OMSMAF
OLD MUTUAL STAFF MEDICAL AID FUND

Administered by Universal Healthcare (Pty) Ltd
Universal House, 15 Tambach Road, Sunninghill Park, Sandton, 2191
PO Box 1411, Rivonia, 2128, South Africa
Tel +27 (11) 208 1000, Fax +27 (11) 208 1128
www.universal.co.za

Add/Remove Dependant(s)

Please complete in BLOCK LETTERS using black or blue ink.

This form is issued without admission of liability and must be signed by the claimant and forwarded to:

Tel	0860 100 076 or +27 11 208 1021
E-mail	membership@omsmaf.co.za
Fax number	0862 106 635
Postal Address	Old Mutual Staff Medical Aid Fund, PO Box 1411, Rivonia, 2128

MAIN MEMBER'S DETAILS

Membership Number:

Surname:

Name(s):

Staff code:

A1. ADD DEPENDANT(S)

If your membership details change, for example, you get married or have another child, you must notify the Fund within 30 days, or a waiting period will apply during which no benefits will be paid for that dependant.

Documentation required for the classification of dependant

• Married in terms of any law or custom, if surnames differ	Copy of marriage certificate or other appropriate proof
• Birth/adoption of a child	Copy of birth certificate or adoption papers
• Child placed in custody	Copy of birth certificate and court order
• Partners	Signed affidavit (An affidavit can be requested to be sent to you by contacting 0860 100 076 or +27 11 208 1021 or emailing enquiries@omsmaf.co.za/membership@omsmaf.co.za)
• Indigent parents/siblings	Signed affidavit (An affidavit can be requested to be sent to you by contacting 0860 100 076 or +27 11 208 1021 or emailing enquiries@omsmaf.co.za/membership@omsmaf.co.za)
• Over-age dependant children (21-30)	Signed affidavit (An affidavit can be requested to be sent to you by contacting 0860 100 076 or +27 11 208 1021 or emailing enquiries@omsmaf.co.za/membership@omsmaf.co.za)

Dependant information

1.
Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

Date from when dependant should be registered: (DD/MM/YYYY)

2.
Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

Date from when dependant should be registered: (DD/MM/YYYY)

3.

Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

Date from when dependant should be registered: (DD/MM/YYYY)

4.

Title: Initials: Identity/Passport number:

Surname:

Name(s):

Date of birth: (DD/MM/YYYY) Gender: Male Female

Relationship: Spouse Son Daughter Other

Date from when dependant should be registered: (DD/MM/YYYY)

Do waiting periods apply to new members and dependants?

Yes, waiting periods apply to new members and dependants individually.

- No waiting period will apply for new employees who apply to join the Fund within 90 days of first becoming an employee of Old Mutual or within 90 days of their return to employment after a period of unpaid leave or secondment.
- No waiting period will apply to a dependant whose application is submitted within 30 days after they became eligible to join the Fund as a dependant.
- No waiting period will apply to children born into the Fund, in other words, children who were born while you were a member of the Fund, provided that the new-born or adopted child is registered within 30 days from birth or adoption finalization.
- No waiting period will apply to an employee who undergoes a life-changing event and applies to join the Scheme within 30 days from the life-changing event taking place. A life-changing event is defined as divorce, marriage, retrenchment, a spouse's or partner's change of employment, or death. Proof of such an event needs to be provided.

Waiting periods will apply as follows:

- If you have never been a member or dependant of a medical scheme or were not covered for a period of more than 90 days immediately before applying to the Fund, the Fund may impose the general waiting period and the condition-specific waiting period (if the beneficiary suffers from a pre-existing condition). In this case the waiting periods will also apply to Prescribed Minimum Benefits.
- If you have been a member or dependant of a medical scheme for less than 24 months and you apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), a condition-specific waiting period will apply. If the beneficiary suffers from a pre-existing condition, the Fund may also impose any unexpired balances imposed by the previous scheme. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits.
- If you have been a beneficiary of a medical scheme for more than 24 months and apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), the general waiting period will apply. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits.

Late joiner penalties:

A Late Joiner penalty will be applied to any dependant over the age of 35, who has not been on a medical scheme before. Please refer to the member guide for more information.

Years without medical cover Late joiner penalty (L JP) payable:

Term	Penalty Payable
1 – 4 years	5% of contribution
5 – 14 years	25% of contribution
15 – 24 years	50% of contribution
25 + years	75% of contribution

Previous medical history

Are/were you or any of your nominated dependants, beneficiaries of a registered medical scheme(s)? Yes No

If "yes", a certificate of membership with an end date **(not a membership card)** must be attached to this application. Waiting periods apply.

A2. MEDICAL HISTORY AND GENERAL HEALTH QUESTIONS

To be completed by each applicant in respect of him/herself and all his/her dependants. Please complete all required information by ticking the correct box. If the answer to any question is "yes", please provide details in section B3 in respect of you and your dependants.

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

1.	**Are you or any of your dependants currently pregnant?**		**Yes**		**No**
	Name of person:				
	No. of months:				
2.	**Have you or any of your dependants ever had the following? If "yes", provide full details in section B3.**			**Yes**	**No**
2.1	Any disorder of the heart (e.g. heart attack, rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations)?				
2.2	High blood pressure or disease of the blood vessels (e.g. raised cholesterol, stroke or circulatory disorder)?				
2.3	Any respiratory or lung trouble (e.g. asthma, bronchitis, persistent cough, tuberculosis)?				
2.4	Any disease or disorder 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)?				
2.5	Any disease or disorder of 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)?				
2.6	Any nervous or mental complaint (e.g. chronic headaches, trigeminal neuralgia, epilepsy, migraine, blackouts, loss of consciousness, paralysis, anxiety disorder or depression)?				
2.7	Any ear, eye, nose or throat disorder (e.g. ear discharge, defective vision, recurrent tonsillitis, swollen glands, persistent mouth sores, cataracts or any hereditary eye disease, functional nose impairment, chronic sinusitis)?				
2.8	Any disease or disorder of the muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout, slipped disc) or other back problems?				
2.9	Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder?				
2.10	Any lumps, growths (benign or malignant), types of cancers (incl. Hodgkin's and leukaemia), skin cancers or skin disorders?				
2.11	Any disease or disorder of the muscles, bones, joints, limbs, spine (e.g. rheumatism, arthritis, gout, slipped disc) or other back problems?				
2.12	Diabetes, sugar in blood or urine, thyroid or other glandular or blood disorder?				
2.13	Any lumps, growths (benign or malignant), types of cancers (incl. Hodgkin's and leukaemia), skin cancers or skin disorders?				
3.	**Have or are you or any of your dependants receiving surgical, medical, major dental implants, chiropractic, optical or gynaecological treatment, procedures, advice or tests?**		**Yes**		**No**
4.	**Do you or any of your dependants have any physical (incl. dental) abnormality, deformity, handicap or defect, whether congenital or as a result of an accident, disease or some other cause? If, "yes", please provide full particulars in section B3.**		**Yes**		**No**
5.	**Do you or any of your dependants currently use medication on a daily basis?**		**Yes**		**No**
6.	**Has your weight or the weight of any of your dependants changed by more than five (5) kg in the last 12 months? If so, why?**		**Yes**		**No**
7.	**Do you or any of your dependants suffer from any other ailment or disease at present? If, "yes", please provide full particulars in section G.**		**Yes**		**No**
8.	**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 or other conditions including pregnancy for which advice has been sought or treatment has been received or recommended during the past five (5) years? If, "yes", please provide full particulars in section B3.**		**Yes**		**No**
9.	**Are you or any of your dependants expecting to undergo any procedure, operation, confinement or receive any major dental treatment during the next 12 months? If, "yes", please provide full particulars in section B3.**		**Yes**		**No**

If you answered "yes" to any of the questions in section A2 above, please provide details in section A3. If additional space is required, please attach a separate sheet of paper to this document.

A3. ADDITIONAL MEDICAL INFORMATION

	Dependant name	**Dependant name**	**Dependant name**
Question number:			
Type of illness/condition (diagnosis):			
Date on which illness began:			
Frequency of attacks (hourly/daily/weekly):			
Date of last attack:			
If hospitalised, when and how many days:			
Duration of illness and condition:			

Treatment and/or type of medication in the past:			
Question number:			
Treatment:			
Condition			

Current treatment and/or type of medication received:			
Treatment:			
Condition:			

Approximate monthly cost of treatment/type of medication:			
Treatment:			
Condition:			
Details of operation previously performed:			
Operations and/or treatment needed in future:			
Name of attending doctor:			

Additional information:

B. TERMINATION OF DEPENDANT(S)

You are required to inform the Fund 30 days before the date on which you want a dependant to be de-registered.

Dependant name	Date of de-registration	Reason

C. DECLARATION BY THE APPLICANT

In terms of the Rules of the Fund in which I am participating as a member, I hereby nominate the dependant(s) specified in section B1 on page 2 of this form for participation and request the Fund to admit such dependant(s) in said Fund.

I warrant that all the answers given in this application are true, correct and complete in every respect.

I undertake to disclose to the Administrator any material alteration to the facts disclosed in this application and any change in my state of health or that of my dependants which may occur between the date of signature of the application by me and the date of receiving written acceptance of this application, and that such notification shall give the Fund the right to reconsider the application and to process new terms of acceptance. I am also aware that my membership shall not commence unless the Fund notifies me in writing of their acceptance of the risk. I accept that the failure to make such disclosure will render my membership null and void, benefits may be reversed and any monies paid to the Fund shall be forfeited to the Fund.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risk and the consideration of any claim for benefits in respect of the membership, I hereby authorise any healthcare provider and any other person who may be in possession of any information concerning my health or that of any of my dependants to disclose the information to the Fund or its authorised Representative and its contracted third parties. A photostat copy or facsimile of this authorisation shall be considered as effective and valid as the original.

I am aware of the fact that on joining the Fund during the course of the calendar year, the maximum benefits to which I may be entitled, shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular benefit year.

I agree that any amounts due by me, may be offset against any amounts due to me by the Fund.

Upon termination of membership of the Fund, I agree that the Fund may deduct any amount due to the Fund by me from any monies due to me. If I resign from the Fund during a benefit year and have used the annual PMSA benefit to such an extent that there is an outstanding debt to the Fund, this debt will become fully due on the date of termination of my membership.*

I confirm that I am familiar with the conditions and benefits of the Fund. I declare that neither I nor my nominated dependants are covered by any other medical aid scheme.

I declare that I will inform the Fund of any change of income including additional income.

I undertake to cancel my membership with the Fund or that of my nominated dependants immediately upon becoming a member or a dependant of another medical aid scheme.

Signed at: (PLACE) _____ on the (DD) _____ day of (MM/YYYY) _____

Signature of applicant

_____

*Recovery of overspent PMSA balances

If you resign from the Fund during a benefit year and you have used the annual PMSA benefit to such an extent that there is a debt, this debt will become fully due on the date of termination of membership. This practice is supported by the Rules of the Fund.

The Fund will attempt to collect any outstanding debt from your payroll department. If unsuccessful, The Fund will notify you in writing and telephonically of any outstanding debt.

The Fund will notify you in writing and telephonically of any outstanding debt when you resign from the Fund. This outstanding debt will become fully due on notification of your resignation. Such communication will be delivered to your last known contact details either via electronic media or post.

The Fund will transfer all unsettled accounts to its Debt Recovery Service Provider within 120 days of resignation from the Fund. Unsettled accounts will incur recovery costs once handed over to the Debt Recovery Service Provider.

PROTECTION OF PERSONAL INFORMATION

Old Mutual Staff Medical Aid Fund takes the protection of Personal Information very seriously and for this reason we take all reasonable measures to protect your Personal Information and to keep it confidential. Personal information refers to information that identifies or relates specifically to you, for example, your name, age, gender, health status, identity number and your email address. In short, any information that we know about you will be regarded as your Personal Information.

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

- Underwriting
- 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.