CHANGE IN MEMBERSHIP DETAILS

Imperial™ Motus Med

PLEASE COMPLETE IN BLOCK LETTERS.

PLEASE NOTE THAT THIS FORM MUST BE SUBMITTED TO YOUR PAYROLL DEPARTMENT.

Instructions: When requesting a change in membership details, please ensure that sections A and I are completed together with the section pertaining to the change required. Where section F or H is completed, please ensure that the medical history form is completed.

A. MEMBER INFORMATION

Member number

Surname

First name(s)

Date on which change will become effective DD/MM/YYYY

B. EMPLOYER DETAILS

Employer name

Branch number Employee number

Branch address

Code

C. CHANGE IN GROSS MONTHLY INCOME

Proof of income must accompany this form.

	OLD	NEW
Gross monthly income	R	R

D. CHANGE IN POSTAL ADDRESS AND CONTACT NUMBERS

Current/new postal address

Code

New contact numbers Work Home

Fax Cell number

New email address

E. CHANGE IN BANK DETAILS FOR DIRECT CREDIT OR REFUND

Please attach a copy of your ID and a bank statement or a stamped letter from your bank (not older than three months).

Name of account holder

Name of bank

Account number

Branch name

Eight-digit branch code

Account type ☐ Current ☐ Savings ☐ Transmission ☐ Cheque

I hereby request and authorise Imperial and Motus Medical Aid to credit any medical scheme refunds that may accrue to me to the above-mentioned account.

Signature of account holder _____

Date _____
DD/MM/YYYY

F. NOMINATION OF ADDITIONAL DEPENDANTS

Please complete the cell number, email and residential address fields of your spouse/partner/dependant that is 18 or older.
See Annexure F1 for dependant classification and the proof that is required in each instance.

If your dependant is known to your doctor by a nickname – i.e. the name that will be reflected on any accounts – please supply it.

1. Surname _____ Date of birth _____ DD/MM/YYYY

First name(s) _____ Nickname _____

ID/Passport number _____ Cell number _____

Relationship to applicant _____ (e.g. wife or son) Gender ☐ Male ☐ Female

Email address _____

Residential address _____

_____

_____ Code _____

2. Surname _____ Date of birth _____ DD/MM/YYYY

First name(s) _____ Nickname _____

ID/Passport number _____ Cell number _____

Relationship to applicant _____ (e.g. wife or son) Gender ☐ Male ☐ Female

Email address _____

Residential address _____

_____

_____ Code _____

F. NOMINATION OF ADDITIONAL DEPENDANTS – CONTINUED

3. Surname | Date of birth | DD/MM/YYYY

First name(s) | Nickname

ID/Passport number | Cell number

Relationship to applicant | (e.g. wife or son) | Gender | Male | Female

Email address

Residential address

Code

4. Surname | Date of birth | DD/MM/YYYY

First name(s) | Nickname

ID/Passport number | Cell number

Relationship to applicant | (e.g. wife or son) | Gender | Male | Female

Email address

Residential address

Code

5. Surname | Date of birth | DD/MM/YYYY

First name(s) | Nickname

ID/Passport number | Cell number

Relationship to applicant | (e.g. wife or son) | Gender | Male | Female

Email address

Residential address

Code

Annexure F1: Dependant classification

DEPENDANT DEFINITION	DOCUMENTS REQUIRED	DOCUMENTS ATTACHED	
Adopted child	Court order and ID or birth certificate (if over 21 and a student, provide proof of registration)	☐ Yes	☐ No
Common-law partner	Affidavit and ID	☐ Yes	☐ No
Customary spouse	Affidavit and ID	☐ Yes	☐ No
Foster child	Court order and ID or birth certificate (if over 21 and a student, please provide proof of registration)	☐ Yes	☐ No
Natural child	ID or birth certificate (if over 21 and a student, provide proof of registration)	☐ Yes	☐ No
Parents of member	Affidavit and ID	☐ Yes	☐ No
Same-sex partner	Affidavit and ID	☐ Yes	☐ No
Sibling	Affidavit and ID	☐ Yes	☐ No
Spouse	Marriage certificate and ID	☐ Yes	☐ No
Stepchild	Marriage certificate and ID or birth certificate (if over 21 and a student, provide proof of registration)	☐ Yes	☐ No
Grandchild	Affidavit and ID (parent of grandchild should be a registered dependant of the principal member)	☐ Yes	☐ No

NOTE: Please remember to indicate if documents are attached.

G. CANCELLATION OF DEPENDANT'S MEMBERSHIP

A month's notice is required for the voluntary termination of a dependant's membership.

NAME OF DEPENDANT	DATE OF CANCELLATION (DD/MM/YYYY)

Please note: Reasons for the deletion (copy of divorce decree, death certificate or affidavit form N – for common-law spouse, partner or fiancé/e – must accompany this form); a month's notice is required for the voluntary termination of a dependant's membership.

H. OTHER CHANGES

	TYPE OF CHANGE	✓	EFFECTIVE DATE OF CHANGE (DD/MM/YYYY)	PLEASE SUPPLY THE FOLLOWING DOCUMENTATION:
1.	Reinstate membership			Proof of previous medical scheme membership and reason for reinstatement
2.	Death			Death certificate; marriage certificate; ID of deceased and surviving spouse; name and postal address of executor of the estate; letter from spouse or other dependants for continued membership as dependants
3.	New branch			As provided on reconciliation file
4.	Pensioner due to:			
	Ill health			Documentation from company stating that you qualify for membership as a pensioner. A debit order form must be completed. It can be obtained from www.imperialmotusmed.co.za or from the Scheme's Client Service Department on 0860 467 374.
	Pensionable age reached			
5.	Resignation			Document from payroll officer stating reason for cancellation
6.	Promotion			As provided on reconciliation file

I. DECLARATION BY THE APPLICATION (MUST BE COMPLETED BY MEMBER)

I declare that the above information is correct. I confirm that I have informed my employer to adjust my monthly contribution deduction should this change result in an increase or decrease in my monthly contribution.

Signed at _____ on the _____ of _____ _____

DAY MONTH YEAR

Signature of applicant

Signature of HR representative

COMPANY STAMP

MEDICAL HISTORY FORM

Imperial™ Motus Med

FOR OFFICE USE ONLY	MEMBER NUMBER	REGISTRATION DATE (DD/MM/YYYY)

PLEASE COMPLETE IN BLOCK LETTERS.

J. APPLICANT

Surname of applicant

First name(s) of applicant

Date of birth DD/MM/YYYY

K. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS

Please provide the required information by ticking the relevant boxes with a 'yes' or 'no' below. If the answer to any question is 'yes', please provide details in section L overleaf.

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

1.	Are you or any of your dependants currently pregnant? If so, for how many months have you/she been pregnant? Number of months ____ Name and surname of person ____	☐ Yes	☐ No
2.	Have you or any of your dependants ever had any of the following?		
2.1	Any disorder of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?	☐ Yes	☐ No
2.2	High blood pressure or diseases of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder)?	☐ Yes	☐ No
2.3	Any respiratory or lung trouble (e.g. asthma, bronchitis, persistent cough, tuberculosis)?	☐ Yes	☐ No
2.4	Any disorder 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
2.5	Any disease or disorder 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
2.6	Any nervous or mental complaint (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety state or depression)?	☐ Yes	☐ No
2.7	Any ear, eye, nose or throat disorder (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment or chronic sinusitis)?	☐ Yes	☐ No
2.8	Any disorder or disease of the muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)?	☐ Yes	☐ No
2.9	Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder?	☐ Yes	☐ No
2.10	Any lumps, growths (benign or malignant), types of cancers (including Hodgkin's disease and leukaemia), skin cancer or skin disorders?	☐ Yes	☐ No
2.11	Any tropical disease (e.g. bilharzia, malaria and cholera)?	☐ Yes	☐ No
2.12	Any other condition, illness, disease, disorder, disability or accident that required medical, radiological, surgical, pathological or dental investigation during the past twelve months?	☐ Yes	☐ No
2.13	Been tested for or received or expect to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or any AIDS-related condition or any sexually transmitted disease (e.g. hepatitis B, gonorrhoea or syphilis)?	☐ Yes	☐ No

K. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS – CONTINUED

3.	Have or are you or your dependants receiving surgical, medical, major dental (implants), chiropractic, optical or gynaecological treatment, procedures, advice or tests?	☐ Yes	☐ No
4.	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
5.	Do you or any of your dependants currently use medication on a daily basis?	☐ Yes	☐ No
6.	Has your weight or the weight of your dependants changed by more than 5 kg in the last 12 months?	☐ Yes	☐ No
7.	Do you or any of your dependants suffer from any other ailment or disease at present?	☐ Yes	☐ No
8.	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 or other conditions including pregnancy for which advice has been sought or treatment has been received or recommended during the past five years?	☐ Yes	☐ No
9.	Are you or any of your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months?	☐ Yes	☐ No

If you require additional space, please complete a separate sheet of paper and attach it to the application. Please attach the relevant medical reports. Should you be HIV positive and do not wish to disclose this on your application form, please note that once you have received your membership number, you must fax confirmation of your HIV/AIDS status to the HIV YourLife Programme on 0860 109 793 to ensure registration on the programme. Please note that this may result in you receiving a second membership card from the Scheme pending whether your application will require underwriting, as per current legislation.

L. ADDITIONAL MEDICAL INFORMATION

		1.	2.	3.
Question number				
Name of attending doctor				
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 attack				
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/medication	Treatment			
	Medication			
Details of operations previously performed				
Operations and/or treatment needed in future				

L. ADDITIONAL MEDICAL INFORMATION – CONTINUED

		4.	5.	6.
Question number				
Name of attending doctor				
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 attack				
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/medication	Treatment			
	Medication			
Details of operations previously performed				
Operations and/or treatment needed in future				

M. MEDICAL SCHEME HISTORY (PLEASE ATTACH COPIES OF ALL PREVIOUS MEMBERSHIP CERTIFICATES)

Are or were you or any of your nominated dependants beneficiaries of a registered medical scheme? ☐ Yes ☐ No

If 'yes', a membership certificate – **not a membership card** – from the previous medical scheme must accompany this application. The entry date, as well as the cancellation date, must be indicated on the certificate.

Failing the above, waiting periods, unexpired waiting periods and late-joiner penalties may be imposed.

Was a late-joiner penalty imposed? ☐ Yes ☐ No

If 'yes', please provide details of penalty rate

Reason for termination of membership/de-registration as dependants:

M. MEDICAL SCHEME HISTORY (PLEASE ATTACH COPIES OF ALL PREVIOUS MEMBERSHIP CERTIFICATES) – CONTINUED

Details required if applicant was a member or dependant of another medical scheme.
Certificates of membership of previous medical schemes are required **– not a membership card.**

Name of applicant | Name of scheme
Period of membership: from DD/MM/YYYY to DD/MM/YYYY

Name of applicant | Name of scheme
Period of membership: from DD/MM/YYYY to DD/MM/YYYY

Name of applicant | Name of scheme
Period of membership: from DD/MM/YYYY to DD/MM/YYYY

Name of applicant | Name of scheme
Period of membership: from DD/MM/YYYY to DD/MM/YYYY

Name of applicant | Name of scheme
Period of membership: from DD/MM/YYYY to DD/MM/YYYY

Have you ever been a member of Imperial Motus Med? ☐ Yes ☐ No

If so, please state your previous membership number: | | | | | | | | | | | |

N. DECLARATION BY THE APPLICANT (MUST BE COMPLETED)

I declare that the above information is correct.

Signed at _____ on the _____ of _____ _____
DAY MONTH YEAR

Signature of member _____