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

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	membership@omsmaf.co.za
Fax number	0864 647 808 / +27 11 758 7087
Postal Address	Universal House, 15 Tambach Road, Sunninghill Park, Sandton, 2191

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 2021/22 benefit year will commence on the 1st of July 2021 and run to the 31st of March 2022. This will be a 9-month benefit year. As the Fund aligns the future benefit year start date with the employer's salary review, the 2022/23 benefit year will run from the 1st of April 2022 to the 31st of March 2023, a 12-month benefit year. If a person joins the Fund during the benefit year they will receive pro rata benefits. The same applies if there is a movement in membership for example the addition or removal of a dependent, benefits will be adjusted and prorated accordingly.

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 280
- R5 281 - R7 920
- R7 921 - R10 570
- R10 571 - R14 110
- R14 111 - R20 920
- R20 921 - R34 890
- R34 891 - R52 380
- R52 381+

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.

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.

I accept the terms and conditions as set out in the section below “PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION”.

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 YOUR PERSONAL AND HEALTH INFORMATION

This Section explains how Old Mutual Staff Medical Aid Fund (the Fund) collects, uses, shares and processes your personal information that you give to the Fund, and this information may include your health and benefit information ("Personal Information"), in terms of the Protection of Personal Information Act, 4 of 2013 ("POPI").

It is important that you read and understand the terms of this Section carefully before accepting these terms and conditions. The acceptance of these terms and conditions is voluntary, but in order to activate your Fund membership, these terms and conditions must be accepted by yourself and your dependants. If you do not accept these terms and conditions, we will not be able to provide you with the full range of our medical scheme services.

It is also important to note that when you accept these terms and conditions, you provide the Fund with your consent and the consent of your dependants, registered on your membership, to activate your personal health record and enrol you on any managed healthcare programmes for your and your dependants' healthcare benefit.

Terms and Conditions:

1. The Fund collects, uses, processes, retains and shares your and your dependants' personal information for the purpose of providing medical scheme benefits and managed healthcare services to you and your dependants. This includes the collecting and sharing of your and your dependants' personal information with our third-party healthcare partners, facilities and associated partners of the Fund, who are essential to the membership process.
2. The personal information of you and your dependants may also be shared with emergency service providers, including hospital facilities, in medical emergency situations that may result in serious bodily impairment, dysfunction or death.
3. The Fund, its administrator and its managed care organisation will keep all personal information of you and your dependants given to us in this application or collected from other sources, confidential and will only provide the personal information to additional third parties not involved in the administration of your membership or healthcare needs, with your consent.
4. You confirm that when you provide us with your personal information and that of your dependants, you have the appropriate permission to disclose their personal information to us for the purposes of receiving medical scheme benefits and related services. In the event of your providing personal information and consent on behalf of a minor dependant person younger than 18 years old, or adult dependant unable to provide their own consent, or any person registered as a dependant on your membership, you confirm that you are authorised to do so on their behalf.
5. You agree to us processing (which shall include collecting, collating, processing, storing, disclosing and retaining) your and your dependants' personal information):
    a. for the administration of your benefit option;
    b. for providing managed healthcare services to you or any dependant/s based on your benefit option;
    c. for providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your benefit option;
    d. for academic research conducted by the Fund, contracted third parties of the Fund, its marketing agents, affiliates and partners;
    e. for any managed healthcare programme or initiative that will benefit you or your dependants in managing any healthcare condition and optimise your medical scheme benefits; and
    f. to activate your personal health record and prepopulate your personal health record with your health and personal information, from the previous 12 months.
6. You acknowledge that your personal information may be stored in a secure web-based facility, where we endeavour to ensure that your personal information is kept confidential at all times.
7. You acknowledge that you have the right to contact the Fund at any time to update, correct or delete your personal information. You and your dependants can update or correct your information at any time by logging on to www.omsmaf.co.za.
8. You have the right to object to the processing of your personal information at any time and revoke any consent you have given for yourself or your dependants. Please contact the Fund to do so.
9. You have the right to request a copy of the personal information we hold about you. Please contact us to find out how to request your personal information.
10. Please note that these terms and conditions may be changed from time to time; please check the OMSMAF website for an updated version.
11. Should you believe that we have used your personal information in a way that is against POPI or without your consent, please contact us immediately to resolve the problem.
12. The terms and conditions applicable to the personal health record can be found on our website at www.omsmaf.co.za, and it is your responsibility to ensure you have read and understood the terms and conditions.

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Affidavit Form: Declaration of Income

If you are exempted from submitting a SARS tax return or cannot provide a tax return/assessment, please complete the following affidavit. A Commissioner of Oaths must sign this affidavit.

Main Member Name:

Surname:

ID Number:

Membership Number:

My total monthly income* is currently R

I acknowledge that the Fund's definition of income for retirees is the value of the last salary received from the Employer. This declaration confirms that my income* has changed to the aforementioned amount since the date of my retirement.

** Income includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (including self-employment and informal employment), pension and annuity proceeds, interest earned on active and passive investments, including rental income from leasing properties and distributions received from a trust.*

I, the undersigned, hereby warrant that all information given in this declaration is true, correct and complete in every respect.
I accept the terms and conditions as set out in the section below "PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION".

Member's signature:

Date:
(DD/MM/YYYY)

A Commissioner of Oaths must complete this section.

Commissioner Name:

Signature: Commissioner of Oaths

STAMP