MEDSHIELD
medical scheme

EXISTING BENEFICIARY TRANSFER (To another Membership)

Email: membership@medshield.co.za

This form needs to be completed if existing Medshield beneficiaries (immediate family) need to be transferred to your membership.
There can be no break in membership upon a transfer between the two (2) memberships.

Please complete in black ink. All sections to be completed in full. Print clearly using capital letters. Only one character per block.
Leave one block between words.

Transfer **FROM** Membership number:

Transfer **TO** Membership number:

DOCUMENT CHECKLIST

In order to avoid rejection of your transfer application, please provide one of the following documents:	Please Tick
Signed termination letter from the current Principal Member	
Death certificate of current Principal Member (Applicable if surviving dependants are transferred to their parent(s) active Medshield Membership)	
Marriage certificate for transfer of spouse	
Additional documents for Special Dependants (foster/adopted children, niece, nephew, sibling, grandchild): **Adopted/Foster Child:** • Legal documentation of adoption or foster arrangement **A parent or grandparent of the Principal Member:** • Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent • Proof of income such as payslip, bank statement, or proof of pension **A grandchild, niece, nephew or sibling:** • Certified affidavit from pPrincipal Member and parent(s) confirming residency, employment, and income of child and both parents • Proof of income if dependant is employed	

SECTION A — TO BE COMPLETED BY THE CURRENT PRINCIPAL MEMBER

Membership Number:

Member ID number:

Member Name:

Member Surname:

I hereby request to terminate the following dependant(s) from my membership as they are seeking to transfer to another Medshield membership.

Dependant 1 First Name:

Dependant 1 Surname:

Termination Effective Date: D D M M Y Y Y Y

Dependant 2 First Name:

Dependant 2 Surname:

Termination Effective Date: D D M M Y Y Y Y

Dependant 3 First Name:	
Dependant 3 Surname:	
Termination Effective Date:	D D M M Y Y Y Y

Principal Member Signature: _____ Date: D D M M Y Y Y Y

SECTION B TO BE COMPLETED BY THE NEW PRINCIPAL MEMBER (Transfer to)

Initials:	
Surname:	
Membership Number:	
ID/Passport Number:	
Date of Birth:	D D M M Y Y Y Y

SECTION C DETAILS OF BENEFICIARIES TO BE TRANSFERRED

For special dependants (e.g. parents, foster/adopted children, niece, nephew, grandchild, parents) please attach the following:

Adopted/Foster Child:
- Legal documentation of adoption or foster arrangement.

A parent or grandparent of the Principal Member:
- Certified affidavit from Principal Member confirming residency, employment status and income of parent/grandparent.
- Proof of income such as payslip, bank statement, or proof of pension.

A grandchild, niece, nephew or sibling:
- Certified affidavit from Principal Member and parent(s) confirming residency, employment, and income of child and both parents.
- Proof of income if dependant is employed.

If the dependant is classified as a student and falls within the age range of 21 to 27 or will reach the age of 21 in the next three months, student proof in the form of a stamped or signed letter, on a letterhead from the accredited institution for tertiary education for the current year must accompany this form.

Include copies of the dependants' ID, birth certificate or passport.

Acceptance of dependants will be in accordance with the Rules of the Scheme.

Dependant 1

Name of Dependant:																	
Surname: (If Different to Principal Member)																	
ID Number / Passport number for non-South African Citizens:																	
Date of Birth:	D	D	M	M	Y	Y	Y	Y									
Dependant Email Address:																	
Dependant Cell Number:																	
Relationship to Principal Member:																	

Gender: (Mark with an X)	M	F		Adult Over 21: (Mark with an X)	Y	N

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 2

Name of Dependant:																	
Surname: (If Different to Principal Member)																	
ID Number / Passport number for non-South African Citizens:																	
Date of Birth:	D	D	M	M	Y	Y	Y	Y									
Dependant Email Address:																	
Dependant Cell Number:																	
Relationship to Principal Member:																	

Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

Dependant 3

Name of Dependant:																	
Surname: (If Different to Principal Member)																	
ID Number / Passport number for non-South African Citizens:																	
Date of Birth:	D	D	M	M	Y	Y	Y	Y									
Dependant Email Address:																	
Dependant Cell Number:																	
Relationship to Principal Member:																	

Gender: (Mark with an X)	M	F	Adult Over 21: (Mark with an X)	Y	N

If the dependant is classified as a special dependant **(e.g parents, foster child, niece, nephew, sibling, grandchild), please answer the following compulsory questions**

Is the dependant reliant on you for family care and support?	Y	N
Does the dependant live with you?	Y	N
If the dependant is an adult, does the dependant earn a monthly income e.g salary, pension?	Y	N
If yes, what is the monthly income?	R	

Please complete for statistical purposes. If you do not wish to disclose your dependant's race, please mark the relevant box with an X.

Race:	African	Caucasian/ White	Coloured	Indian	Asian	Other
I do not wish to disclose:						

SECTION D

FAMILY PRACTITIONER (FP) NOMINATION – MediPhila, MediCurve, MediValue Compact and MediPlus Compact

If you have selected MediPhila, MediCurve or one of the Compact options, it is compulsory for you and your dependants to nominate a Family Practitioner (FP). If you do not nominate a FP as per the criteria listed per option below, your application form will not be processed by the Scheme.

MediPhila: Each beneficiary MUST nominate only ONE (1) Family Practitioner from the MediPhila Family Practitioner Network to a maximum of two (2) Family Practitioners per family.

MediCurve: Each beneficiary must nominate only ONE (1) Family Practitioner from the MediCurve Family Practitioner (FP) Network.

MediValue Compact and MediPlus Compact: Each beneficiary MUST nominate ONE (1) Family Practitioner (FP) which MUST be from the Compact Family Practitioner (FP) Network.

MediValue Prime and MediPlus Prime: Voluntary - can nominate a FP which MUST be from the FP network to a MAXIMUM of two (2) FP's per beneficiary. *Where a FP was nominated from the FP Network & Day-to-Day benefit is depleted the member will qualify for an additional 2 visits per FAMILY from OAL.*

The registered networks per option are available on the website, please visit: **www.medshield.co.za**

Beneficiary	Beneficiary Name	Nominated Family Practitioner Name	Practice Number / Telephone
Principal Member		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 1		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 2		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 3		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Beneficiary	**Beneficiary Name**	**Nominated Family Practitioner Name**	**Practice Number / Telephone**
Dependant 4		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 5		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 6		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY
Dependant 7		1	1
		2 PRIME OPTION ONLY	2 PRIME OPTION ONLY

SECTION E EMPLOYER APPROVAL (Companies/Group members only)

Name of Employer:

Paypoint Code:

Employee Payroll No.:

Employment Date: D D M M Y Y Y Y

COMPANY STAMP

Tick this box if no Company Stamp is available ☐

By selecting this box you confirm that the Employer has granted approval ☐

We confirm that the applicant is employed by us and commenced employment on the above date and all fields of Section D have been completed:

Employer's Email Address:

Employer's Representative's Name:

Employer's Representative's Designation:

Date: D D M M Y Y Y Y

Employer's Representative's Signature: _____

SECTION F CONSENT (Consent for Medshield Medical Scheme to process personal information)

The Scheme understands that your personal information and that of your dependants is important. Medshield undertakes to keep this information confidential and shall take all reasonable steps to comply with the provisions of legislation protecting your personal information.
We require your consent to obtain, process and disseminate your personal information so we can provide you with the services stipulated in our contractual agreement, as detailed for your chosen benefit option and in compliance with the Medical Schemes Act 131/1998. These services include but is not limited to:

a. Treatment Authorisations;
b. Claims Assessment;
c. Claims Payment;
d. Communication;
e. Disease Management; and
f. Wellness Initiatives.

While your consent is voluntary, it is a requirement for the administration of your Medshield membership. **If you object to the processing of your personal information, the Scheme will not be able to activate and service your membership.**

Please carefully read and consent to the items listed below:
I hereby 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, managed healthcare services and medical scheme specific value adds. This includes the collecting and sharing of my personal information with the Scheme's partners and facilities who are essential to the administration and ongoing membership process.

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

(1) I hereby acknowledge and declare that as the Principal Member of the Scheme, I have received the necessary consent from my dependant(s) and act on their behalf in any matter relating to this application and the administration of our Medshield Membership and to access and view their healthcare claims.

(2) Confirm that if I (Principal Member) am part of a group membership by virtue of employment, I grant permission to Medshield Medical Scheme to share information relating to my membership with my employer and my employer's appointed broker This will be limited to information that is relevant to my application, collection of contributions and information that is required for the ongoing servicing of my membership, but will not include any health information unless I have given Medshield permission to do so.

(3) Give permission that the Scheme may share my personal information including that of my dependants with my chosen Financial Advisor/ Broker, if any, who is an accredited Medical Aid Broker of my choice.

Principal Member Signature: _____ Date: D D M M Y Y Y Y

SECTION G MEMBER DECLARATION

I, _____ (Principal member's full name) the undersigned, declare that: I understand that Medshield will rely upon the facts set out herein for the accurate loading of details. I understand and accept that should any details contained herein prove to be incorrect, or should I fail to inform Medshield of any subsequent change to the details, Medshield will not be held responsible.

Principal Member Signature: _____ Date: D D M M Y Y Y Y