# Rand Water Medical Scheme

RAND WATER

**Form No. RW MED.AID 02001 F**
**Revision No: 05**
**Effective date: January 2013**

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## New Application Form

| Medical Scheme No | | RDW Board No | |
|---|---|---|---|

## For Office use only

Date Processed _____

Name _____

Date Checked _____

Name _____

Date Membership Cards Processed and handed over to the member _____

Waiting Periods and Conditions _____

_____

_____

Date _____

Signed on behalf of the Board _____

**Please complete all relevant sections of this form in BLOCK CAPITALS throughout.**
**Specify your choices by ticking relevant boxes**

## Personal and Address Details

**(Certified Copy of ID Document for Adult Dependent/s and Birth Certificate for Child Dependent/s to be attached)**

Title Mr ☐ Mrs ☐ Ms ☐ Pro ☐ Dr ☐ Other (Specify) _____

Surname _____ Initial(s) _____

Full Name (s) _____ DOB _____

Preferred Names _____ ID _____

Marital Status Single ☐ Married ☐ Partnership ☐

If Married, indicate: Date _____

Home Code _____ No. _____ Cell No. _____

Work Code _____ No. _____ Fax Code _____ No _____

E-Mail Address _____

Postal Address _____ Postal Code _____

Residential Address (Physical Address) _____ Postal Code _____

## EMPLOYMENT DETAILS

**(Must be signed by authorised employee of Rand Water)**

Department employed with at Rand Water: _____

Position: _____

Physical Site Address Details: _____

_____

Date on which the Applicant commenced Permanent Employment at Rand Water: _____

Date on which the Applicant is eligible and would like to join the Rand Water Medical Scheme:

_____

Should the above two dates differ, please give reasons:

_____

Please note: it is the responsibility of the employee to ensure that the application form has reached the Medical Aid and is being processed accordingly. All required documents should be attached on submission if incomplete the application will be returned and processing not completed.

_____

## For office use –HR Office to Complete

**If the application is received and processed by the Medical Scheme after the 3rd of a month it may result in a double Deduction the following month.**

Please Note: Payment for the Medical Aid will be deducted from the Employee's Salary and is due in arrears and is raised from the month of commencement of employment. (see the date on p 3)

Pay point Number (52/10/53) _____

Board Number _____

Date Employed _____

I hereby declare that the employment details of this member have been verified as correct.

| | |
|---|---|
| Option A Option | |
| B Plus Income | |
| Category | |
| Salary Type: Cost To Company or Subsidy? | |

Date _____

Position of Authorised HR Employee _____

Signature of Authorised HR Employee _____

| SAP File Dates 2021 | |
|---|---|
| 08.01.2021 | 09.07.2021 |
| 08.02.2021 | 06.08.2021 |
| 08.03.2021 | 08.09.2021 |
| 09.04.2021 | 08.10.2021 |
| 07.05.2021 | 08.11.2021 |
| 08.06.2021 | 06.12.2021 |

## Banking Details
**Required to pay Funds Directly into your Bank Account**

Name of Bank

Branch Name | Branch Code

Account No.

Type of Account ☐ Cheque ☐ Savings ☐ Transmission

**Note: If these details are incorrect, the Scheme will not be able to refund claims electronically.**
**No credit card details will be accepted.**
**It should be noted that this is NOT a debit order mandate.**

**Please Attach: Original cancelled cheque OR Copy of bank statement OR Letter from bank with details of account for verification purposes.**

**PLEASE NOTE: ABSA BRANCH CODE (632005)**

## Dependents you wish to Register

| First Names (State Where Surname is Different) | Known As | Date Of Birth | Age | Sex | Relationship | Id Number | Date To Admit |
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**THE FOLLOWING DOCUMENTS NEED TO BE ATTACHED/RETURNED IN RESPECT OF DEPENDANTS REGISTERED WITH THE SCHEME:**

**(a) Certified copies of all main members & dependant's ID documents or birth certificates**
**(b) Medical Questionnaire**
**(c) Letter from the institution where each student dependant is studying**
**(d) Affidavit of guardianship or proof thereof in case of legal dependency**
**(e) Motivational form (this is only applicable if you would like to add your parent/s)**
**(f) Original letter from your bank or bank statement specifying your bank account and branch code.**
**(g) Common law spouse, affadvid required.**
**(h) Unabridged Birth Certificate if the surname of your child is not the same as yours.**
**(i) Affidavit for adding parents, siblings or grandchildren, as well as co-habitation**

## MEDICAL HISTORY

**Failure to disclose existing medical condition could limit and / or exclude you from receiving certain benefits, or result in the termination of your membership**

1. Do you or any of your dependants suffer from a chronic illness (e.g. raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and / or thyroid disorders) ? If yes, provide details. YES ☐ NO ☐

| Name of Beneficiary | Condition | Name of Medication | Are you currently receiving treatment? | Date of treatment | Attending Doctor |
|---|---|---|---|---|---|
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2. Do you or any of your dependants suffer from any gastro –intestinal disorders (e.g. gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorders, Crohn's disease, ulcerative colitis, diverticuilitis and / or a spastic colon)? If yes provide details. YES ☐ NO ☐

| Name of Beneficiary | Condition | Name of Medication | Are you currently receiving treatment? | Date of treatment | Attending Doctor |
|---|---|---|---|---|---|
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3. Do you or any of your dependants suffer from muscle, bone, skin or nerve illnesses or disorders (e.g. back- and neck-related conditions including injury, arthritis, gout, multiple sclerosis, knee or hip problems, osteoporosis, dermatitis etc.)? if yes provide details. YES ☐ NO ☐

| Name of Beneficiary | Condition | Name of Medication | Are you currently receiving treatment? | Date of treatment | Attending Doctor |
|---|---|---|---|---|---|
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4. Do you or your dependants suffer from any urinary or genital disorders (e.g. kidney stones, kidney failure, prostate, endometriosis, ovarian cysts, menstrual disorders)? If yes provide details. YES ☐ NO ☐

| Name of Beneficiary | Condition | Name of Medication | Are you currently receiving treatment? | Date of treatment | Attending Doctor |
|---|---|---|---|---|---|
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5. Do you or your dependants sufer from ear, nose or throat disorders (e.g. glaucoma, cataracts, visual disorders, deafness, rhinitis, orthodontics)? If yes provide details. YES ☐ ____ NO ☐ _____

| Name of Beneficiary | Condition | Name of Medication | Are you currently receiving treatment? | Date of treatment | Attending Doctor |
|---|---|---|---|---|---|
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## Medical Hisrory – Continued

6. Do you or any of your dependants suffer from any blood disorders, immune deficiency state, HIV /Aids, cancer, heamophyllia, etc.? If yes, provide details. YES ☐ NO ☐

| Name of Beneficiary | Condition | Name of Medication | Are you currently receiving treatment? | Date of treatment | Attending Doctor |
|---|---|---|---|---|---|
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7. Are you or any of your dependants pregnant? If yes, provide details. YES ☐ NO ☐

| Name of Beneficiary | Last menstrual period | Expected delivery date | Attending Doctor |
|---|---|---|---|
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8. Have you or any of your dependants had surgery in the past, or are you planning to have a surgical procedure in the next 12 months? If yes, provide details. YES ☐ NO ☐

| Name of Beneficiary | Type of Surgery | Date of Surgery | Are you currently receiving treatment? | Attending Doctor |
|---|---|---|---|---|
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9. Is there any other condition or symptoms not listed above, for which medical advice, diagnosis care or treatment has been recommended or received, or could potentially result in a medical claim in the next 12 months? If yes, provide details. YES ☐ NO ☐

| Name of Beneficiary | Condition | Name of Medication | Are you currently receiving treatment? | Date of treatment | Attending Doctor |
|---|---|---|---|---|---|
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Current Doctor - Name and Surname _____

Telephone _____ He or she has been my doctor for _____years.

## PREVIOUS MEDICAL SCHEME INFORMATION

Have you as the principal member, or any of your dependants had previous medical aid cover?
If yes, please give full details of your and / or your spouse / partner / adult depenants' membership of previous medical aid schemes.
It is important that you attach a copy of the most recent medical cover Certificate of Membership with a **resigned date** on it to this application form.

| Name of Beneficiary | Name of Scheme | Membership Number | Date Joined | Date Terminated |
|---|---|---|---|---|
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Are you changing your Medical Scheme due to Change of Employment? _____

Have condition-specific waiting periods, exclusions or general waiting periods ever been imposed by a previous medical scheme on application by you, your partner or any of your dependants? _____

# DECLARTION TO BE COMPLETED BY THE MAIN MEMBER

**THIS APPLICATION FORM WILL NOT BE VALID UNLESS EVERY QUESTION HAS BEEN ANSWERED AND THE MEDICAL HISTORY HAS BEEN COMPLETED AND INSERTED.**

1. I hereby apply for admission to membership of the Rand Water Medical Scheme(RWMS) in terms of the rules of the Scheme. I warrant that I have been advised that the Rules will be made available on request and I understand that I am responsible to read the Rules and any amendments to the Rules and that I am bound by them.
2. I warrant that the information I have provided pertaining to me and my dependants is true and correct. Should there be any non-disclosure or material misrepresentation, I understand that my membership may be terminated and that I may forfeit my contributions to RWMS and also RWMS has the right to claim damages it may suffer due to misrepresentation.
3. Should any of my or my dependants circumstances alter subsequent to the date of filling the application, but prior to to the acceptance of my membership by RWMS, I shall promptly notify RWMS of the change. I acknowledge that failure to do so may lead to the termination or amendment of the terms and conditions of my membership, and RWMS shall also be entitled to reclaim any amounts it may have erroneously paid to any service provider on my or my dependants behalf.
4. I authorise and instruct my employer to deduct and pay over any amounts (that may become due and owing on my behalf) to RWMS from time to time and also authorise any persons, bodies or institutions who may hold retirement funds for my benefit, to deduct and pay to RWMS all amounts that may become due and owing to RWMS from time to time. I agree that should RWMS incur any legal costs and expense to recover any contributions, I shall be responsible for such cost and expenses on the attorney/client scale.
5. Notwithstanding the above, I understand that it is my responsibility as a member to ensure that the monthly contributions are received by RWMS.
6. Should any contributions be unpaid, it may result in me and my dependants being suspended from RWMS until all arrear contributions have been settled. Should two months contributions be outstanding RWMS shall have the right to immediately cancel my RWMS membership. I also understand that should my membership be terminated I shall not be entitled to any benefits from my membership whatsoever.
7. I shall inform the scheme of any changes to my dependants health or personal status as required by the scheme rules, within 30 days of the change of circumstances.
8. I authorise my healthcare provider to disclose information to the scheme and its contracted third parties, provided such information is treated as confidential at all times.
9. I agree to provide RWMS with my medical or historical information or grant RWMS access to medical information reasonably requested pertaining to a particular ailment, disease, disorder, condition or disability.
10. I declare that my depndants are not beneficiaries of another registered medical scheme.
11. I understand that the following waiting periods may be applicable as prescribed by the Medical Schemes Act No 131 of 1998:
    11.1 A 3 (three) month wiaitng period in respect of all benefits
    11.2 A 12 (twelve) month waiting period in respect of pre-existing conditions
12. I authorise and permit RWMS to take all reasonable steps to verify information provided by me in this application form.
13. I agree to submit proof of identification to RWMS on demand.
14. I consent to my telephone conversations with RWMS being recorded and forming part of RWMS records. I also agree that such records shall remain the sole property of RWMS.
15. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of monies owing to RWMS.
16. I warrant the information provided above is true and accurate and should my application be accepted by RWMS, the contents of this application shall constitute the basis of my agreement with RWMS.
17. I hereby agree that: upon termination of my employment with RWMS, my membership with RWMS will terminate on the date of such termination, except in respect of Continuation membership as stipulated in the Rules of the Scheme

I acknowledge that I have read and understood the content of this application form. If I am illiterate, I confirm that the content of this registration form and the implications thereof have been read and explained to me.
All information declared shall be kept confidentially by RWMS.

Date: _____ Signature of Member: _____