

# CHANGES TO MEMBERSHIP

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Administered by Medscheme Holdings (Pty) Ltd. | ✉ PO Box 1101, Florida Glen, 1708



As amalgamated with Lonmin Medical Scheme

## PLEASE INDICATE WHAT YOU WANT TO CHANGE:

1. DEPENDANTS
2. OPTION CHANGE
3. CONTACT DETAILS
4. RETIREMENT
5. PAYROLL CHANGE
6. CANCEL MEMBERSHIP

## PERSONAL DETAILS OF PRINCIPAL MEMBER

Title  Initials  First names   
Surname   
ID/Passport number  Date of birth  Industry number

## I. CHANGES OF DEPENDANTS

Please note that when adding dependants the following documentation is required:

- Spouse/Common law spouse – marriage certificate or affidavit, health declaration and copy of ID.
- Newborn baby – copy of birth certificate.
- Children – copy of birth certificate.
- Children aged 21 to 25 – affidavit confirming that child is unemployed and financially dependent on the member.

### A: ADDITIONS

EFFECTIVE FROM DATE

**AI** First names  Surname   
ID/Passport number  Country of issue  Date of birth   
Nature of person Individual Foreign individual Individual Eetate (Including late estate)  
Relationship to member  Gender M F Disability (If selected, complete section below)

**Complete if over 18:** Cell  Email   
Address   
SARS Tax number   
Date  Signature

If the applicant has a DISABILITY – please complete:

Type of disability Hearing disability Vision disability Speech disability  
Mental disability Physical disability Intellectual disability  
Nature of disability Temporary Permanent  
Disability limitation Mild Moderate Severe  
Disability start date  Disability end date   
Medical practitioner  Practitioner email   
Practice number  Tel  Cell

MEMBER SURNAME

INDUSTRY NUMBER

**A2** First names

Surname

ID/Passport number

Country of issue

Date of birth

Nature of person

Individual

Foreign individual

Individual estate (Including late estate)

Relationship to member

Gender

M

F

Disability

(If selected, complete section below)

**Complete if over 18:**

Cell

Email

Address

SARS Tax number

Date

Signature

**If the applicant has a DISABILITY – please complete:**

Type of disability

Hearing disability

Vision disability

Speech disability

Mental disability

Physical disability

Intellectual disability

Nature of disability

Temporary

Permanent

Disability limitation

Mild

Moderate

Severe

Disability start date

Disability end date

Medical practitioner

Practitioner email

Practice number

Tel

Cell

**B: DELETIONS**

EFFECTIVE FROM DATE

**REASON FOR DELETION OF DEPENDANTS: (Must be given)**

Divorced

Deceased

Turned 21

Unhappy with benefits

Dependant moved away from home

Other (please specify)

**B1** First names

Surname

ID/Passport number

Country of issue

Date of birth

Relationship to member

Gender

M

F

**B2** First names

Surname

ID/Passport number

Country of issue

Date of birth

Relationship to member

Gender

M

F

**B3** First names

Surname

ID/Passport number

Country of issue

Date of birth

Relationship to member

Gender

M

F

## 2. CHANGE OF OPTION

**Please change my plan to: (Please select one)**

Heritage Plan

Diversity Plan

Pride Legacy Plan

Effective from date

MEMBER SURNAME

INDUSTRY NUMBER

### 3. CONTACT DETAILS

Principal member

Adult dependant

New contact details

Home

Work

Cell

Email

Physical address

Postal code

Postal address

Postal code

### 4. RETIREMENT (ACTIVE MEMBER TO PENSIONER)

#### NOTES:

- Payroll office to notify Sisonke Health Medical Scheme one month in advance of member's retirement.
- The member (new pensioner) must provide ONE month's contributions in advance together with the Employer subsidy (if any).
- The member (new pensioner) must also complete either a Pension Fund deduction form or a debit order form.

Effective from date

Payment to be deducted from pay-run of last month of employment

YES

NO

Amount

**R**

Debit order attached

Pension fund form attached

Employer subsidy (if applicable)

Amount

**R**

### 5. TRANSFER OF MEMBER TO ANOTHER PAY POINT

#### CURRENT PAY POINT:

Membership number

Member's name

Transferring from

End date

Signed (Payroll)

#### NEW PAY POINT:

Transferring to

Pay point

Start date

Signed (Payroll)

### 6. CANCELLATION / TERMINATION

All medical costs owing by me upon termination may be recovered by Gold Fields Ltd. / Sibanye-Stillwater Gold Ltd. / DRD Gold. I will also be liable for any of the outstanding costs not recovered by Gold Fields Ltd. / Sibanye-Stillwater Gold Ltd. / DRD Gold.

Please cancel my membership with effect from

REASON:

Move to another Scheme

Resignation

Member's signature

### 7. PRINCIPAL MEMBER'S SIGNATURE

I hereby confirm that all the information given on this form is true and correct.

Signed by member

Date

Signed by payroll officer

Date

**PAYROLL STAMP**

# MEDICAL INFORMATION



As amalgamated with Lonmin Medical Scheme

Have you or any of your dependants ever experienced, been treated for, or currently suffer from any of the following conditions?

CONDITION CATEGORY	YES / NO	BENEFICIARY/IES (M = Member / S = Spouse / 1-5= Oldest to youngest child)							MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED (dd/mm/yyyy)	DATE OF LAST RELATED SYMPTOMS/ CONSULTATION/ HOSPITALISATION (dd/mm/yyyy)	CURRENTLY ON TREATMENT FOR THIS CONDITION?	MEDICATION USED FOR THIS CONDITION AND DATE LAST TAKEN (dd/mm/yyyy)
		M	S	1	2	3	4	5					
<b>1. Cardiovascular (Heart)</b> E.g. high blood pressure, raised cholesterol, heart failure, angina (chest pain), heart attack, heart murmurs, palpitations, rheumatic fever, previous heart surgery	Yes No	M	S	1	2	3	4	5				Yes No	
<b>2. Blood</b> E.g. haemophilia, bleeding disorders, thrombosis (blood clots), leukemia, lymphoma	Yes No	M	S	1	2	3	4	5				Yes No	
<b>3. Mental/Emotion</b> E.g. depression, anxiety, anorexia or other eating disorder, Attention Deficit Hyperactivity Disorder, schizophrenia, Alzheimer's	Yes No	M	S	1	2	3	4	5				Yes No	
<b>4. Nervous System</b> E.g. epilepsy, multiple sclerosis, paralysis, Parkinson's, stroke, migraine	Yes No	M	S	1	2	3	4	5				Yes No	
<b>5. Eyes</b> E.g. glaucoma, cataract, macular degeneration, visual impairment, conjunctivitis, disorders of the cornea	Yes No	M	S	1	2	3	4	5				Yes No	
<b>6. Mouth</b> E.g. dental problems, gum disease, over/underbite, missing/skew teeth, planned dental treatment	Yes No	M	S	1	2	3	4	5				Yes No	
<b>7. Ear, Nose and Throat</b> E.g. allergic rhinitis, ear infections, hearing/speech impairment, tinnitus (ringing ears)	Yes No	M	S	1	2	3	4	5				Yes No	
<b>8. Respiratory</b> E.g. asthma, chronic obstructive pulmonary disease, cystic fibrosis, emphysema, chronic bronchitis, shortness of breath, persistent cough, coughing up blood, any lung surgery	Yes No	M	S	1	2	3	4	5				Yes No	

CONDITION CATEGORY	YES / NO	BENEFICIARY/IES (M = Member / S = Spouse / 1-5= Oldest to youngest child)							MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED (dd/mm/yyyy)	DATE OF LAST RELATED SYMPTOMS/ CONSULTATION/ HOSPITALISATION (dd/mm/yyyy)	CURRENTLY ON TREATMENT FOR THIS CONDITION?	MEDICATION USED FOR THIS CONDITION AND DATE LAST TAKEN (dd/mm/yyyy)
		M	S	1	2	3	4	5					
<b>9. Gastrointestinal</b> E.g. peptic ulcer, heartburn, irritable bowel, ulcerative colitis, hiatus hernia	Yes No	M	S	1	2	3	4	5				Yes No	
<b>10. Liver/Pancreatic Disorders</b> E.g. hepatitis, cirrhosis, liver failure, gallstones, pancreatitis	Yes No	M	S	1	2	3	4	5				Yes No	
<b>11. Kidney/Urinary/Reproductive system</b> E.g. renal failure, prostate problem, kidney stone, recurrent infection, nephritis, blood/protein in urine, polycystic kidneys	Yes No	M	S	1	2	3	4	5				Yes No	
<b>12. Gynaecological</b> E.g. ovarian cysts, endometriosis, fibroid, disorder of the cervix, menstrual disorder	Yes No	M	S	1	2	3	4	5				Yes No	
<b>13. Skin problems</b> E.g. eczema, acne, rosacea, psoriasis	Yes No	M	S	1	2	3	4	5				Yes No	
<b>14. Muscle/Bones</b> E.g. osteoporosis, gout, arthritis (osteo or rheumatoid), pain, previous fractures, myasthenia gravis, loss of limb, back problems/operations, slipped disk, backache	Yes No	M	S	1	2	3	4	5				Yes No	
<b>15. Connective tissue disorders</b> E.g. systemic lupus erythematosus, scleroderma, dermatomyositis/polymyositis, mixed connective tissue disorder	Yes No	M	S	1	2	3	4	5				Yes No	
<b>16. Metabolic/Endocrine</b> E.g. diabetes, thyroid problem, Addison's disease, growth problems, pituitary problems, Cushing's syndrome	Yes No	M	S	1	2	3	4	5				Yes No	
<b>17. Infections/tumors</b> E.g. HIV, cancer, hepatitis, tuberculosis, benign tumors	Yes No	M	S	1	2	3	4	5				Yes No	
<b>18. Other</b> Please specify	Yes No	M	S	1	2	3	4	5				Yes No	

PLEASE COMPLETE THE FOLLOWING GENERAL MEDICAL QUESTIONS (*M = Member / S = Spouse / 1-5= oldest to youngest child*)

19. Height (metres)	Member (M)		Spouse (S)		1		2		3		4		5	
20. Weight (kilograms)	Member (M)		Spouse (S)		1		2		3		4		5	

QUESTIONS (If YES, indicate applicable beneficiary/ies & provide details)	YES / NO		M	S	1	2	3	4	5	DETAILS
21. Do you/your dependants smoke?	Yes	No								
22. Are you/your dependants pregnant or suspect pregnancy?	Yes	No								How many weeks?
23. Have you/any of your dependants undergone an operation recently?	Yes	No								
24. Do you/any of your dependants consume alcohol? Specify details	Yes	No								Rarely                      Moderately                      Frequently
25. Do you/your dependants take part in professional/dangerous sport?	Yes	No								
26. Do you/your dependants use chronic medication?	Yes	No								
27. Do you/your dependants have a congenital/hereditary or physical disability?	Yes	No								
28. Are you/your dependants expecting any surgery/hospitalisation/treatment in the next year?	Yes	No								
29. Have you/your dependants had surgery or been admitted to hospital in the past year?	Yes	No								
30. Have you/your dependants in the last 24 months been involved in a motor vehicle accident, been injured on duty or contracted a work-related illness?	Yes	No								
31. Have you/your dependants ever had or are currently suffering from alcohol/ drug problems?	Yes	No								

If there is any further relevant medical information, which has not been disclosed above, please provide details: