



Informed Healthcare Solutions (IHS)

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Email: info@medicalaidcomparisons.co.za
Web: www.medicalaidcomparisons.co.za

FAX COVER SHEET

To:	Graham Pike of IHS	From:	
Fax:	086 627 7012	Company:	
Tel:	021 712 6686	Tel:	
Pages:		Date:	
Re:	FedHealth Medical Aid Application		

Comments:

Instructions:

1. Print this document.
2. Fill in the application form and cover letter.
3. Fax the form to us on 086 627 7012 or scan and email it to forms@medicalaidcomparisons.co.za
4. Sit back while we do all the complicated stuff.

Save time and hassle with your medical aid application and make sure it gets the best possible chance of success

Maxima

ENROLMENT FORM



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

FEDHEALTH
www.fedhealth.co.za
 Call Centre 0860 002 153

SECTION 1 CHOICE OF OPTION

Choose ONE product option by placing "x" in the appropriate box

<input type="checkbox"/> MAXIMA PLUS Including OHEB and Savings	<input type="checkbox"/> MAXIMA STANDARD Including OHEB and Savings	<input type="checkbox"/> MAXIMA BASIS Including OHEB and without Savings	<input type="checkbox"/> MAXIMA CORE Including Savings and without OHEB
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I wish to join the scheme from m y y y

Membership number (administrative use only)

SECTION 2 DETAILS OF PRINCIPAL MEMBER

Surname

Maiden name (if applicable)

Title First name/s Initials

Gender M F Date of birth ID/ passport number

Tax Number

Telephone (H) Telephone (W)

Cellular 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 - FOR STATISTICAL PURPOSES ONLY Ethnic group Black Coloured Indian White Asian Marital status Single Married Divorced Widowed Common law partner/ spouse

SECTION 3 DETAILS OF YOUR SPOUSE / PARTNER YOU WISH TO REGISTER

SPOUSE / PARTNER Surname

Maiden name (if applicable)

Title First name/s Initials

Relationship to principal member Gender M F

ID/ passport/ birth certificate number Date of birth

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 4

DEPENDANTS YOU WISH TO REGISTER

Title Surname First name/s Relationship to member ID number or passport number (Please include copy of passport) Date of birth Marital Status	1	Adult* <input type="checkbox"/>	Child <input type="checkbox"/>	Title <input type="text"/> Initials <input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		d d m m y y y y Gender <input type="checkbox"/> M <input type="checkbox"/> F			
		* Adult dependant = 27 years of age or older			

Title Surname First name/s Relationship to member ID number or passport number (Please include copy of passport) Date of birth Marital Status	2	Adult* <input type="checkbox"/>	Child <input type="checkbox"/>	Title <input type="text"/> Initials <input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		d d m m y y y y Gender <input type="checkbox"/> M <input type="checkbox"/> F			
		* Adult dependant = 27 years of age or older			

Title Surname First name/s Relationship to member ID number or passport number (Please include copy of passport) Date of birth Marital Status	3	Adult* <input type="checkbox"/>	Child <input type="checkbox"/>	Title <input type="text"/> Initials <input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		d d m m y y y y Gender <input type="checkbox"/> M <input type="checkbox"/> F			
		* Adult dependant = 27 years of age or older			

Title Surname First name/s Relationship to member ID number or passport number (Please include copy of passport) Date of birth Marital Status	4	Adult* <input type="checkbox"/>	Child <input type="checkbox"/>	Title <input type="text"/> Initials <input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		d d m m y y y y Gender <input type="checkbox"/> M <input type="checkbox"/> F			
		* Adult dependant = 27 years of age or older			

Title Surname First name/s Relationship to member ID number or passport number (Please include copy of passport) Date of birth Marital Status	5	Adult* <input type="checkbox"/>	Child <input type="checkbox"/>	Title <input type="text"/> Initials <input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		d d m m y y y y Gender <input type="checkbox"/> M <input type="checkbox"/> F			
		* Adult dependant = 27 years of age or older			

Title Surname First name/s Relationship to member ID number or passport number (Please include copy of passport) Date of birth Marital Status	6	Adult* <input type="checkbox"/>	Child <input type="checkbox"/>	Title <input type="text"/> Initials <input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		d d m m y y y y Gender <input type="checkbox"/> M <input type="checkbox"/> F			
		* Adult dependant = 27 years of age or older			

If the physical or postal address for any of the dependants differs from the principal member, please complete the following:

Dependant no.

Postal address

Physical address

SECTION 5

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 and date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, 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	

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.

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

Division code Dept. name

Persal number *if applicable* Fedhealth paypoint code

Medical scheme start date

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

SECTION 7

BANK DETAILS OF PRINCIPAL MEMBER

Refund of claim and savings payments/ debit order instruction

I hereby instruct Fedhealth to electronically collect contributions and to deposit claims and savings refunds, via the ACB system, 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 electronic transfer of funds error without prior notice. Note: Direct paying members can select either of the following two dates for debit order collections.

- 25th of the month First working day of the following month

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 and savings 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 AND SAVINGS 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
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SECTION 8

DECLARATION BY PRINCIPAL MEMBER

- I, the undersigned hereby apply for membership of Fedhealth Medical Scheme (hereinafter referred to as "the Scheme") and also nominate my dependants as specified. I hereby undertake to observe and carry out the provisions of the Medical Schemes Act (Act 131 of 1998) and of the rules of the Scheme as amended from time to time.
- 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.
- 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.
- 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.
- I accept any penalties/ waiting periods that may be applied in accordance with the Medical Schemes Act of 1998. 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.
- I hereby authorise the Scheme to deduct from my salary or any other available funds via debiting of my bank account, all subscriptions 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.
- It is my sole responsibility as a member to ensure that the monthly premium is received by the Scheme.
- 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.
- 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.
- 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.
- I acknowledge that non-disclosure of any information by me 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.
- Should there be any additional information required by the Scheme which is not received within 7 days, the Scheme will automatically suspend the application.
- I acknowledge that I am not a member of more than one medical aid.
- I hereby authorise the Scheme or any of its nominated representatives to confirm my bank details.
- If applicable – I hereby appoint the financial adviser who has submitted this application on my behalf, to be my nominated financial adviser. I acknowledge that a monthly commission of 3% of my total monthly premium up to a maximum of R60.70 will be paid to the financial adviser in terms of the Medical Schemes Act 131 of 1998 (or as amended). I am aware that I can cancel this appointment at any time.
- I agree to provide the Scheme with three months' written notice to inform Fedhealth of my intention to terminate my membership.

Signed at on this day of 20.....

Signature of principal member

Print name

.....

Identity number

SECTION 9**INTERMEDIARY / FINANCIAL ADVISER***This section must be signed by the broker/ agent/ adviser if applicable*

Broker code	0 0 4 2 8	FSB licence number	1 2 2 3 9
Name of brokerage/ broker/ agent	INFORMED HEALTHCARE SOLUTIONS (PTY) LTD		
Telephone number (W)	021 712 6686	Cell	
Fax number	021 712 6626		
E-mail address	ihs@ihshealth.co.za		
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 premium up to a maximum of R60.70 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 signature Date

d	d	m	m	y	y	y	y
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Name of broker consultant *if applicable*