Rand Water Medical Scheme	Form No. RW MED.AID 00001 F Revision No: 05 Effective date: January 2013

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Dependant Registration Form

Medical Scheme		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 ☑

Beneficiary Details
(Certified Copy of ID Document / Pasport to be attached)

Member Number		Rand Water Board No	
Member Initials		Member First Name	
Dependant 1			
Initial		First Name	
South African ID / Pasport No		Surname	
Date of Birth			
Relationship to principal Member		Preferred Name	
Gender (M=Male F=Female)		Maritial Status Single, Married, Domestic Partnership, Divorced, Widowed Other	
		Date of Marriage	
Contact Details if different from the Principal Member			
Telephone Home		Work	
Fax		Cell	
e-mail			
Postal Address			
		Code	

Dependant 2			
Initial		First Name	
South African ID / Pasport No		Surname	
Date of Birth			
Relationship to principal Member		Preferred Name	
Gender (M=Male F=Female)		Maritial Status Single, Married, Domestic Partnership, Divorced, Widowed Other	
		Date of Marriage	
Contact Details if different from the Principal Member			
Telephone Home		Work	
Fax		Cell	
e-mail			
Postal Address			
		Code	
Dependant 3			
Initial		First Name	
South African ID / Pasport No		Surname	
Date of Birth			
Relationship to principal Member		Preferred Name	
Gender (M=Male F=Female)		Maritial Status Single, Married, Domestic Partnership, Divorced, Widowed Other	
		Date of Marriage	
Contact Details if different from the Principal Member			
Telephone Home		Work	
Fax		Cell	
e-mail			
Postal Address			
		Code	

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.

MEDICAL HISTORY MAY BE SUBMITTED DIRECTLY TO SANLAM HEALTH OR RAND WATER MEDICAL SCHEME FOR CONFIDENTIALITY PURPOSES

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

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

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

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

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

Medical History – 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

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

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

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

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

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?
_____

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 parents, sibilings or children you do not have legal guardianship over)
(f) Original letter from your bank or bank statement specifying your bank account and branch code.
(g) Common law spouse, affadavid required.
(h) If the dependent has a different surname from the member please attached Unabridged Birth Certificate and an affadavit
(i) Affidavit for common law partnership

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 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 me or my dependant's 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 dependant's 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 dependants 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 waiting 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: _____