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
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Application for Membership – Continuation Member

Please complete in BLOCK LETTERS

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

OMSMAF Contact Centre

Tel	0860 100 076 / +27 11 208 1021
E-mail	register@medscheme.co.za
Fax number	0860 111 783 / +27 11 758 7087
Postal Address	Old Mutual Staff Medical Aid Fund, PO Box 74, Vereeniging 1930

The Fund allows for the continuation of membership for:

1) Active members who retire from Old Mutual may continue to belong to the Fund as continuation members.
2) If the main member of the Fund passes away, his/her dependants may choose to remain with the Fund as continuation members.

MAIN MEMBER'S DETAILS

Main Member Name(s):

Surname:

Membership number:

Registration date: (DD/MM/YYYY)

INFORMATION

The dependants of a deceased member, who are registered with the Fund as his dependants at the time of such member's death, shall be entitled to membership of the Fund without any new restrictions, limitations or waiting periods. Provided such dependant notifies the Fund within three (3) months of the death of the member of his/her intention to obtain membership of the Fund, such dependant will be admitted as a member of the Fund.

If the principal member passes away, dependants have the choice to become continuation members. In such a case, the Fund needs to receive the following documents within three months of the member's date of death to ensure continuation membership for the dependants:

A. Copy of the death certificate of the principal member.
B. Copy of the ID of the surviving spouse/ beneficiary.
C. Copy of bank statement to upload bank details for debit order/refund purposes.
D. Proof of income of the continuation member who will become the new main member - SARS assessment (ITA34) or Fund affidavit.

The Fund's benefit year runs from 1 July to 30 June of the following year. If your application is submitted to the Fund during the benefit year, you will remain on the same Medical Plan until the end of the benefit year. You have an opportunity to review and change your choice of Plan at the start of the new benefit year on 1 July each year. Once you have selected a Plan for the benefit year, you will not be allowed to change your Plan during the benefit year.

Please refer to your Member Guide for a comparison of the benefits offered by the Fund. Your Member Guide provides detailed information about the benefits and the administration of the Fund.

The Fund offers medical aid benefits to qualifying members and their dependants. There are clear guidelines as to who qualifies to receive benefits, especially relating to dependants and you will need to provide certain documentation to prove their dependency on you. Your monthly contribution will increase as the number of your dependants increases. Please refer to the contribution tables in your Member Guide.

You will no longer be a member of the Fund if:

- You die (your dependants may continue as members of the Fund); and/or
- You join your spouse's or partner's medical scheme as a dependant.

Medical aid contributions are paid in arrears for Pencare members and in advance via debit order for direct-paying members.

- If your membership is terminated up to and including the 14th of the month, no contribution will be due for that particular month and you will be entitled to benefits until the date of termination.
- If your membership is terminated on the 15th or later of a month, a full contribution for that month will be due and you will be entitled to benefits until the end of the month.

A. APPLICANT'S INFORMATION

Identity number: Title:

Surname:

Name(s):

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

Marital Status:

Contact number: H Cell

W Fax

E-mail address:

Postal address:

Code

Home address:

Code

B. EMPLOYMENT DETAILS

Occupation:

Income bracket: ☐ R0 – R5 040 ☐ R5 041 – R7 560 ☐ R7 561 – R10 090 ☐ R10 091 – R13 470

☐ R13 471 – R19 970 ☐ R19 971 – R33 300 ☐ R33 301+

Additional income: Please declare all forms of income (e.g. retirement, investment, other). Non-disclosure will lead to a default to the highest income band until such proof is provided.

In respect of retirees (continuation members), income will be the value of the last salary received from the employer. Confirmation of such income may be required from time to time in the form of a copy of your South African Revenue Services tax return.

C. BANKING DETAILS FOR PAYMENT OF CONTRIBUTIONS VIA DEBIT ORDER

Please check that all your details are correct and attach supporting documentation e.g. a cancelled cheque, a copy of a bank statement etc.

Account holder's name:

Bank's name:

Branch name & town:

Branch code: Account type: ☐ Cheque ☐ Savings ☐ Transmission

Account number:

I hereby authorise you to pay any medical aid fund benefit that may be due to me to the above-mentioned bank account or any other bank account which I might change to in future.

D. BANKING DETAILS FOR CLAIMS REFUNDS

☐ Please check box if your banking details for claims refunds are the same as your banking details for **debit order** above

Please check that all your details are correct and attach supporting documentation e.g. a cancelled cheque, a copy of a bank statement etc.

Account holder's name:

Bank's name:

Branch name & town:

Branch code: Account type: ☐ Cheque ☐ Savings ☐ Transmission

Account number:

I hereby authorise you to pay any medical aid fund benefit that may be due to me to the above-mentioned bank account or any other bank account which I might change to in future.

E. DECLARATION BY THE APPLICANT

I, the undersigned, hereby make application to be admitted as a continuation member of the Fund. If admitted, I agree to abide by the Rules of the Fund. 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 Fund shall be forfeited to the Fund.

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

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 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.