



MEMBERSHIP AMENDMENT FORM

RETURN TO MEDICAL SCHEME ADMINISTRATOR

1 MEMBERS INFORMATION

Membership Number

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Membership number to be completed by members

Surname: _____

Title (Dr, Mr, Mrs or Miss): _____

Initials: _____ Employee No.: _____

First Name (in full): _____

Identity Number: _____

Postal Address: _____

Code: _____

Email: _____

Home No.: () _____

Work No.: () _____

Fax No.: () _____

Cell no.: _____

COMPLETE SECTIONS 2 – 5 WHERE APPLICABLE

Marital Status

Married Single Divorced Widow/er

Please indicate with an "X" in the appropriate block.

Date of Marriage/divorce

D	D	M	M	Y	Y	Y	Y
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NB. If divorced, attach a copy of final order of divorce with addendums if any.

Banking Account Details:

Required for the direct debiting and crediting of member's portions of claims where applicable.

Account No.: _____

Bank: _____

Branch: _____

Branch Number: _____

PO Box: _____

Town/City: _____

Postal Code: _____

Type of Account: Current Savings Transmission

2 DEPENDANT REGISTRATION (PLEASE COMPLETE SECTIONS 2.1 TO 2.5)

2.1 DEPENDANT PERSONAL DETAILS (NO PERSON MAY BE ENROLLED WITH DIFFERENT MEDICAL SCHEMES SIMULTANEOUSLY)

Initials	Surname	Full First Name	Over 21 years	Relationship (Son, wife, etc.)	Monthly Income	Identity Number *
1						
2						
3						
4						
5						

* Copy of identity document or birth certificate.

Where a dependant is over the age of 21 years, please tick the correct box and attach a copy of the relevant documentation.

1. The dependant is full-time student Attach a certificate from learning institution.
2. The dependant is mentally or physically impaired Attach a medical report.

Where the dependant is a common-law husband/wife and/or additional adult dependant, an affidavit to this effect must be attached.

2.2 PREVIOUS MEDICAL AID MEMBERSHIP HISTORY (PLEASE ATTACH COPIES OF ALL PREVIOUS MEDICAL AID CERTIFICATES.)

Are or were you or any of your nominated dependants members of a registered medical aid scheme(s) during the last two years? YES NO

If "YES", a certificate of membership (not a membership card) must be attached to this application. Immediate benefits may be granted if you were a member of a registered scheme(s) for two or more years prior to joining FISHING INDUSTRY MEDICAL SCHEME. If not, a waiting period may be imposed.

	CURRENT MEDICAL AID MEMBERSHIP	PREVIOUS MEDICAL AID MEMBERSHIP (If more, use separate page.)
Name of scheme	<input type="text"/>	<input type="text"/>
Member number	<input type="text"/>	<input type="text"/>
Date of commencement	<input type="text"/>	<input type="text"/>
Date of cessation	<input type="text"/>	<input type="text"/>
Exclusions imposed	<input type="text"/>	<input type="text"/>

2.3 QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please complete all the required information by inserting a tick in the relevant box. If the answer to any question is "YES", provide details overleaf.

I understand that if I do not provide full information about all medical conditions known to me at the time of this application or before acceptance of the application, my membership may be declared null and void.

1. Have you or any of your dependants ever had any of the following?
 - 1.1 Any disorder/dysfunction of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)? YES NO
 - 1.2 High blood pressure or disorder/dysfunction of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder/dysfunction)? YES NO
 - 1.3 Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis/persistent cough, tuberculosis)? YES NO
 - 1.4 Any disorder/dysfunction of the digestive system, gall bladder or liver (e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion, hiatus hernia, hepatitis B or persistent diarrhoea)? YES NO
 - 1.5 Any disorder/dysfunction of the kidneys, bladder or reproductive organs (e.g. albumin in urine, stones, prostatitis, pancreatitis or venereal disease) or gynaecology-related symptoms or conditions (i.e. problems with female organs)? YES NO
 - 1.6 Any nervous or mental disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)? YES NO
 - 1.7 Any ear, nose or throat disorder/dysfunction (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment, chronic sinusitis)? YES NO
 - 1.8 Any disorder/dysfunction of muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)? YES NO
 - 1.9 Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder/dysfunction? YES NO
 - 1.10 Any lumps, growths (benign or malignant), types of cancers (including Hodgkins and leukaemia) skin cancers or skin disorders/dysfunctions? YES NO
 - 1.11 Any tropical diseases (e.g. bilharzia, malaria, cholera)? YES NO
 - 1.12 Any other condition, illness, disease, disorder/dysfunction, disability or accident which required medical, radiological, surgical, pathological or dental investigations during the past 12 months? YES NO
 - 1.13 Been tested for or received or expected to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or an AIDS-related condition or any sexually transmitted infection (e.g. hepatitis B, gonorrhoea or syphilis)? YES NO
 - 1.14 A weight change or the weight of your dependants changed by more than 5kg over the last 12 months? YES NO
2. Do you or any of your dependants have any physical (including dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? YES NO
3. Do you or any of your dependants currently use medication on a daily basis? YES NO
4. Are there, in respect of you or your dependants, any other circumstances not mentioned elsewhere in this declaration/questionnaire relating to past or present diseases, accidents, operations, tests or other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months? YES NO
5. Are you or any of your dependants expecting to undergo any medical procedure, operation, confinement or receive any major dental treatment during the next 12 months? YES NO

If you answered "YES" to any of the questions above, please complete details below in full. If additional space is required, please complete a separate sheet of paper and attach it to the application.

2.4 ADDITIONAL MEDICAL INFORMATION

		1	2	3
Question number				
Name of person suffering from the illness				
Type of illness/condition (diagnosis)				
Date on which the illness began				
Frequency of attacks (hourly/daily/weekly/monthly)				
Date of last occurrence				
If hospitalised, when and for how many days				
Duration of illness or condition				
Treatment and/or type of medication received in the past	Treatment Medication			
Current treatment and/or type of medication received	Treatment Medication			
Approximate monthly cost of treatment/type of medication	Treatment Medication			
Details of operations previously performed				
Operations and/or treatment needed in future				
Name of attending medical practitioner				

2.5 ADDITIONAL INFORMATION

3. DEPENDANT RESIGNATION

	Initials	Surname	Full First Name	Date of resignation
1				
2				
3				
4				
5				

4. CHANGE OF STATUS

<input type="checkbox"/> Retirement	Effective date	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
<input type="checkbox"/> Disability*	Effective date	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
<input type="checkbox"/> Change of employer group	Effective date	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			

*** Copy of medical report required.**

5. DECLARATION BY THE MEMBER

I hereby certify that the above information is true and complete and that I am aware that the company **does not subsidise any special dependant's contribution.**

Date

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Signature of member _____

Date

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Signature of employer _____

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THIS SECTION MUST BE COMPLETED BY AN AUTHORISED OFFICIAL AFTER THOROUGH SCRUTINY. I certify the foregoing details to be a true statement and that the applicant is a permanent member of the staff.

OFFICIAL EMPLOYER'S STAMP