UMVUZO HEALTH

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CHANGES IN MEMBERSHIP STATUS

Membership number		Date	Y	Y	Y	Y	M	M	D	D

DETAILS OF THE PRINCIPAL MEMBER

Race - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured

Dr		Ref		Mr		Mrs		Miss	

Surname															
Full Names															
Member's date of birth	Y	Y	Y	Y	M	M	D	D	Race						
ID number															
Residential address															
													Code		
Postal address															
													Code		
Telephone number (H)															
Telephone number (W)															
Cellphone number															
Email address															

Name of employer		Employee number	
HR Department contact person		Telephone number	

ONLY COMPLETE THE SECTION(S) RELATING TO THE MEMBER OR APPLICANT

REGISTRATION AS DEPENDANT

Race - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured

Births

Full Names		Surname	

Date of birth	Y	Y	Y	Y	M	M	D	D	Gender		Race	

ID number													

Date of registration as dependant	Y	Y	Y	Y	M	M	D	D	(Please attach a copy of Birth Certificate)

CHANGES IN MEMBERSHIP STATUS

MEMBERSHIP NUMBER	

Marriage

Date of marriage	Date	Y	Y	Y	Y	M	M	D	D

(Please note that a spouse must be registered from month of marriage, within 30 days, to enjoy full benefits)
(Please attach the following documents: **i)** Copy of the marriage certificate **ii)** Certificate of membership of previous medical scheme)
NOT APPLICABLE ON CORPORATE GROUPS

Surname	
Full Names	
Date of birth	Y Y Y Y M M D D · Gender: · Race:
ID number	
Date of registration as dependant	Y Y Y Y M M D D

Child dependant - until age of 25 years

Surname	
Full Names	
Date of birth	Y Y Y Y M M D D · Gender: · Race:
ID number	
Date of registration as dependant	Y Y Y Y M M D D (Please attach a copy of Birth Certificate)
Relationship to principal member	

Adult dependant - 25 years and older

Surname	
Full Names	
Date of birth	Y Y Y Y M M D D · Gender: · Race:
ID number	
Date of registration as dependant	Y Y Y Y M M D D (Please attach a copy of ID document)
Relationship to principal member	
Dependant’s membership from previous medical aid, if any	

MEDICAL QUESTIONNAIRE

Complete the following by ticking YES (Y) or NO (N)

Full Names	· Surname:
Date of birth	Y Y Y Y M M D D · Gender:
ID number	
Date of registration as dependant	Y Y Y Y M M D D (Please attach a copy of Birth Certificate)

Question	Y	N
1. Heart and circulation. Includes high blood pressure, heart valve problems, blocked blood vessel, stroke, blood clots, rheumatic fever, varicose veins, heart rhythm problems, ischemic heart disease, etc.	Y	N
2. COPD / Chronic bronchitis / Emphysema. Includes asthma, recurrent infections such as bronchitis and pneumonia, sinus problems, emphysema, tuberculosis, disease that makes breathing difficult, tonsillitis, adenoid problems, snoring and sleep apnoea, etc. If any beneficiaries smoke, this must be indicated.	Y	N
3. Cancer. Includes all types of cancer and their treatments.	Y	N
4. HIV/Immune deficiencies. include all immune deficiencies, cancer-related immune suppression, use of drugs that lowers the immune systems capabilities such as chemotherapy, continuous use of cortisone, HIV, AIDS, etc.	Y	N
5. Pregnancy. Includes if you are currently pregnant or suspect that you are pregnant, previous pregnancy-related problems such as high blood pressure, miscarriage, caesarean section, etc.	Y	N
6. Other. Includes any serious medical condition that needed treatment in the 12 months. Rather list problems that you think are irrelevant than not to mention them.	Y	N

Continue Next Page

CHANGES IN MEMBERSHIP STATUS

MEMBERSHIP NUMBER

Please elaborate on the questions answered "YES" above and mention for whom it is

PREVIOUS MEMBER STATUS

Note: This section is not applicable on corporate group members

IMPORTANT: If the applicant is currently a member / dependant of a medical scheme or was a member / dependant of a medical scheme for the past two years, please furnish a **CERTIFICATE OF MEMBERSHIP** together with the application form (not a member card)

Is or the applicant a Member / Dependant of a medical scheme If "YES" please state	Y	N

SCHEME'S PARTICULARS		STATUS		PERIOD	
Name of scheme	Member number	Member	Dependant	From	To

Is or was the applicant subject to any restriction / exclusions on another medical scheme?	Y	N

If "YES" please state the names of the principal member / dependant in question and the nature of the restriction / exclusions

CANCELLATION OF DEPENDANT 1

Race - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured

Surname															
Full Names															
Date of birth	Y	Y	Y	Y	M	M	D	D	Gender		Race				
ID number															
Date of deletion	Y	Y	Y	Y	M	M	D	D							
Reason															

CANCELLATION OF DEPENDANT 2

Race - **A** = African/Black, **I** = Indian/Asian **W** = White **C** = Coloured

Surname															
Full Names															
Date of birth	Y	Y	Y	Y	M	M	D	D	Gender		Race				
ID number															
Date of deletion	Y	Y	Y	Y	M	M	D	D							
Reason															

CHANGES IN MEMBERSHIP STATUS

MEMBERSHIP NUMBER

RETIREMENT / EARLY RETIREMENT / RETIREMENT DUE TO INDISPOSITION / DISABILITY

Date of retirement / disability	
Reason for retirement / disability as set out in the heading	
Effective date of retirement on membership	

Does the retiree want to retain his / her membership with the scheme after retirement?	Y	N

If "YES", please supply us with banking details

Bank			
Branch Code		Branch	
Account number			
Name of account holder			
Type of account (e.g. current, savings)			

DEATH OF MEMBER

Date of birth	Y	Y	Y	Y	M	M	D	D	
Employer, if applicable, of surviving spouse									
ID number of surviving spouse													

(Please attach hereto a copy of the death certificate and a copy of the surviving spouse's ID document)

Does surviving spouse retain his / her membership of the scheme	Y	N

If "YES" please supply us with banking details

Bank			
Branch Code		Branch	
Account number			
Name of account holder			
Type of account (e.g. current, savings)			

REMARKS / ADDITIONAL INFORMATION

Member Signature

Date | Y | Y | Y | Y | M | M | D | D |

Namestamp of employer

Human Resource Manager / Practitioner Signature

Date | Y | Y | Y | Y | M | M | D | D |