

CHANGE IN MEMBERSHIP DETAILS

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.

Gross monthly income OLD NEW

D. CHANGE IN PHYSICAL ADDRESS AND CONTACT NUMBERS

Current/New physical address

Code

New contact numbers Work Home

Cell number

New email address

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

Physical 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

Physical 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

Physical 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)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Common-law partner	Affidavit and ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Customary spouse	Affidavit and ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foster child	Court order and ID or birth certificate (if over 21 and a student, please provide proof of registration)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Natural child	ID or birth certificate (if over 21 and a student, provide proof of registration)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parents of member	Affidavit and ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Same-sex partner	Affidavit and ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sibling	Affidavit and ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spouse	Marriage certificate and ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stepchild	Marriage certificate and ID or birth certificate (if over 21 and a student, provide proof of registration)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grandchild	Affidavit and ID (parent of grandchild should be a registered dependant of the principal member)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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. Reinstatement 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 physical 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:			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.
Ill health			
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

FOR OFFICE USE ONLY	MEMBER NUMBER <input style="width: 150px;" type="text"/>	REGISTRATION DATE (DD/MM/YYYY) <input style="width: 100px;" type="text"/>
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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? Yes No
 Number of months Name and surname of person
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 you 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. **Please note:** Your HIV status should not be disclosed in this form. To enrol on the YourLife Programme for HIV management, please contact **0860 109 793** or email **yourlife@imperialmotusmed.co.za**. **All correspondence is 100% confidential.** 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

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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 _____