GOLDEN ARROW
EMPLOYEES' MEDICAL BENEFIT FUND

MEMBERSHIP AMENDMENT FORM

PLEASE COMPLETE IN BLOCK LETTERS

Please submit the completed and signed form by email to goldenarrowmembership@mhg.co.za.

1. MAIN MEMBER'S DETAILS

Membership number | Gender ☐ Male ☐ Female

Title | Initials | Employee/Pensioner number

First names

Surname

Identity/Passport number | Date of birth (DD/MM/YYYY)

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er ☐ Co-habitee | Date of marriage (DD/MM/YYYY) | Date of divorce (DD/MM/YYYY)

(**If divorced**, attach a copy of final order of divorce with addendums, if any)

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

Contact numbers | Home | Work

Cell phone

Postal address

Postal code

Email address

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 | 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.

Dependant information continued on page 2

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		Signature of employer	
Date	(DD/MM/YYYY)	Date	(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.

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	
Account number	
Name of bank	
Branch name	
Branch code	
Tax reference number	

Account type

- ☐ Current
- ☐ Savings
- ☐ Transmission

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		
Membership number		
Date of commencement		(DD/MM/YYYY)
Date of termination		(DD/MM/YYYY)
Exclusions imposed		

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		
Membership number		
Date of commencement		(DD/MM/YYYY)
Date of termination		(DD/MM/YYYY)
Exclusions imposed		

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)?	☐ Yes	☐ No
1.2	High blood pressure or disorder/dysfunction of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder/dysfunction)?	☐ Yes	☐ No
1.3	Any respiratory or lung disorder/dysfunction (e.g. asthma, bronchitis/persistent cough or tuberculosis)?	☐ Yes	☐ 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)?	☐ Yes	☐ 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)?	☐ Yes	☐ No
1.6	Any nervous or mental disorder/dysfunction (e.g. epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder/dysfunction or depression)?	☐ Yes	☐ 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)?	☐ Yes	☐ No
1.8	Any disorder/dysfunction of muscles, bones, joints, limbs or spine (e.g. rheumatism, arthritis, gout, slipped disc or other back trouble)?	☐ Yes	☐ No
1.9	Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder/dysfunction?	☐ Yes	☐ No
1.10	Any lumps, growths (benign or malignant), types of cancers (including Hodgkin's and leukaemia), skin cancers or skin disorders/dysfunctions?	☐ Yes	☐ No
1.11	Any tropical diseases (e.g. bilharzia, malaria or cholera)?	☐ Yes	☐ 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?	☐ Yes	☐ 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)?	☐ Yes	☐ No
1.14	A weight change or the weight of your dependants changed by more than 5 kg over the past 12 months?	☐ Yes	☐ 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				

8. ADDITIONAL INFORMATION

02/2023

Golden Arrow Employees' Medical Benefit Fund

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Website www.goldenarrowmed.co.za