FEDHEALTH

Sanlam preferred healthcare provider

fedhealth member

APPLICATION FORM

EMAIL TO:
newapps@fedhealth.co.za

OR MAIL COMPLETED FORM TO:
Fedhealth Medical Scheme
Private Bag X3045
Randburg
2125

SECTION 1 CHOICE OF OPTION

Choose ONE product option by placing "x" in the appropriate box

maxiFED

☐ maxima **EXEC** ☐ maxima **PLUS**

myFED

☐ myFED*

- If your contribution is paid by your employer, please also complete section 6.
- If your contribution is not paid by your employer, please also complete section 11.

* Please also complete Section 10 for nomination of a Fedhealth network GP (General Practitioner).

sureFED

☐ sureFED Plus* ☐ sureFED Essential*

* Please also complete Section 10 for nomination of a Fedhealth network GP (General Practitioner).

flexiFED

☐ flexiFED 1* ☐ flexiFED 2* ☐ flexiFED 3* ☐ flexiFED 4

☐ flexiFED 1 Elect* ☐ flexiFED 2 Elect* ☐ flexiFED 3 Elect* ☐ flexiFED 4 Elect*

☐ flexiFED 2 GRID* ☐ flexiFED 3 GRID* ☐ flexiFED 4 GRID*

* Please also complete Section 10 for nomination of a Fedhealth network GP (General Practitioner).

flexiFED CHOICE OF DAY-TO-DAY

☐ **HOSPITAL PLAN**

☐ **FEDHEALTH SAVINGS PLAN**

I choose to select this option according to the recommended activation as per the flexiFED brochure and understand that this may be pro-rated as per my membership join date.

☐ **FEDHEALTH BACKUP SAVINGS PLAN**

Fedhealth Savings refers to the innovative MediVault and Wallet facility for day-to-day expenses

- I do not want to activate an amount now ☐
- I would like to activate the following amount: (Minimum R600) R
- I would like to activate my full Fedhealth Savings benefit ☐

Repayments are calculated at a maximum of 12 equal instalments based on the amount activated. I understand that the chosen amount may be pro-rated as per my membership join date:

- I wish to repay my Fedhealth Savings over 12 months ☐
- I wish to repay my Fedhealth Savings over ☐ number of months*

*This can be anything from 1 - 11 months

I wish to join the scheme from 0 1 m m y y y y

I choose: ☐ **Contribution collection in ADVANCE*** ☐ **Contribution collection in ARREARS***

* **Advance:** you will have access to benefits once contributions are received.
* **Arrears:** a minimum of 1 month general waiting period will apply.

SECTION 2 DETAILS OF PRINCIPAL MEMBER

Surname

Maiden name (if applicable)

Title First name/s

Preferred name Initials

Gender M F Date of birth d d m m y y y y Nationality

ID number Passport number, if no ID

Country of issue of passport

Income Tax Number

Telephone (H) ( ) Telephone (W) ( )

Cellphone number

Email address

Postal address

Postal code

Physical address

Postal code

Country

SECTION 2 DETAILS OF PRINCIPAL MEMBER (CONTINUED)

You can find your e-card on the Fedhealth Member App and the Fedhealth WhatsApp Service.

Have you had previous medical aid cover? Yes No

Are you changing your medical scheme due to a change in your employment? Yes No

If yes, please provide details below

Name of previous medical scheme/s	Membership number	Date joined	Date left

PLEASE [x] – FOR STATISTICAL PURPOSES ONLY Ethnic group Black | Coloured | Indian | White | Asian Marital status Single | Married | Divorced | Widowed | Common law partner/spouse

SECTION 3 INTERMEDIARY/FINANCIAL ADVISER

This section must be signed by the broker/agent/adviser if applicable

Broker code 21038 FSCA number 7761

Name of brokerage Classique Medical Aid Consultants

Name of broker/agent/adviser Shamiem Ahmed

Telephone (W) 021 797 8885 Cellular

Email address enquiries@classmed.co.za

Postal address

Physical address 7 Torrens Road, Golf Links Estate, Wynberg 7800

FINANCIAL ADVISER DECLARATION

1. I hereby acknowledge that I am an accredited Fedhealth Financial Adviser and that I am licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act 37 of 2002.
2. I acknowledge that the applicant has appointed me as his/her financial adviser and that the applicant is entitled to cancel my services at any time.
3. I confirm that the applicant was provided with my personal details, physical and postal address and telephone number.
4. I acknowledge that a monthly commission of 3% of the total monthly contribution up to a maximum, as legislated from time to time, will be paid to me in terms of the Medical Schemes Act 131 of 1998 (or as amended).
5. I confirm that there has been no material misrepresentation of any fact by me and that in the event of material misconduct or unlawful conduct, I undertake to refund all monies paid in consequence of such misrepresentation or conduct.
6. The applicant is familiar with the information requested in the application form and all the relevant information was provided by the applicant.
7. The applicant is familiar with the information relating to the Protection of Personal Information Act (POPIA) as displayed on www.fedhealth.co.za and;

7.1. I, the Member give consent for the Financial Advisor to have access to my data relating to:

1. Personal Information Yes No
2. Benefits Yes No
3. Financial Information Yes No
4. Medical Information Yes No
5. Fund Documents Yes No

Member signature: .....

(Member must sign acknowledgment on Broker section.)

Date d d m m y y y y

8. The advice and assistance given to the applicant was impartial and in the best interest of the applicant.
9. The applicant has personally signed the application form.
10. I acknowledge that a member must complete a broker note in the event of a member account transfer from a company exclusive broker appointment to an individual membership account.

Broker's/agent's/adviser's signature .....

Date d d m m y y y y

SECTION 4 DETAILS OF YOUR SPOUSE/PARTNER YOU WISH TO REGISTER

I confirm that I am authorised to provide and disclose the personal information of this listed dependant to the Scheme for the purpose of receiving benefits and related services.

SPOUSE/PARTNER Surname

Maiden name (if applicable)

Title First name/s Preferred name

Cellphone number Email address Initials

Relationship to principal member Gender M F Date of birth d d m m y y y y

ID number Nationality

Country of issue of passport

Passport number, if no ID Income Tax Number

Has this dependant had previous medical aid cover? Yes No *If yes, please provide details below*

Name of previous medical scheme/s	Membership number	Date joined	Date left

SECTION 5 DEPENDANTS YOU WISH TO REGISTER

I confirm that I am authorised to provide and disclose the personal information of these listed dependants to the Scheme for the purpose of receiving benefits and related services.

	1 Adult ☐ Child* ☐	2 Adult ☐ Child* ☐
Title	Initials / Relationship to member	Initials / Relationship to member
Surname		
First name/s		
Preferred name	Marital status	Marital status
ID number/passport number		
Nationality		
Country of issue of passport		
Income Tax Number		
Date of birth	d d m m y y y y Gender M F	d d m m y y y y Gender M F
Email address	Cell	Cell

** Child dependant = the member's dependent child up to the age of 27.*

	3 Adult ☐ Child* ☐	4 Adult ☐ Child* ☐
Title	Initials / Relationship to member	Initials / Relationship to member
Surname		
First name/s		
Preferred name	Marital status	Marital status
ID number/passport number		
Nationality		
Country of issue of passport		
Income Tax Number		
Date of birth	d d m m y y y y Gender M F	d d m m y y y y Gender M F
Email address	Cell	Cell

** Child dependant = the member's dependent child up to the age of 27.*

Please note:

- For any dependant, other than your biological children, please supply supporting legal documentation of adoption or foster arrangement; as well as an affidavit confirming residency, income, employment and marital status of both child and natural parents.
- For adult dependants, please supply an affidavit confirming residency, marital status, employment status and income.

SECTION 6 EMPLOYER INFORMATION

This section must be completed by your employer only if employer pays your contribution

Name of employer

Employee number

Employment date d d m m y y y y

Division code

Dept. name

Persal number *if applicable*

Fedhealth paypoint code

Medical scheme start date 0 1 m m y y y y

We confirm that the applicant is employed by us and commenced employment on the above date

Name of salary administrator

Designation

Monthly salary of myFED applicant

Company stamp

Signature .....

Date signed d d m m y y y y

SECTION 7 BANK DETAILS OF PRINCIPAL MEMBER *Refund of claims and debit order instruction*

I hereby instruct Fedhealth to electronically collect contributions and Fedhealth Savings instalments as a single debit order and to deposit refunds, using the information provided below (Direct Paying Members only). Should the collection date fall on a public holiday, the Scheme reserves the right to collect prior to or after the holiday. I understand that transfers cannot be done to and from credit card accounts. I hereby authorise Fedhealth to reverse any erroneous transactions and/or rectify any EFT errors without prior notice.
Note: Direct paying members can select from the following dates for debit order collections:

☐ **1st of the month** ☐ **5th of the month** **OR** ☐ **25th of the month**

Should you miss a payment, Fedhealth reserves the right to deduct on a different date to collect the missed premium. Bank charges will apply for rejected debit orders.
The debit order collection description will have the following prefix before your membership number for **current** contribution collections: FDHSUBS, for **arrear** contribution collections: FDHARR and a Fedhealth Savings instalment collection: FDHVLT for arrears, or for a single debit order collection FDHSUBSVLT. Any arrear collection will include ARR with previous abbreviates.

Due to changes in cross-border payment regulations within the Common Monetary Area (CMA), which includes South Africa, Namibia, Lesotho, and Eswatini, Fedhealth can no longer debit your account. Payments must now be paid directly into the Scheme bank account.
Nedbank SA,
Account number: 1984563009, Branch Code:198405.

☐ 1. USE THIS ACCOUNT FOR ALL COLLECTIONS INCLUDING FEDHEALTH SAVINGS INSTALMENTS AND REFUNDS

☐ 2. USE THIS ACCOUNT FOR ALL COLLECTIONS ONLY
NB: If you tick this option, you must complete bank details for claims refunds on the right.

Bank name	
Branch name	
Bank branch code	
Type of account	Cheque / Transmission / Savings
Name of account holder	
Bank account number	

☐ USE THIS ACCOUNT FOR REFUNDS ONLY
NB: If you ticked no. 2 on the left, bank details must be completed here.

☐ USE THIS ACCOUNT FOR FEDHEALTH SAVINGS DEDUCTIONS ONLY

Bank name	
Branch name	
Bank branch code	
Type of account	Cheque / Transmission / Savings
Name of account holder	
Bank account number	

If only one bank account is provided, it will be used for both collections and refunds.

Account/s holder's signature ..... Date d d m m y y y y

3rd Party Payor

Should a third party pay the contribution and/or Fedhealth Savings instalment on your behalf, the following supporting documents are required, certified by a commissioner of oaths and not older than three months:
- Account holder's identity document
- Account holder's bank statement
- Account holder's letter of authority to the Scheme to deduct contributions on behalf of the member. This also needs to include the relationship of the account holder to the principal member as well as a physical address, and where an individual, their Income Tax Number.

3rd Party Details

Surname			
Title		First name/s	
Physical address			
Relationship to principal member		Nationality	
ID number		Passport number, if no ID	
Country of issue			
Income Tax Number		Company registration number	

SECTION 8 DISCLOSURE OF HEALTH CONDITIONS IMPACTING FUNCTIONALITY/DISABILITY DISCLOSURE

Details of person(s) living with a disability

First name/s			
Initials		Surname	
Date of birth	d d m m y y y y	ID number	
Passport number, if no ID			

Description of Disability

Disability Type *(Please tick the applicable box)*
☐ Hearing Disability ☐ Intellectual Disability ☐ Mental Disability
☐ Physical Disability ☐ Speech Disability ☐ Vision Disability

Nature of Disability *(Please tick the applicable box)*
☐ Temporary ☐ Permanent

Limitation *(Please tick the applicable box)*
☐ Mild ☐ Moderate ☐ Severe

Start Date d d m m y y y y End Date d d m m y y y y

Treating Provider Details

Practice number		Name(s)	
Initial(s)		Surname	
Cellphone		Telephone	( )
Practitioner Email			

Should this space be insufficient, please attach a separate sheet.

SECTION 9 MEDICAL DETAILS

This section must be completed. Failure to disclose information is fraudulent and may result in membership not being granted or termination of membership resulting in claims reversal and refund of payments after debt recovery.

Have you or any of your dependants sought any advice, been diagnosed with or been treated for any conditions in the last 12 months? If yes, please provide details. Yes No

Name of beneficiary	Diagnosis	Date	Name of medication and dosage	Are you currently receiving treatment?		Have you been hospitalised?		Name and contact number of treating GP, Dentist or Specialist
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	
				Yes	No	Yes	No	

Should this space be insufficient, please attach a separate sheet.

SECTION 10 NOMINATED GP DETAILS

If you have selected flexiFED 1, flexiFED 1[Elect], flexiFED 2, flexiFED 2[GRID], flexiFED 2[Elect], flexiFED 3, flexiFED 3[GRID], flexiFED 3[Elect], flexiFED 4[GRID], flexiFED 4[Elect], sureFED[Plus], sureFED[Essential] and myFED you are required to nominate a General Practitioner (GP) from the Fedhealth network for yourself and your dependants. Please note that only visits to a nominated GP will be covered on these options. For a list of GPs on the Fedhealth network visit www.fedhealth.co.za, click on Find a Provider, and follow the prompts. Alternatively you can phone the Customer Contact Centre on 0860 002 153 for more information. You may nominate up to 2 GPs per beneficiary.

	MEMBER/DEPENDANT NAME	NOMINATED GP DETAILS		
		NAME	PRACTICE NUMBER	CONTACT DETAILS
Principal member		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.
Dependant		1.	1.	1.
		2.	2.	2.

SECTION 11 INCOME VERIFICATION FOR THE MYFED OPTION

Please tick appropriate box

Highest household income per month
☐ R1 – R11 494
☐ R11 495 - R16 226
☐ R16 227 - R22 495
☐ R22 496 + >

Income is considered as the income of the highest earner per household. Income to declare 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 (this includes self-employment and informal employment), pension and annuity proceeds, interest earned on active and passive investments, rental income from leasing properties and distributions received from a trust. Members will be required to declare income on an annual basis at the beginning of the new Benefit Year.

Please note:
Should you declare income lower than your actual income, it will be considered fraud and will lead to the immediate cancellation of your membership.

What you are required to do:
Complete the Income Verification Form and attach all relevant proof of income and other supporting documents requested in each section to avoid any administrative delays.

SECTION 12 THIRD PARTY POWER OF AUTHORITY

Should you want to give permission to a third party to act on your behalf, when you are unable to, please complete a separate Third Party Power of Authority Consent form.

SECTION 13 DECLARATION & TERMS AND CONDITIONS

13.1 DECLARATION BY PRINCIPAL MEMBER

1. I, the undersigned hereby apply for membership of Fedhealth Medical Scheme (the Scheme) and also nominate my dependants as specified.
2. I hereby undertake to observe and carry out the provisions of the Medical Schemes Act 131 of 1998 (the Act) and of the rules of the Scheme as amended from time to time.
3. I agree that the Scheme shall not be bound in any way by any representations or undertakings made or given by any person or agent which is in contradiction with the registered rules of the Scheme.
4. I further agree that the commencement of my membership and the liability of the Scheme as a result of this application is conditional upon the first contribution being paid and received by the Scheme, as well as the Fedhealth Savings instalment. In addition, should I default on payment of any subsequent contributions or instalments, and fail to remedy such default within the time periods allowed in the rules, any benefits paid by the Scheme on my behalf after the receipt of my last contribution shall be reversed and payment of these claims shall be for my account.
5. I hereby authorise and request any doctor or medical professional person, or any other person who may be in possession of, or may hereafter acquire, any information concerning my/the nominated dependant's health, whether such information relates to the past or future, to disclose such information to the Scheme or its administrator and agree that this authorisation and request shall remain in force after my/their deaths, as well as prior thereto. I indemnify the Scheme and its trustees, agents and administrator against any claim, of whatsoever nature, which may be made against them as a result of, or arising out of the disclosure of any test results or medical information.
6. I accept any penalties/waiting periods that may be applied in accordance with the Act. I understand that these waiting periods may include a 3 (three) month general waiting period, a 12 (twelve) month waiting period for pre-existing conditions and, if applicable, a late joiner penalty fee.
7. I hereby authorise my employer and/or Payroll of my company to deduct from my salary or any other available funds and/or via debiting of my bank account, all contributions, instalments, arrears, or any other amounts that I may owe to the Scheme as per the rules and agreement selected. In the event of arrears, I will be responsible for any legal costs that may arise in the recovery thereof.
8. It is my sole responsibility as a member to ensure that the monthly contribution, instalments and any amounts that may become due by me in terms of the Scheme rules, is received by the Scheme.
9. I hereby acknowledge that any credit extended by the Scheme to myself or my dependants whilst a member of the Scheme will become payable in full on termination of my membership.
10. I acknowledge that the Scheme may obtain any information regarding myself from any credit bureau, national loans register, South African Fraud Prevention Services, or any other agent I have dealt with in an event of nonpayment, debt collection or fraudulent activity.
11. I understand and agree to receive written notifications, SMS and other communication to the email address and/or cell number provided by me or my financial advisor. This communication may include changes to the rules of the Scheme as amended from time to time.
12. I understand that should there be any outstanding debt my account will be suspended from the date of default and no claims will be paid thereafter until a payment arrangement is reached and payment received.
13. I acknowledge that non-disclosure of any information by myself or my dependants relevant to the assessment of this application shall render any contracts to which this application relates null and void.
14. Should there be any additional information required by the Scheme which is not received within 7 (seven) days, the Scheme will automatically suspend the application.
15. I acknowledge that I am not a member of more than one Medical Scheme.
16. I hereby authorise the Scheme or any of its nominated representatives to verify and confirm my bank details.
17. I acknowledge that a monthly commission of 3% of my total monthly contribution up to a maximum, as legislated from time to time, will be paid to the financial adviser in terms of the Medical Schemes Act 131 of 1998 (or as amended), only if an advisor/broker is appointed.
18. I agree to provide the Scheme with 3 (three) months' written notice to inform Fedhealth of my intention to terminate my membership.
19. I acknowledge that it is my responsibility to notify the Scheme of any changes to the facts, or any changes in my or my dependants' state of health, between the date of signing this application form and the date when my membership commences. If this is not done before my membership commences, waiting periods may apply and/or future claims or my membership may be rejected.
20. I hereby confirm that I understand the various partnership arrangements (either Designated Service Provider and/or Preferred Provider) applicable to my option and am aware that co-payments and/or lower reimbursement rates may apply to the non-use of Fedhealth partners.
21. I declare that this personal statement, whether in my handwriting or not, is complete, true and correct and that I have not concealed, withheld or misstated any material facts.
22. I consent, with the permission of my dependants, that the Scheme may collect, use, process, retain and share my and my dependant's personal information for the purpose of providing Medical Scheme benefits and managed healthcare services. This includes the collecting and sharing of my personal information with the Scheme's partners and facilities who are essential to the administration and membership process.*

** You can access more details on the Protection of your Personal and Health Information on **www.fedhealth.co.za**. When you accept these terms and conditions you will allow us to provide your family with the full range of our Medical Scheme services.*

Sanlam Wealth Bonus

Do you have a Sanlam Matrix Premier product? Yes ☐ No ☐

If you answer yes, your I.D and membership number will be shared with Sanlam for the purpose of increasing your current Sanlam Wealth Bonus.

13.2 FEDHEALTH SAVINGS TERMS & CONDITIONS

These are the terms and conditions that will apply to the activation and use of your Fedhealth Savings, which is available to all active Members of the Scheme who are on the flexi**FED** range.

The maximum, interest free, loan amount that is available in your Fedhealth Savings, has been pre-determined by the Scheme in line with your selected benefit option and family size or composition. You can decide how much of the total amount available in your Fedhealth Savings you choose to activate, at any time during the benefit year, also known as the Fedhealth Backup Savings. The maximum repayment period for the amount activated will be 12 months. Should you choose to select the Savings Plan repayment amount, a pre-determined amount will be activated. Please consult the Scheme brochure.

General Provisions

a) The Fedhealth Savings is available annually as per the Scheme benefit year, which runs from 1 January to 31 December. Only Fedhealth Backup Savings Plan can be accessed any time of the year.
b) The Fedhealth Savings will be prorated for a member joining the Scheme during the benefit year unless predetermined rules are defined for a Participating Paypoint.
c) The minimum amount which may be activated from the Fedhealth Savings is R600.

Eligibility Criteria

a) The Fedhealth Savings is available to all members on options which offer this benefit. Members automatically accept the terms and conditions upon joining a flexi**FED** option.
b) To qualify for the Fedhealth Savings Benefit the member must be in good standing with the Scheme and over the age of 18 years.
c) Suspended and terminated members will not be allowed to activate any amounts from their Fedhealth Savings, nor will suspended members be able to select the Fedhealth Savings Plan.
d) The legal guardian of a member younger than 18 years of age can apply for the benefit on behalf of the minor member.
e) The Fedhealth Savings is only available to active beneficiaries of the Scheme.

Fedhealth Savings Conditions

a) When a member joins a flexi**FED** option they automatically accept the terms and conditions for Fedhealth Savings.
b) The Fedhealth Savings is provided by the Scheme, in terms of the Scheme Rules, more particularly Rule 19.13 (which empowers the Board to grant repayable loans to members) and Section 30 (b) of the Medical Schemes Act 131 of 1998.
c) The loan amount in the Fedhealth Savings will only be available up to a maximum as specified on the applicable option or company rule for a Participating Paypoint.
d) The loan will not attract any interest (i.e. it will be an interest free loan).
e) Any portion of the Fedhealth Savings not activated during a benefit year will not carry over to the next year.
f) The maximum loan amount available in the Fedhealth Savings may only be utilised once during a benefit year. Repayment of the loan will not result in the loan becoming available again. (i.e. the Fedhealth Savings facility will not be based on a revolving credit basis).
g) The loan is **only** activated once the member instructs the Scheme to activate an amount from the Fedhealth Savings.

Fedhealth Savings Activation

a) The member activates the Fedhealth Savings Benefit by utilising the various platforms available to members. When a member selects the Fedhealth Savings Plan, the annual pre-determined amount will be automatically activated on the 1st January annually.
b) Subject to the provisions under General Provisions above, members on the Fedhealth Backup Savings Plan are not restricted in terms of the number of activations in a benefit year.
c) Any amount held in the Fedhealth Savings account will not earn any interest.
d) A five (5) day cooling off period will be allowed for the purpose of cancelling the activation.

Fedhealth Savings Utilisation

a) The amount activated can only be accessed by submitting a valid claim to the Scheme.
b) The amount available will **only** be utilised once the member's Medical Savings Account has been exhausted.
c) All payments made for the benefit of the member or the member's dependants will only be for the funding of relevant healthcare services and will be made directly by the Scheme to the healthcare provider, medical facility or refunded to the member.
d) The member and his/her dependants will have access to the amount available during any waiting periods (if applicable).
e) Any amount left over at year end will carry over in the following year. This amount will not earn any interest.

Repayment of the Activated amount

a) Repayments of the loan/s are in arrears and will commence on the debit order date selected following an instruction by the member to activate an amount from the Fedhealth Savings before the tenth (10th) of the month. Any transfers after the tenth (10th) will become due in the following month.
b) If the Fedhealth Savings Plan is selected during a benefit year, the pre-determined activation will be pro-rated to ensure repayments are completed by the end of January of the following year (applicable to new members only).
c) Repayment of the loan payment by debit order is compulsory, therefore bank details must be provided, refer to section 7 of the applicaiton form.
d) The debit order deduction will be done on the selected day of the month except where it falls on a public holiday - in which case it will be collected on the day before or after, depending on the circumstances .
e) Each and every loan activated must be repaid over a maximum 12 month period. The repayment term for that loan cannot be amended after the event.
f) You may select a repayment period less than 12 months.
g) Your debit order repayment amount will be adjusted with any subsequent loan activations. The Fedhealth Savings Plan collection will remain the same, on condition that the previous year's instalment is fully paid up and no additional funds are accessed or activated during the year.
h) A single debit order will be deducted from the member's account for contributions as well as the Fedhealth Savings, with the following reference: FDHSUBVLT<member number>, unless a member belongs to a Non-Participating Paypoint Group that only pays for contributions and not the Fedhealth Savings instalment. In this case, a separate debit order deduction will occur with the following reference: FDHVLT<member number>.
i) The member may make additional repayments at any time, but it will not reduce the monthly instalment; only the period of indebtedness.
j) The member will receive a monthly statement reflecting the total Fedhealth Savings Benefit, Fedhealth Savings Benefit used and Fedhealth Savings Benefit available.
k) The statement will also reflect the detail of the Fedhealth Savings Benefit used and repayments thereof.
l) If a member belongs to a Participating Paypoint Group, the repayment will be collected from the Participating Paypoint Group. The member still needs to provide their banking details for collection to ensure continued collection if the member no longer belongs to the Participating Paypoint Group.
m) The member remains ultimately responsible for the repayment of the loan.

Dependant Termination

a) If a dependant is terminated off the membership, the amount available in the Fedhealth Savings will be recalculated according to the new family size and composition.
b) If, at the time of termination of the dependant, the member has activated an amount greater than the recalculated Fedhealth Savings amount, no further activations will be allowed, however the member will still be required to repay all amounts activated.
c) If the member has not utilised more than the recalculated Fedhealth Saings Benefit, the recalculated Fedhealth Savings Benefit will be allocated as the new limit. The new available balance will be the recalculated Benefit minus the amounts activated during the benefit year.

Option Change during the Benefit Year

a) Where there is an option upgrade that takes place during the benefit year, to an option which also offers the Fedhealth Savings Benefit, the Benefit will be recalculated according to the new benefit option.
b) If a member downgrades to an option with a lower Benefit available and at the time of downgrading the member has activated an amount greater than the lower Benefit, no further transfers will be allowed, however the member will still be required to repay all amounts activated.
c) If a member downgrades to an option with a lower Benefit available and at the time of downgrading the member has not utilised more than the lower Benefit, the lower Benefit will become the member's new limit. The new available balance will be the lower Benefit minus any amounts during the benefit year.
d) If the member moves to a Fedhealth option where the Benefit is not available, the member will be required to still repay the utilised amount for the remainder of the repayment period. Any unused credits will be offset with any debt outstanding or refunded to the member on request.

Repayment on Termination

a) Any outstanding loan amount owed by the member on termination of membership will be offset against any credit balances (including Fedhealth Savings balances) due to the member.
b) Any remaining loan balance outstanding must be repaid to the Scheme by the first (1st) of the month following termination.
c) Any amount left after all debt has been settled, will be refunded to the member.

SECTION 13 DECLARATION & TERMS AND CONDITIONS (CONTINUED)

13.2 FEDHEALTH SAVINGS TERMS & CONDITIONS (CONTINUED)

Repayment on Estate Late and Continuation Membership

a) Any outstanding loan amount owed by the deceased member cannot become the responsibility of the new member (continuation of the surviving spouse/dependant) and needs to follow the Death Administration process as defined in Estate Act, 66 of 1965 (as amended).
b) The new member must comply with the Eligibility Criteria set out above.
c) When a new member joins a flexi**FED** option they automatically accepts the terms and conditions for Fedhealth Savings.

Repayment on Beneficiary Swop Membership

a) Members requesting a Beneficiary Swop from being the member to becoming a dependant must pay all outstanding loan balances owed before the transaction will be approved.
b) The new member must comply with the Eligibility Criteria set out above.
c) The new member automatically accept the terms and conditions on joining a flexi**FED** option before activating a amount.
d) The benefit on the new membership will only be activated after a period of 30 (thirty) days from the date of the new membership becoming active, provided that all outstanding amounts were settled by the dependant on the previous benefit.

Debt Collection Process

a) Any outstanding loan amount for an active or terminated member will not be written off and will be pursued through debt collection.
b) Deferred instalments will not be allowed and will result in full membership suspension and no claims will be paid until the member is in good standing, and the Scheme's debt collection process will follow.
c) A member who continues to default on the loan instalment debt will be offset with the available Fedhealth Savings credits and no further access will be allowed to the unused Benefit. Any outstanding instalments will result in full membership suspension.
d) Members will be liable to pay for all fees associated with the collection of outstanding debts.

I consent to my Financial Adviser/Broker activating the Wallet on my membership. I acknowledge that the Financial Adviser/Broker is acting on my behalf and I agree not to hold the Scheme liable for acting on the instructions of my Financial Adviser/Broker. Yes No

Parental/guardian Declaration (Complete if principal member is a minor)

Parent of member (full name)		Relation	
Parent of member's Identity Number			
Guardian of member (full name)		Relation	
Guardian of member's Identity Number			
Parent/Guardian cellphone number	( )	Relation	
Parent/Guardian cellphone number	( )	Relation	
Parent/Guardian email address		Relation	

If parent or guardian is completing this application form on behalf of a minor, please provide certified copies of Parent's/Guardian's Identity Document

I/We ..... Full Name ..... Member/Parent/Guardian, the undersigned, do hereby declare that I/We have read and understood the declaration and terms and conditions as contained in this section.

Signed at..... on this ..... day of ..... 20 .....

Signature of principal member/parent/guardian .....

Print name ..... Identity number

DECLARATION BY PRINCIPAL MEMBER

I/We ..... Full Name ..... Member, the undersigned, do hereby declare that I/We have read and understood the declaration and terms and conditions as contained in this section.

Signed at..... on this ..... day of ..... 20 .....

Signature of principal member .....

Print name ..... Identity number