Topmed Medical Scheme
PO Box 1462, Durban, 4000
Client Services: 0860 00 21 58
Website: www.topmed.co.za

AMENDMENT FORM

To be completed for the following amendments

- Change of address
- Change of contact details
- Change of banking details
- Addition of dependant
- Removal of dependant

A DETAILS OF THE PRINCIPAL MEMBER

Surname

Full Name(s)

Membership Number

B CHANGE OF ADDRESS

Postal Address

Postal Code

Physical Address

Postal Code

C CHANGE OF CONTACT DETAILS

Email Address

Telephone (home)

Telephone (work)

Cellphone Number

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D DEBIT/CREDIT ORDER INSTRUCTION

Member Name

Member/Group Number ID Number

Telephone Number

Postal Address

Postal Code

TO WHOM IT MAY CONCERN

Debit Credit

The details of my/our bank account is/are as follows:

Name of Account Holder

Name of Bank

Branch Name Branch Code

Account Number

Account Type Current Savings Transmission

PLEASE NOTE THAT CREDIT CARD TRANSACTIONS ARE NOT ALLOWED AGAINST YOUR MEDICAL AID CONTRIBUTIONS AND REFUNDS.

I/We hereby instruct and authorise you to debit/credit amounts which may be due to/by me/us to the debit/credit of my/our account with the abovementioned bank, or any other bank to which I/we may transfer my/our account.

I/We understand that the debit/credit transfers hereby authorised will be processed by computer through a system known as ACB Magnetic Tape Service and I/we also understand that no advice of the debit/credit will be provided by my/our bank, but details of each debit/credit will be printed on my/our statement or on any accompanying voucher.

I/We agree to pay any bank charges relating to the debit order instruction.

I/We understand that Billing advices and details will be supplied in the normal way and that the debit/credit will be actioned at least ten days after the date of Statement to/from my/our account.

This authority may be cancelled by me/us by giving thirty days written notice, but I/we understand that I/we shall not be entitled to any refund amounts which have been withdrawn while this authority was in force if such amounts were legally owing by me/us.

SIGNATURE OF ACCOUNT HOLDER (MANDATORY) _____ DATE D D M M Y Y Y Y

SIGNATURE OF PRINCIPAL MEMBER (MANDATORY) _____ DATE D D M M Y Y Y Y

SIGNATURE OF GROUP / EMPLOYER (WHERE APPLICABLE) _____ DATE D D M M Y Y Y Y

SIGNATURE OF BROKER / INTERMEDIARY (WHERE APPLICABLE) _____ DATE D D M M Y Y Y Y

PLEASE NOTE: Changes to your banking details will only be processed upon receipt of a valid copy of your identity document attached to this application.

You will receive your Billing statement and details as usual and the debit order will be actioned at least ten days after the date of statement. If for some reason you do not agree with the statement and do not want the Debit Order actioned, kindly telephone us on **0860 00 21 58** so that alternate arrangements can be made.

GROUP STAMP

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E ADDITION OF DEPENDANT

Start Date D D M M Y Y Y Y

Please complete section J (UNDERWRITING QUESTIONS) in full for all additional dependants.
In the case of newborns added within 30 days of birth, please attach a copy of ID Document or Birth Certificate.

Relationship	Surname & First Names	Gender (M/F)	ID Number
Spouse/Partner			
Child 1			
Child 2			
Child 3			
Child 4			
Other			

- **All newborns must be registered within 30 days of birth as a dependent of the Principal Member.**
- **Proof of Student Registration must be attached for all dependent children aged 21-24 years.**
- **Copies of ID documents/birth certificates must be attached for all dependants.**

I hereby declare that the insured persons with different surnames, are related to me as:

Biological child ☐ Adopted child * ☐

Step child ☐ Married to Principal Member ☐

Foster child * ☐ Partner ** ☐

Please note:
***** Foster/Adopted child - proof of legal guardianship is required.

** Partner - a person with whom the Member has a committed and serious relationship simliar to that of a marriage in which there is mutual, financial and emotional support and a shared household, irrespective of the gender of either party.

DETAILS OF PREVIOUS MEDICAL SCHEME MEMBERSHIP REQUIRED IF DEPENDANT (OLDER THAN 21) BELONGED TO ANOTHER MEDICAL SCHEME

A membership certificate for your dependants' present/previous medical scheme(s) is required. If a membership certificate cannot be supplied, please provide an affidavit with all the information regarding your dependants' (older than 21 years) present/previous medical scheme(s) cover.

Yes ☐ No ☐

Name of Scheme
Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

Name of Scheme
Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

Name of Scheme
Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

Name of Scheme
Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

Is your dependant compelled to terminate membership at their current/previous medical scheme because of change of employment? Yes ☐ No ☐

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F REMOVAL OF DEPENDANT

Surname | Initials

Full Name(s) (including any names or nicknames)

ID No. of Dependant | Date of Resignation D D M M Y Y Y Y

Reason

Surname | Initials

Full Name(s) (including any names or nicknames)

ID No. of Dependant | Date of Resignation D D M M Y Y Y Y

Reason

G DECLARATION BY MEMBER

I hereby declare that the information in this document, whether it is in my own handwriting or not, is complete and correct.

Signature (Principal Member)

Date D D - M M - 2 0 Y Y

H TO BE COMPLETED BY EMPLOYER IF MEMBER HAS COMPLETED SECTIONS E AND F

Name of Employer

Group Number

Total current contribution R

Total new contribution R

Arrears (if applicable) R

Signature (Employer)

Company Stamp

Date D D - M M - 2 0 Y Y

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I UNDERWRITING QUESTIONS

In order to add a Dependant to your membership, please complete the questionnaire below:

PLEASE ANSWER YES ☑ OR NO ☒ TO EVERY QUESTION FOR EVERY BENEFICIARY.

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High Blood Pressure, High Cholesterol or lipids, Ischaemic Heart Disease, heart failure, Angina, Stroke (CVA) or Peripheral Vascular Disease						
2	Obstructive Lung Disease (Asthma, Emphysema or C.O.A.D)						
3	Diabetes (Insulin or Non-insulin Dependant Diabetes Mellitus)						
4	Hypo or Hyperthyroidism						
5	Arthritis (i.e. Osteo, Rheumatoid Arthritis or Gout) - all related musculoskeletal conditions						
6	Osteoporosis						
7	Gastro Oesophageal Reflux Disease (G.O.R.D/heartburn) or stomach/duodenal ulcers (please circle)						
8	Immune Deficiency status (i.e. HIV/AIDS*, immunoglobulin deficiencies)						
9	Anaemia or abnormalities of clotting mechanism						
10	Hormone Replacement Therapy, Endometriosis or ovarian cysts						
11	Depression and/or anxiety disorders						
12	Any nervous or mental complaint (e.g. Epilepsy, blackouts, paralysis or headaches)						
13	Glaucoma, cataracts or any other disorders of the eye						
14	Parkinson's Disease or Multiple Sclerosis (please circle)						
15	Hyperplasia of prostate (BPH) or Prostatism						
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)						
17	Urinary tract infection or calculi (stones)						
18	Back or neck related condition (lumbago, sciatica, injury, spasm, etc)						
19	Are you pregnant? If so, how many weeks?						
20	Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure for the following 12 months?						
21	Are you on any medication at present?						
22	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or which you anticipate receiving, and could potentially result in a medical claim within the next 12 months?						
23	Skin conditions/disorders (e.g Acne, Eczema, Psoriasis, etc)						
24	Ear, nose or throat disorders (e.g. ear discharge, recurrent Tonsillitis)						
25	Infectious diseases (e.g. Tuberculosis, Shingles, Measles, etc)						
26	Malignant neoplasms (cancer, growths or malignant tumours)						
27	Benign neoplasms (non-malignant tumours/growths)						
28	Specialised dentistry/maxillo-facial treatment						
29	Have you had or are you expecting to have plastic or reconstructive surgery?						
30	Do you or your dependants take chronic medication?						

* 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 (Contract) number, we require you to please fax confirmation of your HIV/AIDS status to our HIV/AIDS Department on **0860 448 2273**. Please note that this may result in you receiving a second card from the Scheme depending on whether your application will require underwriting as per current legislation.

IF YOU HAVE ANSWERED 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS BELOW. FAILURE TO DISCLOSE ANY PRE-EXISTING CONDITIONS COULD RESULT IN BENEFITS BEING LIMITED, EXCLUDED AND/OR MEMBERSHIP BEING TERMINATED.

Question No.	Nature and duration of complaint and full details of treatment being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment?

NB: Failure to disclose any pre-exisinting conditions could result in benefits being limited, excluded and/or membership being terminated.

J THE RULES

1. The Rules of Topmed, as amended from time to time, is binding on the Topmed Individual Member and dependants.
2. The person signing the contract on behalf of, or, as the Employer, acknowledges that he has received a set of Rules and that he has read them prior to signing this Contract.
3. Certain Rules are set out in summary below so as to emphasise the Rules which Topmed considers to be particularly important. The failure to draw the Employer's attention to any Rule shall not in any way be regarded as excusing the Employer from the Employer's obligation to thoroughly acquaint himself with the Rules which have been delivered to the Employer. The summary is as follows:

Rule Reference

1. The amounts set out in the Rules are payable by or in respect of Members and each of their Dependants. All such amounts are due monthly in advance, and payable on the first day of the month. The first such payment is payable from the first day of the Month in which a Beneficiary's Inception Date falls, even if a waiting period applies to a Beneficiary.
2. When a Minor Dependant becomes an Adult Dependant the contribution applicable to an Adult Dependant is payable from the first day of the month following that in which the Minor Dependant becomes and Adult Dependant.
3. When Dependants are deregistered, decreased amounts are payable from the first of the Month after the Month during which the Dependants' deregistration took effect.
4. Beneficiaries who are Late Joiners are subject to the penalties set out in Annexure A of the Scheme Rules. Those penalties also apply to Beneficiaries who were subject to similar penalties at previous medical aid schemes of which they had been members or dependants of members. However, any years of Creditable coverage which can be demonstrated by the Beneficiary is subtracted from that Beneficiary's current age in determining the applicable penalty.
5. Where Contributions or any other debt owing to the Scheme have not been paid within 7 days of the due date, the Scheme has the right to suspend payments of all Benefits which have accrued to such member irrespective of when the claim for such Benefit arose. The Scheme further has the right to give the Member notice that, if Contributions or such other debts are not paid within 7 days, membership may be cancelled without further notice.
6. If payments are brought up to date, Benefits must be reinstated without any break in continuity subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default and to recover interestat the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no Benefits will be due to the Member from the date of default and any such Benefit paid may be recovered by the Scheme.
7. The Scheme may withold, suspend or discontinue the provision of a Benefit, or of any right in respect of that Benefit, if the Member attempts to transfer, pledge or hypothecate it.
8. Not withstanding anything to the contrary contained in the Rules, where the Employer/Individual gives late notification to Topmed of termination, the Employer/Individual shall be liable to pay Contributions payable up to the end of the month during which Topmed receives notification of termination.

ADDITIONAL TERMS

1. Topmed is not obliged to pay any Benefits where a Member is in breach of any of the Member's obligations in terms of the Rules and in particular where any Contribution or part thereof is in arrears.
2. The Employer is the agent of the Member and not of Topmed in dealings between an Employee and Topmed.
3. The Employer/Member must notify Topmed within 30 days of any change of address and failure to notify will absolve Topmed from any liability should the Employer or Member's rights be prejudiced or forfeited.
4. The Employer shall only be entitled to terminate the Group's Membership of Topmed consequent upon 3 calendar month's written notice of termination having been given to Topmed.
5. Individual members shall only be entitled to terminate membership of Topmed consequent upon 1 calendar month's written notice of termination having been given to Topmed.

K APPLICATION REQUIREMENTS

Please enclose the relevant documentation with this form.
Important: *Registration will be delayed should this application be incomplete or the required documents not attached, as it will be returned to you.*

Membership certificate(s) or affidavit of previous medical scheme(s) ☐

Copy of ID documents or birth certificates for all dependants ☐

Topmed Medical Scheme reserves the right to list members who are found guilty of comitting unethical behaviour, abuse, collusion or fraud on the Transunion ITC. This information may be viewed by all of the medical schemes that have a contract with the Board of Healthcare Funders Forensic Management Unit.

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L CONSENT

AUTHORISATION FOR TOPMED MEDICAL SCHEME AND THE ADMINISTRATOR TO DISCLOSE INFORMATION

I, the applicant, hereby:

- authorise Topmed Medical Scheme and the Administrator to disclose Benenfits, Financial and Medical information to the party/parties indicated below;
- agree that neither Topmed Medical Scheme nor the Administrator shall be liable for any loss or damage whatsoever, including direct, indirect and consequential, that may arise from the disclosure or any information pursuant to this consent;
- agree that once consent is provided, all information selected may be provided to the party/parties;
- acknowledge that this consent will continue in force until expressly withdrawn by me.

TO WHOM INFORMATION MAY BE SUPPLIED

Providers of Service Yes ☐ No ☐ Beneficiaries - registered dependants Yes ☐ No ☐

Please specify who

Initials and Surname

Relationship ID Number

Initials and Surname

Relationship ID Number

Other: Please specify who

Initials and Surname

Relationship ID Number

M DECLARATION BY APPLICANT

I, the undersigned, apply for membership as set out in this application for myself (and the registration of my dependants). I acknowledge that I (and my dependants) will not be considered as members of Topmed until I receive written confirmation of membership.

The scheme, or its agents may from time to time do the following in respect of me (and any of my dependants):

- Request and receive any medical and medically related information that is relevant to consider this application and any claim-related benefits for me (and any of my dependants for whom this application is accepted). Such information may be obtained from any healthcare provider or healthcare facility.
- Communicate any medical and medically related information from any healthcare provider or healthcare facility to the scheme's contracted healthcare management company. The purpose of this exchange is to ensure that the most cost-effective and high quality medical care benefits are obtained for all members of the Scheme.

I further give my permission for:

- The required information to be requested, communicated and received at any time. This may even be after my death (or that of any of my dependants).
- Any failure to comply with a financial duty towards the scheme to be registered with a credit bureau.

I warrant that the information in this application, whether it is my own handwriting or not, is complete and correct. This also applies to information in other documents provided by me, any of my dependants, or healthcare provider or healthcare facility. 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 information pertains to any of the dependants. Otherwise the Scheme may cancel the registration of the dependant regarding whom the information was incomplete or incorrect. In either case, I shall forfeit the full contributions already paid to the Scheme, or the contributions for the dependant who has been removed from my membership. If my membership is cancelled in full, I shall also pay back to the Scheme all benefits paid out to me and any of my dependants. If a dependant is removed from my membership, I shall pay back all benefits paid for such a dependant.

I undertake to advise Topmed of any change in my state of health (or that of any of my dependants) which occurs prior to my receiving written acceptance of this application.

If any of the medical details that I have supplied in this application change before my membership starts, the Scheme may reconsider my application. The Scheme, at its own discretion and even after my membership has started, may reconsider the full application, or only that of a certain dependant. If this is the case, the terms as explained in this declaration will apply.

I understand that the relationship between me (and any of my dependants) and the Scheme is controlled by the rules of the Scheme. I undertake to familiarise myself (and any of my dependants) with the rules of the Scheme, as well as changes that are made to the Rules from time to time.

Signature of Principal Member

Date Signed D D - M M - Y Y Y Y

Topmed Medical Scheme reserves the right to list members who are found guilty of comitting unethical behaviour, abuse, collusion or fraud with the Board of Healthcare Funders Fraud Management Unit and with a Credit Bureau. This information can be viewed by all of the medical schemes that have a contract with the Board of Healthcare Funders Forensic Management Unit.

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