Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1009

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: _____

Cell number: _____

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, etc).
3. Child dependants who are under 25 years and are either a. studying, b. mentally or physically disabled, or c. totally financially dependent on the main member must provide proof thereof.
4. A dependant is defined by the rules of the Fund as:

- a member's spouse or partner who is not a member or a registered dependant of another medical scheme;
- a member's child dependant (as defined in Rule 4.10), who is not a member or a registered dependant of a another medical scheme; and
- an adult person in respect of whom the member is liable for family care and support.

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: _____

_____

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1009

SIZWE MEDICAL FUND
Caring for the health of the nation

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 during the 12 month period preceding application.

Please ask your treating doctor to help you provide the relevant ICD-10 Code.

Provide full details for any of the conditions stipulated below in the space provided and attach relevant medical reports to this application.	Select Yes or No		ICD-10 Code	Initialled by principal member	Date of last treatment
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: _____ _____ _____					

DISCLAIMER: I will inform the Fund Fund of any changes in my health status or the health of my dependant/s within 30 days of the change occuring from the date of application and within 90 days of the activation date.

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.

FOR INTERNAL USE ONLY

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					

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1009

SIZWE MEDICAL FUND
Caring for the health of the nation

FOR INTERNAL USE ONLY

			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: D D / M M / Y Y Y Y

Processed by (name): _____

Signature: _____ Date: D D / M M / Y Y Y Y

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: D D / M M / Y Y Y Y To: DD / M M / Y Y Y Y

Reason for termination: _____

Name of scheme: _____

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

Membership from: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y

Reason for termination: _____

SECTION 5 TO BE COMPLETED BY PRINCIPAL MEMBER'S EMPLOYER

Date principal member joined scheme: D D / M M / Y Y Y Y

Principal member's date of benefit: D D / M M / Y Y Y Y

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: D D / M M / Y Y Y Y Telephone: ( ) _____

Signature of employer official: _____ Date: D D / M M / Y Y Y Y

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 ☐
Proof of study for dependant/s from the age of 21 years, or affidavit for financially dependent dependant/s, or doctor's letter for mentally or physically disabled children.	Yes ☐	No ☐

ANY QUERIES? CALL CUSTOMER CARE ON 0860 100 871

www.sizwe.co.za

Broker House: Aon South Africa (Pty) Ltd
Tel No: 0860 835 272
Broker Code: 1009

Contact us on: **0860 tel arc / 0860 835 272,** P.O. Box 1874, Parklands, 2121, www.aon.co.za
FSB number: 20555; CMS number: ORG895

Acknowledgement of appointment

I hereby authorise Aon Hewitt to be my duly appointed Broker with immediate effect.

My ID [ ] and membership number [ ]

I have also been informed of the commission due to Aon Hewitt, payable by the medical scheme as part of my monthly contribution, is 3% of the contribution to a maximum of R75.00 excl. Vat per month. I have further been issued with a Statutory Notice and Section 13 certificate.

Signed at (town or city) [ ] on yy/mm/dd [ ]

Signature [ ]

Permission to make certain information available to Aon Hewitt

I give consent for the disclosure of information about me.

Membership number [ ]

Medical Scheme [ ] Aon Hewitt Broker Code [ ]

Title [ ] Initials [ ] Surname [ ]

First name(s) (as per identity document) [ ]

ID or passport number [ ]

To clarify this, the following information will be made available:

Personal examples	Benefit examples	Financial examples	Medical examples
Membership number Date of birth ID number Postal and e-mail Address Contact details Physical address Telephone numbers	Plan type Medical Savings Account amounts available Medical Savings Account choice Scheme Rate or Cost Current Medical Savings Account spent Limits Waiting period: details Wellness benefits Self-payment Gap Above Threshold Benefit	Tax certificate and tax reports Banking details Total contribution and breakdown	Chronic indicator Chronic condition PMB Chronic condition details Confirmation of claims paid (excluding amount and paid from where) Claims transaction history Hospital procedures Procedures codes Procedures done in doctor's rooms paid from Hospital Benefit

I hereby also authorise Aon Hewitt and/or Aon to provide me with any products that they consider appropriate to me.

Yes [ ] No [ ]

Signed at (town or city) [ ] on yy/mm/dd [ ]

Signature [ ]