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Health is Wealth!™

Where did you hear about BESTmed?
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TV	Cinema	Radio	Print & Press	Consultant	Employer	Word of Mouth

CHANGES IN MEMBER STATUS

FOR OFFICE USE ONLY

Member No	Pers No	Date

1. DETAILS OF PRINCIPAL MEMBER Write in BLOCK LETTERS

Title _____ Surname _____

Full names _____

Date of birth of member D D M M Y Y Y Y Language preference Eng Afr

2. ADDRESS AND CONTACT DETAILS (PRINCIPAL MEMBER)

Residential address _____ Postal address _____

_____ _____

_____ _____

Postal code _____ Postal code _____

Tel (w) _____ Tel (h) _____

Cell _____ E-mail _____

3. EMPLOYER DETAILS

Present employer _____ Period employed _____

Occupation _____ Department _____

Postal address _____ _____

_____

Postal code _____ Postal code _____

Tel _____ Fax _____

Only complete the section(s) relating to the member or applicant

4. REGISTRATION AS A DEPENDANT(S) (also complete no 1 - 3, 5 (if applicable), 10 and 14)

4.1 Births

Surname _____ Full names _____

Date of birth D D M M Y Y Y Y Gender M F ID number _____

Date of registration as dependant D D M M Y Y Y Y (please attach copy of birth certificate)

4.2 Marriage

Date of marriage D D M M Y Y Y Y Smoker Y N Name _____

(please attach copy of marriage certificate and certificate of membership of previous medical scheme)

Date of registration as dependant D D M M Y Y Y Y

Full names (Including surname(s) if different from principal member)	Gender	Date of birth	ID number	Relationship (mark applicable block with ✓)
	M F	D D M M Y Y Y Y		Spouse Partner Child Other
	M F	D D M M Y Y Y Y		Spouse Partner Child Other
	M F	D D M M Y Y Y Y		Spouse Partner Child Other
	M F	D D M M Y Y Y Y		Spouse Partner Child Other
	M F	D D M M Y Y Y Y		Spouse Partner Child Other
* Declare other				

4.3 Child dependant until age 21

Surname _____ Full names _____

Date of birth D D M M Y Y Y Y Gender M F ID number

(please attach copy of ID document) Relationship with principal member _____

Does your dependant receive a regular monthly income? Y N If Yes, what amount R _____p.m.

Date on which membership should commence D D M M Y Y Y Y

4.4 Adult dependant 21 and older

Surname _____ Full names _____

Date of birth D D M M Y Y Y Y Gender M F ID number

(please attach copy of ID document) Relationship with principal member _____

Does your dependant receive a regular monthly income? Y N If Yes, what amount R _____p.m.

Date on which membership should commence D D M M Y Y Y Y Smoker Y N

5. PREVIOUS MEMBER STATUS

NB: If you and / or your spouse / partner are / is at present a member / dependant(s) of a medical scheme or were / was a member / dependant(s) of a medical scheme/s in the past two years, a CERTIFICATE/S OF MEMBERSHIP should accompany the application form. (NB: Not a member card!)
If "Yes" please state:

Scheme Details		Status		Period	
Name of scheme	Member number	Member	Dependant	From	To

Were you or was your dependant(s) subject to any restrictions / exclusions in another medical scheme?

YES NO

If "Yes" please furnish the name of the relevant person and the nature of the restrictions / exclusions. _____

6. APPLICATION FOR FURTHER RECOGNITION OF DEPENDANT(S) (also complete 1-3, 10 and 14)

Surname of child _____ Full names of child _____

Date of birth D D M M Y Y Y Y ID number _____

6.1 Full time student

Children of 21 years and older who have not yet reached the age of 26 years
I, the undersigned hereby apply for further recognition of the abovementioned child as dependant and declare that: He / she is completely dependent on me; He / she is a full time student at the University / Technikon of _____

The registration certificate proving that he / she is a full time student for 200_____ is attached hereto. (To be furnished annually). He/she is likely to be completely dependent on me untill D D M M Y Y Y Y

His / her annual income amounts to R _____

6.2 Mentally / physically handicapped dependant

His / her annual income amounts to R _____

He / she is not mentally / physically fit for any work? YES NO

Details of his / her condition _____

(Attach a medical report)

He / she is likely to be completely dependent on me untill D D M M Y Y Y Y

7. DELETION OF DEPENDANTS (also complete no 1 - 3 and 14)

Surname _____ Full names _____

Date of birth D D M M Y Y Y Y Gender M F Date of deletion D D M M Y Y Y Y

Reason _____

8. TRANSFER FROM ONE EMPLOYER TO ANOTHER (also complete no 1-3 and 14)

Present employer _____

New employer _____ Date of transfer D D M M Y Y Y Y

Department with new employer _____

Pers no

9. RESIGNATION / STAFF REDUCTION (also complete no 1-3 and 14)

Date of resignation D D M M Y Y Y Y (This is also the date of termination of membership)

Reason _____

10. MEDICAL HISTORY OF APPLICANT AND DEPENDANT(S)

Please Note: All questions in the medical history questionnaire must be answered by stating YES or NO. In case of a YES, the full details of the relevant person must be furnished in the space provided. If you or any of your dependant(s) are suffering from a chronic condition, a medical report is required setting out details of the condition as well as the estimated annual cost of treatment thereof. If the space provided is insufficient, write details on a separate page and attach to this questionnaire.

Height of applicant (cm) _____ Current weight of applicant (kg) _____

Estimated total cost of medical services rendered to your dependant(s) in the past two years.

Year _____ R _____ Year _____ R _____

(Attach summary statement if your dependant(s) belonged to another medical scheme).

MEDICAL QUESTIONNAIRE

Have you or your dependant(s) received any medical treatment or care in the past 12 months or medical advice relating to any of the following conditions? (Refer to question 1 - 20. Question 21 excluded)	Indicate with a "X" in the appropriate column		Name of patient	Condition		Level / stage of illness condition, nature of treatment, medication dosage and hospitalisation
				Date	Period	
1. Congenital physical deviations e.g. bat-ears, valvular heart disease	YES	NO				
2. Abnormality of skin (including allergies) e.g. eczema, psoriasis	YES	NO				
3. Deviations in skeleton, joints and muscles e.g. arthritis, back problems	YES	NO				
4. Sense organs: Sight, hearing, speech, also state spectacles and / or contact lenses as well as visual strength reading if available	YES	NO				
5. Respiratory organs and cardio-vascular systems e.g. hypertension, cholesterol, asthma	YES	NO				
6. Digestive system e.g. hiatus hernia, stomach ulcer	YES	NO				
7. Bladder, kidney and sexual system	YES	NO				
8. Nervous system e.g. paralysis, epilepsy	YES	NO				
9. Hormone system	YES	NO				
10. Psychiatric or psychological treatment e.g. depression, anxiety	YES	NO				
11. Substance dependance e.g. alcohol, drugs	YES	NO				
12. Dental treatment	YES	NO				
13. Metabolic diseases, obesity, diabetes, porphyria	YES	NO				
14. A condition for which you and your dependant(s) receive a payment and / or medical treatment of whatever nature e.g. IOD claim, third party claim 15. Are you or your dependant(s) pregnant or is there any suspicion of pregnancy?	YES	NO				
16. Previous abnormal pregnancies	YES	NO				
17. Contagious diseases e.g. HIV, Hepatitis B, Tuberculosis	YES	NO				
18. Operations undergone	YES	NO				
19. Are you and or your dependant(s) currently being treated for something?	YES	NO				
20. Present medication	YES	NO				
21. Any other medical condition not mentioned above, even though you or your dependant(s) did not receive treatment or advice or consulted a doctor in the past 12 months.	YES	NO				
22. Do you and / or your dependant(s) participate in professional or dangerous amateur sport, like power-driven vehicle sport, glider sport, scuba diving, bungee or parachute jumping? If so, provide detail:	YES	NO	Nature of the sport	Person(s) participating		Injuries

Date: D D M M Y Y Y Y

Signature of member: _____

11. TEMPORARY SUSPENSION (also complete no 1-3 and 14)

Date of resignation D D M M Y Y Y Y To D D M M Y Y Y Y

Reason _____

12. RETIREMENT (also complete no 1-3 and 14)

Date of retirement D D M M Y Y Y Y Membership must continue Y N

Gross pension income R_____ per annum after retirement.

13. DEATH OF MEMBER (also complete no 1-3 and 14)

Date of death D D M M Y Y Y Y ID no of surviving spouse

Does surviving spouse retain his / her membership to the scheme? Y N

Employer of surviving spouse _____

Gross pension income R _____ per annum (Attach copy of death certificate and surviving spouse's ID document)

14. REMARKS / ADDITIONAL INFORMATION

Name of human resourses practitioner_____

Telephone number of human resources practitioner _____

Signature of member	Namestamp of employer	Signature of human resource practitioner

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