



# BROKER APPOINTMENT FORM FOR MEMBERS/EMPLOYERS

1. Amendments are subject to the rules of Medshield Medical Scheme and the Council for Medical Schemes.
2. For employers, please attach an original letter on a company letterhead signed by the duly authorised person. i.e. Chief Executive Officer, Chief Financial Officer, Chief Operations Officer or the Director of Human Resources.
3. A transfer of a member's request by a broker must be on a company letterhead and signed by both parties who are the key individuals.
4. For members, please attach a copy of the identity document.
5. Please email or fax completed form to [commissions@medshield.co.za](mailto:commissions@medshield.co.za) or 010 597 4709.
6. This form is valid for three months from the date of signature.

SECTION A		NEW BROKER DETAILS	
Broker Name:		Broker Code:	
Email Address:		Contact Number:	
Region:			

SECTION B		TO BE COMPLETED BY THE PRINCIPAL MEMBER	
Membership Number:			
Member ID Number:			
Member Name/s:			
Member Surname:			
Employee Number: (where applicable)			
Contact Number:			
Email Address:			
Physical Address:			

Member's reason for change in broker: \_\_\_\_\_

SECTION C		EMPLOYER DETAILS (For employer appointments only)	
Employer Name:			
Employer Code:			
Contact Person Name:			
Contact Number:			

Employer's reason for change in broker: \_\_\_\_\_

**SECTION D****FINANCIAL ADVISER/BROKER/EMPLOYER REPRESENTATIVE CONSENT**

(To allow disclosure of information to a third party)

Please complete in black ink. Print clearly using capital letters. Only one character per block. Leave one block between words. Mark with a tick where required. All sections must be completed.

**ABOUT THE INFORMATION WE PROVIDE TO THE THIRD PARTY** (Broker/Financial Advisor/Employer Representative)

This section needs to be completed if you want to nominate someone to manage your medical aid membership on your behalf. For instance your financial adviser/broker or a family member or a friend who you trust to administer your membership. We call this giving a Third Party Consent by nominating them on this form, which provides us with your approval that the Scheme may share specific personal information and/or discuss your membership with the specific Third Party you nominated below.

**Additionally, please specify what type of information may be accessed by your financial adviser, employer representative and/or nominated Third Party, and for how long (if no date is specified, the consent will be in effect from the signature date until you revoke the consent in writing).**

**FINANCIAL ADVISER/BROKER**

Your Financial Adviser/Broker

Broker code:

Financial Adviser/Brokerage Name:

Financial Adviser Email address:

Financial Adviser Telephone Number (W):


I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my Financial Adviser/Broker as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N		
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N		
Financial Information: (Banking details, contributions, tax certificate)	Y	N		
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N		
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N		
Request changes and updates on my behalf	Y	N		

**EMPLOYER REPRESENTATIVE** (If applicable)

Your employer representative (if you form part of a group membership by virtue of employment)

Company Name:

Employer Representative Name and Surname:

Employer Representative Email address:

Employer Representative Telephone Number (W):


I, the Principal Member, hereby grant permission, with the consent of all my registered dependants, that my employer representative as indicated above may have access to:

Type of Information	Yes	No	Date from	Date to
Personal Information: (Membership number, date of birth, ID/passport number, postal, physical and e-mail address, cellular number, phone number, payroll number)	Y	N		
Benefits: (Benefit option, available benefit limits, available savings, waiting periods)	Y	N		
Financial Information: (Banking details, contributions, tax certificate)	Y	N		
Medical Information: (Chronic conditions, Prescribed Minimum Benefits, claims transaction history, treatment plans, authorisations)	Y	N		
Scheme Documents/Forms: (Statements, certificate of membership, application form(s))	Y	N		
Request changes and updates on my behalf	Y	N		

**SECTION E** **AUTHORISATION**

I hereby acknowledge the appointment of the above broker.

Name of Principal Member/Authorised Person:

Signature of Principal Member/Authorised person: \_\_\_\_\_ Date:

Name of Broker:

Signature of Broker: \_\_\_\_\_ Date: