AMENDMENT FORM

Selfmed
MEDICAL SCHEME

- Only complete sections of this form applicable to the amendment required.
  i.e. in respect of change in contact details, sections A/B/E would apply.
- Use only black ink.
- Use block capital letters to fill in the spaces.
- Use only one character per block.
- Leave one block empty between words.
- Where necessary, mark square clearly with an X.

Tel: 0860 787 372
Fax: 0860 288 363
Selfmed Medical Scheme
PO Box 5543
Tygervalley 7536
Reg. No: 1446

A DETAILS OF MEMBER

Name

Surname

Membership number

ID number

B CHANGE IN CONTACT DETAILS

Postal address

Postal code

E-mail address

Telephone (h)

Telephone (w)

Cellphone number

Date of change D D M M Y Y Y Y

C ADDITION OF DEPENDANT

In order to add a dependant to your membership (if application is not made in 30 days of date of acquisition). Please complete sections C1 and C2. Please provide copies of all ID documents)

C1 ADDITION OF DEPENDANTS

In the case of newborns, within 30 days of birth and in case of marriage, within 30 days of wedding date. Please attach copy of the birth certificate/marriage certificate

	Full Names	Surname	Gender M/F	Date of birth	ID number	Relationship to principal member
1.						
2.						
3.						
4.						
5.						
6.						

C2 PREVIOUS MEDICAL SCHEME HISTORY

Please attach copies of all previous medical scheme certificates. Copies of membership cards will not be accepted.

Is/Are dependant(s) to be added changing Medical Schemes as a result of change of employment? Y N

(If YES, please provide letter of resignation from company)

Please provide details of all medical schemes that your dependants to be added, previously belonged to: If you do not provide full details of their previous membership, waiting periods and late joiner penalties may be imposed. The Scheme reserves the right to request documented proof of membership if required.

	Scheme Name	Member Number	Registration Date	Cancellation Date	Reason for cancellation of membership
Applicant					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					
Dependant 5					

D HEALTH STATEMENT

Medical details of dependant(s) to be added (excluding a child registered within 30 days of date of birth)
Information must be supplied in respect of all the questions below. Please indicate your answers with an "X" in the appropriate block and provide full details below. All questions in this section must be completed or application will be considered incomplete.

General Practitioner's Name

General Practitioner's Contact Number

During the past 12 months, have any of your dependants to be added, been diagnosed with or received treatment/advice for any condition/impairment or illness relating to one of the following categories listed? Indicate specific condition by underscoring the specific condition. As this is not an all-inclusive list, if the dependant(s) to be added particular condition does not appear in the list of examples, it is imperative that you insert the condition in the relevant block. Please note all medication must be disclosed in this application for membership, irrespective of the medical facility through which the medication is being obtained e.g. any State health facility such as Day Hospitals or Clinics, etc.

Section A: Use table on next page to supply detail				
A1	Heart, blood vessels, or circulatory system	e.g. Cardiac murmurs, high blood pressure, chest pain, tightness of chest, palpitations, coronary thrombosis, valve defects, shortness of breath, stroke, high cholesterol, cramps during light exercise or walking, varicose veins, cardiac irregularities, swelling of the legs, or leg ulcers.	Y	N
A2	Respiratory system or lungs	e.g. Asthma, tuberculosis (TB), chronic bronchitis, pneumonia, persistent cough, coughing up blood, emphysema/COPD (Constructive obstructive Pulmonary disease) or bronchospasm.	Y	N
A3	Digestive system or liver	e.g. Ulcers of the stomach or duodenum, chronic indigestion, jaundice, liver disease, Hepatitis B, bleeding from the rectum, any related hernia, ulcerative colitis, Crohn's Disease, gall stones, heartburn, persistent abdominal pain, loss of weight (not due to diet), persistent diarrhoea, or persistent constipation.	Y	N
A4	Kidneys, bladder or sexual organs	e.g. Kidney stones, infections, blood or protein in the urine, or difficulty in passing urine.	Y	N
A5	Nervous system and psychological disorders	e.g. Depression, anorexia, anxiety or stress-related disorders, nervous tension, frequent headaches, psychological disturbances, migraine, fits, fainting, blackouts, multiple sclerosis, epilepsy, paralysis, brain impairment, Alzheimer's or dizziness.	Y	N
A6	Eye, ear, nose, mouth or throat	e.g. Defective sight, glaucoma, retinitis pigmentosa, hearing impairment, recurrent ear infections, balance disturbance, vocal problems, hoarseness, impaired speech, allergies, cataracts, chronic sinusitis, strabismus, ulcer or infection of mouth or gums.	Y	N
A7	Optical	Do you or any of your dependants wear spectacles or contact lenses?	Y	N

A8	Skeleton, vertebral column, joints, muscles, or skin	e.g. Back pain, displacement of the vertebrae and/or discs, any other back or neck trouble or operations, arthritis or arthritic pain, chronic gout, rheumatism, eruptions or diseases of the skin such as porphyria, psoriasis, dermatitis, acne – vulgaris or nodular cystic, any physical disability, any chiropractic treatment, eczema or sciatica.	Y	N
A9	Reproductive system	e.g. Ovarian cysts, hysterectomy, venereal diseases, any condition of the cervix, breast lumps, symptomatic excessive enlargement of breast, prostatitis, testicular tumours, endometriosis, bladder, urological condition or fertility treatment.	Y	N
A10	Dental system	e.g. Poor closure of the jaws, implants, orthodontic, periodontic or maxillo-facial surgery.	Y	N
A11	Tropical or infectious diseases	e.g. Malaria, bilharzia, brucellosis, typhoid fever, HIV/AIDS, etc.	Y	N

Section B: Use table on next page to supply detail			
B1	Are you (or any of your dependants) currently pregnant? If so, please specify the expected date of delivery _____ and specify how many months_____. I acknowledge that the Scheme has the right to cancel my membership, should an investigation confirm the nondisclosureof a pregnancy gestation of 6 - 8 weeks or more, at the time of signing the application.	Y	N
B2	Have you or any of your dependants had cancer, growths, or any other kind of tumours, lumps (benign or malignant) incl. Hodgkins disease during the past 12 months?	Y	N
B3	Have you or any of your dependants had diabetes, sugar in the urine, leukaemia, haemophilia, bleeding disorders, anaemia, thyroid gland or other glandular or blood diseases and/or any related endocrine disorder during the past 12 months?	Y	N
B4	Have you or any of your dependants had dialysis for renal failure during the past 12 months?	Y	N
B5	Have you (or any of your dependants), during the past 12 months, undergone any specialised tests or examinations such as the following: ECG, X-rays, ultrasound, CT, MRI scans or any other pathological tests (such as cholesterol tests)? If so, please provide full details of the results.	Y	N
B6	Are you (or any of your dependants) currently taking any prescribed medication?	Y	N
B7	Are you (or any of your dependants) receiving any treatment for a medical or other problem	Y	N
B8	Are your or any of your dependants planning to undergo any surgical procedure during the next 12 months?	Y	N
B9	Is there any other condition or symptom, which is not mentioned above, for which medical advice, diagnosis, care or treatment has already been recommended or received, and could potentially result in a medical aid claim during the next 12 months?	Y	N

If the answer to any of the questions in sections A and B was "YES", please give full details below of treatment received:

Question number	Name of applicant (or dependent)	Nature of illness, ailment, abnormality or treatment prescribed/ received	Frequency, duration and dates of last symptoms of each illness ailments or treatments	Name of medication

Signature

Date D D M M Y Y Y Y

E DECLARATION BY MEMBER

I, the undersigned, warrant that the information in this amendment form, whether it is in my own handwriting or not, is to my knowledge, complete and correct. If any information is not complete or correct the Scheme may cancel my membership in full. The Scheme may also cancel my membership in full if the incomplete or incorrect is about any of the dependants. Otherwise the scheme may cancel the registration of the dependant regarding whom the information was incomplete or incorrect. If my membership is cancelled in full, I shall also pay back all benefits paid for such a dependant and the scheme will refund the contributions.

Signature of principle member Date D D M M Y Y