoid waiting period):	Yes ☐	No ☐
Documentary proof if the dependant is adopted or a foster child:	Yes ☐	No ☐
Marriage certificate when registering a spouse (within 30 days of marriage to avoid waiting period):	Yes ☐	No ☐
Affidavit when registering a common law spouse or partner confirming co-habitation (where applicable):	Yes ☐	No ☐
Dependant's membership certificate from previous medical aid (where applicable):	Yes ☐	No ☐
Written confirmation that the dependant is a member of the Unemployed Insurance Fund (if unemployed):	Yes ☐	No ☐
Dependant's proof of taxable income (ie pay slip, SARS IT34 form etc):	Yes ☐	No ☐

ANY QUERIES? CALL CUSTOMER CARE ON 0860 100 871

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