



MEMBERSHIP AMENDMENT FORM

PLEASE COMPLETE IN BLOCK LETTERS

Please submit the completed and signed form by email to membership@goldenarrowmed.co.za.

1. MAIN MEMBER'S DETAILS

Membership number	<input type="text"/>	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Title	<input type="text"/> Initials <input type="text"/>	Employee/Pensioner number	<input type="text"/>	
First names	<input type="text"/>			
Surname	<input type="text"/>			
Identity/Passport number	<input type="text"/>	Date of birth	<input type="text"/>	(DD/MM/YYYY)
Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	Date of marriage <input type="text"/> (DD/MM/YYYY)
	<input type="checkbox"/> Separated	<input type="checkbox"/> Widow/er	<input type="checkbox"/> Co-habitee	Date of divorce <input type="text"/> (DD/MM/YYYY)
	(If divorced, attach a copy of final order of divorce with addendums, if any)			
Race*	<input type="checkbox"/> African	<input type="checkbox"/> Coloured	<input type="checkbox"/> Indian/Asian	<input type="checkbox"/> White
	<input type="checkbox"/> Other	<input type="checkbox"/> Don't wish to disclose		
Contact numbers	<input type="text"/>	Home	<input type="text"/>	
	<input type="text"/>	Cell phone	<input type="text"/>	
Postal address	<input type="text"/>			
	<input type="text"/>	Postal code	<input type="text"/>	
Email address	<input type="text"/>			

2. DEPENDANT INFORMATION

NO PERSON MAY BE ENROLLED ON DIFFERENT MEDICAL FUNDS SIMULTANEOUSLY.

Where a dependant is over the age of 21 years, please tick the correct box and **attach a copy of the relevant documentation.**

- The dependant is a full time student **(attach a certificate from a learning institution)**
- The dependant is mentally or physically disabled **(attach a medical report)**
- The dependant is your spouse **(attach an identity document and marriage certificate)**

Dependant 1

Title	<input type="text"/> Initials <input type="text"/>	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
First names	<input type="text"/>			
Surname	<input type="text"/>			
Maiden name (if applicable)	<input type="text"/>	Relationship to applicant (e.g. wife, son)	<input type="text"/>	
Identity/Passport number	<input type="text"/>	(copy of identity document to be attached to the application form)		
Date of birth	<input type="text"/>	(DD/MM/YYYY)		
Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
	<input type="checkbox"/> Widow/er	<input type="checkbox"/> Co-habitee		
Race*	<input type="checkbox"/> African	<input type="checkbox"/> Coloured	<input type="checkbox"/> Indian/Asian	<input type="checkbox"/> White
	<input type="checkbox"/> Other	<input type="checkbox"/> Don't wish to disclose		
Contact numbers	<input type="text"/>	Home	<input type="text"/>	
	<input type="text"/>	Cell phone	<input type="text"/>	
Postal address	<input type="text"/>			
	<input type="text"/>	Postal code	<input type="text"/>	
Email address	<input type="text"/>			

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

2. DEPENDANT INFORMATION (CONTINUED)

Dependant 2

Title Initials Gender Male Female

First names

Surname

Maiden name (if applicable) Relationship to applicant (e.g. wife, son)

Identity/Passport number (copy of identity document to be attached to the application form)

Date of birth (DD/MM/YYYY)

Marital status Single Married Divorced Separated Widow/er Co-habitee

Race* African Coloured Indian/Asian White Other Don't wish to disclose

Contact numbers Home Work

Cell phone

Postal address

Postal code

Email address

Dependant 3

Title Initials Gender Male Female

First names

Surname

Maiden name (if applicable) Relationship to applicant (e.g. wife, son)

Identity/Passport number (copy of identity document to be attached to the application form)

Date of birth (DD/MM/YYYY)

Marital status Single Married Divorced Separated Widow/er Co-habitee

Race* African Coloured Indian/Asian White Other Don't wish to disclose

Contact numbers Home Work

Cell phone

Postal address

Postal code

Email address

*Optional information required by the Council for Medical Schemes (CMS) for statistical purposes.

3. DEPENDANT RESIGNATIONS

Initials	First names	Surname	Date of resignation (DD/MM/YYYY)
1.			
2.			
3.			
4.			
5.			

4. CHANGE OF STATUS

Retirement Effective date (DD/MM/YYYY)

Disability (**copy of medical report required**) Effective date (DD/MM/YYYY)

Change in employer group Effective date (DD/MM/YYYY)

Change in status continued on page 3

4. CHANGE OF STATUS (CONTINUED)

I hereby certify that the above information is true and complete.

Signature of member	<input type="text"/>	Signature of employer	<input type="text"/>
Date	<input type="text"/> (DD/MM/YYYY)	Date	<input type="text"/> (DD/MM/YYYY)

THIS SECTION MUST BE COMPLETED BY AN AUTHORISED OFFICIAL AFTER THOROUGH SCRUTINY.

I hereby certify the foregoing details to be a true statement and that the applicant is a permanent member of staff.

<input type="text"/>
OFFICIAL EMPLOYER'S STAMP

5. BANKING AND TAX REFERENCE DETAILS

Required for the direct debiting and crediting of member's portions on claims where applicable.

Account holder	<input type="text"/>	Account type
Account number	<input type="text"/>	<input type="checkbox"/> Current
Name of bank	<input type="text"/>	<input type="checkbox"/> Savings
Branch name	<input type="text"/>	<input type="checkbox"/> Transmission
Branch code	<input type="text"/>	
Tax reference number	<input type="text"/>	

6. PREVIOUS MEDICAL SCHEME MEMBERSHIP

PLEASE ATTACH COPIES OF ALL PREVIOUS MEDICAL AID CERTIFICATES.

Are or were you or any of your nominated dependants members of a registered medical fund during the last two years? Yes No

If 'Yes', a certificate of membership (not a membership card) must be attached to this application.

CURRENT MEDICAL FUND MEMBERSHIP

Name of fund	<input type="text"/>		
Membership number	<input type="text"/>		
Date of commencement	<input type="text"/>	(DD/MM/YYYY)	
Date of termination	<input type="text"/>	(DD/MM/YYYY)	
Exclusions imposed	<input type="text"/>		

Previous medical scheme membership continued on page 4

6. PREVIOUS MEDICAL SCHEME MEMBERSHIP (CONTINUED)

PREVIOUS MEDICAL FUND MEMBERSHIP

(If more information is needed, please use a separate sheet of paper and attach it to the application)

Name of Fund	<input type="text"/>	
Membership number	<input type="text"/>	
Date of commencement	<input type="text"/>	(DD/MM/YYYY)
Date of termination	<input type="text"/>	(DD/MM/YYYY)
Exclusions imposed	<input type="text"/>	

PLEASE NOTE: If you belong to another medical fund, but did not declare your membership during your registration on the Fund, the Fund will hold you responsible for any costs incurred during your membership of the Fund.

7. QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH

To be completed by each applicant in respect of himself/herself and all his/her dependants. Please provide all the required information by ticking the relevant box. If the answer to any question is 'Yes', provide details in the table on page 5.

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

1. Have you or any of your dependants had any of the following?

- | | | | | |
|---|--------------------------|-----|--------------------------|----|
| 1.1 Any disorder/dysfunction of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.2 High blood pressure or disorder/dysfunction of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder/dysfunction)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.3 Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis/persistent cough or tuberculosis)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.4 Any disorder/dysfunction 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)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.5 Any disorder/dysfunction 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)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.6 Any nervous or mental disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.7 Any ear, nose or throat disorder/dysfunction (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)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.8 Any disorder/dysfunction of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.9 Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder/dysfunction? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.10 Any lumps, growths (benign or malignant), types of cancers (including Hodgkin's and leukaemia), skin cancers or skin disorders/dysfunctions? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.11 Any tropical diseases (e.g. bilharzia, malaria or cholera)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.12 Any other condition, illness, disease, disorder/dysfunction, disability or accident that required medical, radiological, surgical, pathological or dental investigations during the past 12 months? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.13 Been tested for or received or expected to receive any medical advice, counselling, treatment or blood test in connection with HIV/AIDS or an AIDS-related condition or any sexually transmitted infection (e.g. hepatitis B, gonorrhoea or syphilis)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 1.14 A weight change or the weight of your dependants changed by more than 5 kg over the past 12 months? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Questions regarding medical history and general health continued on page 5

7. QUESTIONS REGARDING MEDICAL HISTORY AND GENERAL HEALTH (CONTINUED)

2. 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
3. Do you or any of your dependants currently use medication on a daily basis? Yes No
4. 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, tests or other conditions (including pregnancy) for which advice has been sought or treatment has been received or recommended during the past 12 months? Yes No
5. Are you or any of your dependants expecting to undergo any medical procedure, operation or to receive any major dental treatment during the next 12 months? Yes No
6. Are you and/or any of your dependants pregnant? Yes No
- Name of person Number of months

If you answered 'Yes' to any of the questions above, please provide full details in the table below. If additional space is required, provide the details on a separate sheet of paper and attach it to the application.

		1	2	3
Question number				
Name of person suffering from the illness				
Type of illness/condition (diagnosis)				
Date on which the illness began (DD/MM/YYYY)				
Frequency of attacks (hourly/daily/weekly/monthly)				
Date of last occurrence (DD/MM/YYYY)				
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/type of medication	Treatment			
	Medication			
Details of operations previously performed				
Operations and/or treatment needed in future				
Name of attending medical practitioner				

[Empty box for additional information]

12/2025

Golden Arrow Employees' Medical Benefit Fund

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