MEMBER RECORD
AMENDMENT / DEPENDANT REGISTRATION

RHODES UNIVERSITY MEDICAL SCHEME

CALL CENTRE (041) 395 4476

E-MAIL ADDRESS rumed@providence.co.za

P.O. Box 1672 Port Elizabeth 6001

7 Lutman Road Richmond Hill Port Elizabeth 6000

ADMINISTERED BY PROVIDENCE HEALTHCARE RISK MANAGERS.

INSTRUCTIONS

- ☐ **CHANGE OF ADDRESS / CONTACT DETAILS** — *Complete Sections 1, 2, 7 and 8*
- ☐ **ADVICE OF CHANGE IN MARITAL STATUS** — *Complete Sections 1, 3, 7 and 8*
- ☐ **CHANGE OF BANK DETAILS** — *Complete Sections 1, 4, 7 and 8*
- ☐ **TERMINATION OF DEPENDANT(S)** — *Complete Sections 1, 5, 7 and 8*
- ☐ **REGISTRATION OF BIRTHS** — *Complete Sections 1, 6, 7 and 8; Attach copy of Birth Certificate*
- ☐ **REGISTRATION OF DEPENDANT(S)** — *Complete Sections 1, 6, 7, 8 and 9; Attach copy Identity Document/ Birth Certificate / Marriage Certificate / Proof of previous membership/ Student Registration*

- Sections 1, 7 and 8 *must always* be completed.
- Please complete in block letters.
- Complete blocks from left to right, one letter/number per block.
- Registration and amendments are subject to the rules of the Scheme.
- The Scheme must be notified within 30 days from date of change.
- Should you have any queries, please contact our customer care department.

SECTION 1 | PRINCIPAL MEMBER DETAILS

Title | Initials | Surname

Medical Aid Number

SECTION 2 | CHANGE OF ADDRESS / CONTACT DETAILS

Telephone Number (Work)

Telephone Number (Home)

Cellular Number

Fax Number

E-mail address

Physical Address

Postal Address

SECTION 3 | ADVICE OF CHANGE IN MARITAL STATUS

PLEASE INDICATE WITH AN "X" IN THE APPROPRIATE BOX: Single ☐ Married ☐ Widowed ☐ Date of Marriage: _____

Please attach a copy of the marriage certificate

☐ My spouse is not a member of another scheme. ☐ My spouse is employed. Name of employer: _____

Title | Initials | Surname

SECTION 4 | CHANGE OF BANK DETAILS

APPLICATION FOR ELECTRONIC TRANSFER OF FUNDS

I hereby instruct Rhodes University Medical Scheme to electronically collect contributions or to deposit refunds into my bank account. I understand that credit card accounts may not be used for these transactions. I also irrevocably authorise Rhodes University Medical Scheme to reverse any erroneous transaction and/or to rectify any incorrect electronic transfer of funds without prior notice.

Signature: ..... Date: .....

PLEASE TICK (MORE THAN ONE OPTION CAN BE SELECTED)

BANK STAMP REQUIRED

NOTE :For a cheque account, please attach an original cancelled cheque

BANK NAME

BRANCH NAME

ACCOUNT HOLDER NAME

BANK ACCOUNT NUMBER

BRANCH CODE

TYPE OF ACCOUNT CURRENT ☐ CHEQUE ☐ SAVINGS ☐ TRANSMISSION ☐

SECTION 5 | TERMINATION OF DEPENDANT(S)

Name | Date of Birth (Y Y Y Y M M D D)

Relationship | Female | Male | Date of Termination (Y Y Y Y M M D D)

Reason

Name | Date of Birth (Y Y Y Y M M D D)

Relationship | Female | Male | Date of Termination (Y Y Y Y M M D D)

Reason

Name | Date of Birth (Y Y Y Y M M D D)

Relationship | Female | Male | Date of Termination (Y Y Y Y M M D D)

Reason

SECTION 6 | REGISTRATION OF BIRTHS / SPOUSE / PARTNER / ADDITIONAL ADULT OR CHILD DEPENDANT

Relationship to member

First Name | Date of Birth (Y Y Y Y M M D D)

Surname | Female | Male | Date Effective (Y Y Y Y M M D D)

Relationship to member

First Name | Date of Birth (Y Y Y Y M M D D)

Surname | Female | Male | Date Effective (Y Y Y Y M M D D)

Relationship to member

First Name | Date of Birth (Y Y Y Y M M D D)

Surname | Female | Male | Date Effective (Y Y Y Y M M D D)

PLEASE ANSWER THE FOLLOWING COMPULSORY QUESTIONS - Mark the appropriate block with an "X"
(not compulsory for registration of a newborn baby)

1. Does the dependant receive a monthly income?

   Yes | No If yes, complete the following:

   Monthly salary. State name of employer _____ R_____

   Pension - state whether old age, military or disability _____ R_____

   Pension - state other than above, including an annuity _____ R _____

   _____ TOTAL R_____

2. Is the dependent entirely reliant on you for maintenance and support?

   Yes | No Give reasons _____

SECTION 9 | MEDICAL HISTORY (continued)

If you answered "yes", to any of the previous questions, please provide full details by completing this schedule

Question Number	Diagnosis and Date of Onset	Condition resolved Yes or No?	Name of current medication	Further treatment expected	Date of last treatment or symptoms	Prognosis	Name and contact number of treating GP, dentist or specialist

SECTION 9 | MEDICAL HISTORY (not compulsory for registration of a newborn baby)

Patient Name

CONDITION INFORMATION

Has your dependant ever experienced or been treated for, or is currently suffering from any of the following conditions?
If Yes, Please tick the appropriate block or specify the conditions

1. Cardiovascular and or Blood disorders
- ☐ Chest Pain (Angina)
- ☐ Valve defect
- ☐ Rheumatic heart disease
- ☐ Heart attack
- ☐ Murmurs
- ☐ Hypertension (Blood pressure)
- ☐ Arrhythmia
- ☐ Hypercholestrolcernia
- ☐ Anemia
- ☐ Leukemia

Other, Specify

2. Respiratory problem (Lungs or breathing)
- ☐ Difficulty in breathing
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Asthma
- ☐ Croup
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Coughing up blood

Other, Specify

3. Ear, Nose & Throat
- ☐ Hearing/speech impairment
- ☐ Ear Infections
- ☐ Sinus problems
- ☐ Allergic rhinitis

Other, Specify

4. Kidney / Urinary System
- ☐ Blood in urine
- ☐ Kidney infections
- ☐ Prostate conditions
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Congenital urinary conditions
- ☐ Recurrent urinary tract infections

Other, Specify

5. Gynaecological
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Abnormal pap smears
- ☐ Fibroid
- ☐ Enlarged uterus
- ☐ Menstrual disorders
- ☐ Pregnant at present

Other, Specify

6. Glandular/ Endocrine
- ☐ Diabetes Mellitus
- ☐ Addison's disease
- ☐ Cushing's syndrome
- ☐ Growth disorders
- ☐ Disorders of the pituitary gland
- ☐ Hypo/hyperactive thyroid gland

Other, Specify

7. Neurological (Nervous system)
- ☐ Paralysis
- ☐ Stroke
- ☐ Epilepsy
- ☐ Migraine
- ☐ Brain or spinal cord disorder
- ☐ Multiple sclerosis

Other, Specify

8. Gastrointestinal
- ☐ Malena Stools (Bleeding)
- ☐ Ulcers
- ☐ Jaundice
- ☐ Change in bowel habits
- ☐ Pancreatic disorders
- ☐ Colitis
- ☐ Gall Stones/Cholecystitis
- ☐ Pancreatic disorders
- ☐ Irritable bowel syndrome

Other, Specify

9. Musculoskeletal
- ☐ Joint or spine condition, including Rheumatoid/Osteo-arthritis
- ☐ Neck or Back problems
- ☐ Recurrent back pain
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis

Other, Specify

10. Lumps or Growths
- ☐ Benign tumours
- ☐ Malignant tumours
- ☐ Lymph cancer
- ☐ Leukemia
- ☐ Melanoma

Other, Specify

11. Emotional / Psychological
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Attention deficit disorder
- ☐ Anorexia
- ☐ Anorexia or any other eating disorders
- ☐ Alzheimers disease
- ☐ Bi-polar disorders

Other, Specify

12. Eyes
- ☐ Glaucoma
- ☐ Blindness
- ☐ Impaired vision
- ☐ Retinitis
- ☐ Conjuntivitis
- ☐ Macular degeneration
- ☐ Cataract

Other, Specify

Has your dependant had, or is he/she currently undergoing or anticipating any specialist dentist treatment? ☐ Y or ☐ N
(E.g. Orthodontic treatment or impacted wisdom teeth)

Does your dependant have any congenital, hereditary or physical disability? ☐ Y or ☐ N

Does your dependant participate in any hazardous sports or pursuits e.g. mountain climbing, paragliding? ☐ Y or ☐ N

Are you aware of any other conditions which may not have been specified on this form? ☐ Y or ☐ N
If the answer is 'Yes', please supply details on the reverse.

3. Does the dependant live with you?

Yes	No

Please attach an affidavit confirming the relationship to the principal member and length of stay.

4. Is the dependant a student?

Yes	No

If yes, state whether full time, part time, name of academic institution and expected period of study. Also attach proof of student registration. _____

_____

5. Has the dependant been a beneficiary of any medical scheme before this application?

Yes	No

If yes, provide Name of Scheme _____ Membership Number_____

Date Joined _____ Date left_____

Reason membership terminated_____

Please attach a copy of a membership certificate, reflecting join and exit dates.
Please note that a copy of a medical aid card is not sufficient.

SECTION 7 | EMPLOYER TO COMPLETE AND SIGN

Company Name

Scheme Join Date (Y Y Y Y M M D D)

Payroll Number

Date of Employment (Y Y Y Y M M D D)

Date of Benefit (Y Y Y Y M M D D)

Total current contribution

Total new contribution

Arrears (if applicable)

We confirm that the applicant is employed by us and commenced employment on the above mentioned date. Contributions are being deducted according to the Scheme rules
All sections of the application form have been completed.

Employer's Telephone Number (C O D E)

Employer's Fax Number (C O D E)

Employer's E-mail Address

Name of Medical Aid/Salary Administrator

Designation

COMPANY STAMP REQUIRED

Signature: _____ (Y Y Y Y M M D D)

SECTION 8 | DECLARATION BY PRINCIPAL MEMBER

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT

Date (Y Y Y Y M M D D)

Principal Member's signature _____

ADMINISTERED BY

PROVIDENCE
Healthcare Risk Managers