Bonitas

Member record amendment

Please Note

1. Please use block letters
2. Complete blocks from left to right, and one letter/number per block
3. Registration and amendments are subject to the Rules of the Fund
4. Please notify the Fund, within 30 days of any change to the membership status of your dependant/s
5. If you have any queries, please contact the Call Centre on 0860 002 108

- **Dependant registration**
- **Dependant termination**
- **Change of marital status**
- **Change of personal details**
- **Change of banking details**

Please tick appropriate block

☐ **Dependant registration** **Complete sections 1, 2, 3, 4, 5, 6, 9, and 11**

☐ **Member record amendment** **Complete sections 1, 2, 3, 7, 8, 9, and 10**

Section 1. Membership details (must be completed)

Title | Initials | First name/s

Surname

Membership number

Section 2. Confirmation or change of address / contact details

Telehone (h) | Cell

Telephone (w) | Fax

E-mail address

Street address

Postal address

Section 3. Bank details of principal member - For refund of claim/s, savings payments and / or debit order instruction, please provide the following documents:

- If account holder differs from that of principal member, a letter from the account holder is required approving the loading of the bank account details for contribution collection is required.
- Copy of the account holder's ID
- Copy of the bank statement / cancelled cheque / letter from the bank / bank letterhead confirming the account holder's details
- Account holder's signature

Use this account for contribution collections and refunds	Use this account for refunds only
Bank name	Bank name
Branch name	Branch name
Bank branch code	Bank branch code
Type of account	Type of account
Name of account holder	Name of account holder
Bank account number	Bank account number

Account holder's signature

Date signed D D M M Y Y Y Y

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Section 4. Registration of spouse / partner / newborn / additional adult or child dependant

An adult dependant is anyone who is 21 years of age or older. Child rates apply to fulltime students 21-24 years of age provided the student proof (registration details) is attached to the application for the current academic year. You are able to register adult or child dependants on this form. Provide valid ID numbers and / or password numbers for all beneficiaries. Acceptance of the dependants will be in accordance with the Rules of the Fund. **Please attach copies of ID / passport, marriage certificates, birth certificates, legal adoption or foster care court order documents and previous membership certificates with terminated date, where appropriate.**

1. Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname (if different from principal member) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name/s ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to principal member eg. spouse, child etc. ☐☐☐☐☐☐☐☐☐☐☐☐ Gender M F Date of birth D D M M Y Y Y Y

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

Maiden name (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID / passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Tax number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname (if different from principal member) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name/s ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to principal member eg. spouse, child etc. ☐☐☐☐☐☐☐☐☐☐☐☐ Gender M F Date of birth D D M M Y Y Y Y

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

Maiden name (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID / passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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3. Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname (if different from principal member) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name/s ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to principal member eg. spouse, child etc. ☐☐☐☐☐☐☐☐☐☐☐☐ Gender M F Date of birth D D M M Y Y Y Y

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

Maiden name (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID / passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Tax number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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4. Adult ☐ Child ☐ Title ☐☐☐☐ Initials ☐☐☐☐

Surname (if different from principal member) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name/s ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relationship to principal member eg. spouse, child, etc. ☐☐☐☐☐☐☐☐☐☐☐☐ Gender M F Date of birth D D M M Y Y Y Y

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

Maiden name (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ID / passport number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Tax number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section 5. Medical details

Please note: failure to disclose medical conditions could limit and / or exclude you from receiving certain benefits, or result in the termination of your membership.

Do you or any of your dependants currently suffer or have suffered from any of the following:

1. Chronic illness? (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression, anxiety, systemic lupus erythematosus, epilepsy, and / or thyroid disorder) If yes, please provide details.

Y N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

2. Gastro-intestinal disorders? (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticulitis and / or spastic colon) If yes, please provide details.

Y N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

3. Muscle, bone, skin or nerve illnesses or disorders? (e.g. back and neck related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc.) If yes, please provide details.

Y N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

4. Urinary or genital disorders? (e.g. Kidney stones, prostate disorders, endometriosis, ovarian cysts, menstrual disorder) If yes, please provide details.

Y N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

5. Ear, nose or throat disorders? (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics) If yes, please provide details.

	Y	N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

6. Blood disorders, cancer, etc.? If yes, please provide details.

	Y	N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

7. Are you or any of your dependants pregnant? If yes, please provide details.

	Y	N

Name of beneficiary	Trimester of pregnancy	Confirmed pregnancy		Expected date of delivery	Complications (if any)	Attending GP/Specialist
		YES	NO			
		YES	NO			

8. Have you or any of your dependants had surgery in the past, or are you planning to have a surgical procedure in the next 12 months? If yes, please provide details.

	Y	N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

9. Is there any other condition or symptoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months? If yes, please provide details.

	Y	N

Name of beneficiary	Name of condition	Are you currently receiving treatments?		Date of 1st treatment	Date of last treatment	Name of medication	Attending GP/Specialist
		YES	NO				
		YES	NO				

Current Doctor

Name and surname

Telephone

He / she has been your doctor since Y Y M M years

Section 6. Previous medical scheme information

Please attach copy of the previous certificate of membership with the terminated date.

Have you as the principal member, or any of your dependant/s had previous medical aid cover? YES | NO

If yes, please give full details of you and/or your spouse/partner/adult dependants' membership of previous registered medical aid schemes and attach a copy of previous Membership Certificate/s. Should you need additional space to provide the necessary information, please make a copy of this section and attach it to your application. It is important that you specify exact membership join and termination dates for each medical scheme.

Name of beneficiary	Name of scheme	Membership number	Date joined	Date terminated
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y
			D D M M Y Y Y Y	D D M M Y Y Y Y

Are you or your dependant/s changing your medical scheme due to a change in your employment? If yes is selected, please provide a letter from previous employer confirming termination of employment or letter from new employer or new employment. YES | NO

Have condition-specific waiting periods, exclusions or late-joiner penalties ever been imposed by a previous medical scheme/s on your dependant/s membership? YES | NO

Section 7. Change of marital status

Marital status MARRIED | DIVORCED | WIDOWED | COHABITING Date of marriage/divorce/death D D M M Y Y Y Y

Title Initials New surname

Please Note

'Married' – attach a certified copy of marriage certificate. If spouse/partner to be added, complete Dependant Registration form.
'Divorced' – attach a certified copy of divorce order. If spouse/partner to be removed, complete Section 4 of this form.
'Widowed' – attach a certified copy of Death Certificate of spouse/partner.

Section 8. Termination of dependant membership due to death, divorce, over-age child dependant, etc.

Attach certified copy of divorce decree / death certificate

Full name/s as reflected on your fund membership card	Relationship	Date joined	Date terminated
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y
Reason for termination:			

Section 9. To be completed by employer – **compulsory**

Company name

Scheme code | Pay point code | Group | Dependant/s subsidised YES NO

The above details have been noted and contributions will be adjusted in terms of the Scheme Rules and include arrears, if applicable. D D M M Y Y Y Y

EMPLOYER STAMP

Total current contribution R

Total new contribution R

Arrears (if applicable) R

Company representative's signature and designation _____ Date D D M M Y Y Y Y

Section 10. Medical fund acknowledgement and declaration

1. Bonitas takes the protection of personal information very seriously and for this reason all reasonable measures are taken to protect your personal information and to keep it confidential. Personal information refers to information that identifies or relates specifically to you or your dependants, for example, name, age, gender, health status, identity number and email address. In short, any information that we know about you or a dependant will be regarded as your personal information.

   We use your information or obtain information about you for the following purposes:

   - Underwriting (conditions applicable to your membership and benefits)
   - Assessment and processing of medical services claims
   - Fraud prevention and detection
   - Statistical analysis
   - Audit & record keeping purposes
   - Compliance with legal & regulatory requirements
   - Verifying your identity
   - Sharing information with service providers we engage to process such information, on our behalf or who renders services to us.
   - You may access the personal information that we hold and request us to correct any errors or to delete this information.

2. To protect you and your dependants' personal information, Bonitas has data security measures in place, i.e. access control to restrict the disclosure of personal information to only authorised individuals, confidentiality agreements with service providers and staff members, and for the purposes of disaster and data recovery plans.

Section 11. Acknowledgement and declaration

1. I, the undersigned, hereby make application to be admitted as a member of Bonitas Medical Fund. When admitted I agree to abide by the rules of Bonitas which are available for me to read on the Bonitas website www.bonitas.co.za or will be provided to upon my request to Bonitas .
2. I warrant that the information I have provided in this application form, pertaining to me and my dependants are true and correct.
3. I warrant that I have the explicit consent of my dependants to disclose personal information about them to Bonitas and will on request from Bonitas provide such consent, in written form, to Bonitas.

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4. I declare that any false statement in the above application or the non-disclosure of any material information will render my membership null and void, and that any monies paid to the Scheme shall be forfeited to the Scheme.
5. Bonitas also has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation. Should my or my dependants' circumstances alter subsequent to the date of filling in this application, prior to or after the acceptance of my membership by Bonitas, I shall promptly notify Bonitas of the changes. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership, and Bonitas shall also be entitled to reclaim any amounts it may have erroneously paid to any service provider on my or my dependants behalf.
6. I authorise and instruct my employer to deduct and pay over any amounts (that may become due and owing on my behalf) to Bonitas from time to time and I also authorise any persons, bodies or institutions who may hold retirement funds for my benefit, to deduct and pay to Bonitas all amounts that may become due and owing to Bonitas from time to time.
7. I agree that should Bonitas incur any legal costs or expenses to recover any contributions owed by me or any other amount due by me to Bonitas for whatever reason, I shall be responsible for such costs and expenses on the attorney/client scale. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any money owing to Bonitas.
8. I understand that it is my responsibility as the principal member to ensure that the monthly contributions are received by Bonitas.
9. Should any contribution be unpaid, it may result in me and my dependants being suspended from Bonitas until all arrear contributions have been settled. Should two months' contributions be outstanding, Bonitas shall have the right to immediately cancel my Bonitas membership. I also understand that should my membership be suspended or terminated, I shall not be entitled to any benefits arising from my membership whatsoever.
10. I shall inform Bonitas of any changes to my or my dependants' health or personal status, as required by the Bonitas Rule, within 30 days of the change in circumstances.
11. I authorise my and my dependants' healthcare provider to disclose information to Bonitas and its contracted third parties, provided such information is treated as confidential at all times.
12. I agree to provide Bonitas with any medical or historical information or grant Bonitas access to medical information reasonably requested pertaining to a particular ailment, disease, disorder, condition or disability.
13. I agree that should I be accepted as a member of Bonitas, I shall provide Bonitas with all information including medical information that Bonitas may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Bonitas rules. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.
14. I declare that my dependants are not beneficiaries of another registered medical scheme.
15. I understand that the following conditions (underwriting), which will impact my and my dependants' right to benefits may be applicable to my membership as prescribed by the Medical Schemes Act No. 131 of 1998:
    - 15.1 a 3 (three) month general waiting period in respect of all benefits;
    - 15.2 a 12 (twelve) month exclusion in respect of a pre-existing condition;
    - 15.3 a late-joiner contribution penalty
16. I authorise and permit Bonitas to take all reasonable steps to verify information provided by me in this application form.
17. I agree to submit proof of identification to Bonitas on demand.
18. I consent to my telephone conversations with Bonitas being recorded and forming part of Bonitas' records. I also agree that such records shall remain the sole property of Bonitas.
19. I warrant that the information provided above is true and accurate and should my application be accepted by Bonitas, the contents of this application form shall constitute the basis of my agreement with Bonitas.
20. As a government employee, I acknowledge that Bonitas will strictly adhere to Persal policies and procedures.
21. As a direct paying member, I acknowledge that monthly contributions are payable in advance in accordance with the Rules of Bonitas .

Section 12. Acknowledgement and declaration

I acknowledge that I have read and understood the content of this application form. If I am illiterate, I confirm that the content of this application form and the implications thereof have been read and explained to me.

All information declared on the application form will be kept confidential by the medical scheme.

Signed at _____ on this _____ day of _____ 20 _____

Signature of principal member_____