



Rhodes University Medical Scheme

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FORM TE03 – MEMBER RECORD AMENDMENT

APPLICATION TO REGISTER A DEPENDANT/SPECIAL DEPENDANT

DETAILS OF MEMBER		DATE JOINING: _____	
MEMBER NUMBER: _____		NAME: _____	
ADDRESS: _____			
DETAILS OF DEPENDANT			
FIRST NAME(S): _____		SEX: _____	
DATE OF BIRTH: _____		RELATIONSHIP: _____	
SURNAME: _____		MARITAL STATUS: _____	

Kindly complete the following questionnaire:

- Is the dependant in receipt of a monthly income? YES ☐ NO ☐
If yes, State name of employer _____ Salary: R _____
Pension: R _____
- Is the dependant at present under medical treatment (including surgery), or is he/she expected to be so in the future?
YES ☐ NO ☐ If yes, give details _____

- (If female), is the dependant pregnant?
YES ☐ NO ☐ If yes, what is the expected date of confinement?

- Is the dependant entirely dependent on you for maintenance and support?
YES ☐ Give reason(s) _____
NO ☐ Give reason(s) _____
- Does the dependant reside with you?
YES ☐ Give reason(s) _____
NO ☐ Give reason(s) _____
- Is the dependant a student?
YES ☐ Name of academic institution _____
NO ☐ Expected period of studies _____
- Has the dependant been a beneficiary of any medical scheme prior to this application?
YES ☐ Name of scheme _____
NO ☐ Date joined _____ Date left _____

MEDICAL HISTORY

Kindly complete the following section in respect of the dependant:

1. Any disorder of the heart? e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations. ☐
2. High blood pressure or diseases of the blood vessels or circulatory disorder? ☐
3. Any respiratory or lung disease? ☐
4. Any disorder of the digestive system, gall bladder, pancreas or liver? ☐
5. Any disease or disorder of kidneys, bladder or reproductive organs? ☐
6. Any nervous or mental complaint? e.g. epilepsy, blackouts, anxiety state or depression. ☐
7. Any type of nerve ailment? ☐
8. Any ear, eye, nose or throat disorder? e.g. ear discharge, defective vision. ☐
9. Any disorder or disease of skin, muscles, bones, joints, limbs, spine? ☐
10. Diabetes, hormonal imbalance, glandular or metabolic diseases, thyroid or blood disorders? ☐
11. Cancer, growth or tumour of any kind? ☐
12. Any other illness, disorder, operation, disability or accident? E.g. fractured nose, breathing disorders, mammary hypertrophy (enlarged breasts with associated side effects, AIDS, congenital abnormalities, etc) ☐
13. Have any exclusions been imposed by any medical scheme on which the dependant has been registered? ☐

If "YES" please state details:

Question No.	Name of Patient	Nature and duration of complaint and full details of treatment being or expected to be received	Name and telephone number of attending doctor or hospital	When did the dependant last have symptoms or receive treatment

DECLARATION BY MEMBER:

I hereby declare that the information in this application is true and correct and agree that any false declaration will render my application null and void.

SIGNATURE

DATE

CERTIFICATE BY EMPLOYER:

Employer / Company stamp:

Date _____