AECI®
MEDICAL AID SOCIETY

# MEMBER RECORD AMENDMENT / DEPENDANT REGISTRATION

- Sections 1, 7 and 8 must always be completed.
- Please use block letters.
- Complete blocks from left to right, one letter/number per block.
- Registration and amendments are subject to the rules of the Society.
- The Society must be notified within 30 days from change date.
- Should you have any queries, please contact your Society 086 number for assistance.
- The completed form may be hand delivered delivered to our walk-in branches,

**Roodepoort**
(Scheme name)
Membership Department
P O Box 1101
Florida Glen
1708

**Durban**
(Scheme name)
Membership Department
P O Box 2825
Durban
4000

**Port Elizabeth**
(Scheme name)
Membership Department
P O Box 3711
North End
6056

☐ **CHANGE OF ADDRESS / CONTACT DETAILS**

☐ **CHANGE OF MARITAL STATUS**

☐ **TERMINATION OF DEPENDANT MEMBERSHIP**

☐ **REGISTRATION OF:**
- **BIRTHS AND ADOPTIONS**
- **ADDITIONAL ADULT AND CHILD DEPENDANTS**

## SECTION 1: MUST BE COMPLETED

| Field | |
|---|---|
| Membership number | |
| Initials and surname | |

## SECTION 2: CHANGE OF ADDRESS / CONTACT DETAILS

| Field | | | |
|---|---|---|---|
| Telephone (H) | | Tel. (W) | |
| Cellular | | | |
| E-mail address | | | |
| Postal address | | | |
| | | Postal code | |
| Physical address | | | |
| | | Postal code | |

## SECTION 3: CHANGE OF MARITAL STATUS

| Field | | | |
|---|---|---|---|
| Marital status | | Date of marriage | d d m m y y y y |
| Surname | | | |

## SECTION 4: TERMINATION OF BENEFICIARY REGISTRATION DUE TO DEATH, DIVORCE, CHILD SELF SUPPORTING ETC.

Attach certified copy of death certificate if deceased is principal member

| Field | | | | |
|---|---|---|---|---|
| Full name (s) as reflected on your membership card | | | | |
| | Date of birth | d d m m y y y y | Deletion date (last day of the month) | d d m m y y y y |
| Full name (s) as reflected on your membership card | | | | |
| | Date of birth | d d m m y y y y | Deletion date (last day of the month) | d d m m y y y y |
| Full name (s) as reflected on your membership card | | | | |
| | Date of birth | d d m m y y y y | Deletion date (last day of the month) | d d m m y y y y |
| Full name (s) as reflected on your membership card | | | | |
| | Date of birth | d d m m y y y y | Deletion date (last day of the month) | d d m m y y y y |

## SECTION 4: (continued)

| Reason for termination | |
|---|---|
| | |

## SECTION 5: REGISTRATION OF SPOUSE / PARTNER / ADDITIONAL ADULT OR CHILD DEPENDANT (2)

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult | | Child | | Beneficiary join date | d | d | m | m | y | y | y | y | |
| Title | | | Initials | | | | | | | | | | |
| First name/s | | | | | | | | | | | | | |
| Surname | | | | | | | | | | | | | |
| Relationship to principal member | | | | | | | | Gender | | M | F | | |
| ID/passport/birth certificate number | | | | Date of birth | d | d | m | m | y | y | y | y | |
| If adult, is the dependant financially dependant on the principal member? | | | | | | | | Yes | | No | | | |
| Does the dependant receive an income, e.g. pension, salary | | Yes | No | If yes, what is the monthly income | | | | R | | | | | |
| Select general practitioner (if applicable)<br>Only complete if a requirement of your scheme option | GP's practice number | | | | | | | | | | | | |
| | GP's name and surname | | | | | | | | | | | | |
| Has this dependant had previous medical aid cover | | Yes | No | If yes, please provide details | | | | | | | | | |
| Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? | | | | | | | | Yes | | No | | | |

| Name of previous medical scheme | Membership number | Date joined | Date left |
|---|---|---|---|
| | | | |
| | | | |

## REGISTRATION OF SPOUSE / PARTNER / ADDITIONAL ADULT OR CHILD DEPENDANT (2)

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult | | Child | | Beneficiary join date | d | d | m | m | y | y | y | y | |
| Title | | | Initials | | | | | | | | | | |
| First name/s | | | | | | | | | | | | | |
| Surname | | | | | | | | | | | | | |
| Relationship to principal member | | | | | | | | Gender | | M | F | | |
| ID/passport/birth certificate number | | | | Date of birth | d | d | m | m | y | y | y | y | |
| If adult, is the dependant financially dependant on the principal member? | | | | | | | | Yes | | No | | | |
| Does the dependant receive an income, e.g. pension, salary | | Yes | No | If yes, what is the monthly income | | | | R | | | | | |
| Select general practitioner (if applicable)<br>Only complete if a requirement of your scheme option | GP's practice number | | | | | | | | | | | | |
| | GP's name and surname | | | | | | | | | | | | |
| Has this dependant had previous medical aid cover | | Yes | No | If yes, please provide details | | | | | | | | | |
| Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? | | | | | | | | Yes | | No | | | |

| Name of previous medical scheme | Membership number | Date joined | Date left |
|---|---|---|---|
| | | | |
| | | | |

## REGISTRATION OF SPOUSE / PARTNER / ADDITIONAL ADULT OR CHILD DEPENDANT (3)

| | | | |
|---|---|---|---|
| Adult | | Child | |
| Beneficiary join date | d d m m y y y y | | |
| Title | | Initials | |
| First name/s | | | |
| Surname | | | |
| Relationship to principal member | | Gender | M F |
| ID/passport/birth certificate number | | Date of birth | d d m m y y y y |
| If adult, is the dependant financially dependant on the principal member? | Yes | No | |
| Does the dependant receive an income, e.g. pension, salary | Yes | No | If yes, what is the monthly income R |
| Select general practitioner (if applicable) Only complete if a requirement of your scheme option | GP's practice number | | |
| | GP's name and surname | | |
| Has this dependant had previous medical aid cover | Yes | No | If yes, please provide details |
| Have condition specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? | Yes | No | |

| Name of previous medical scheme | Membership number | Date joined | Date left |
|---|---|---|---|
| | | | |
| | | | |

## SECTION 6: MEDICAL DETAILS

It is compulsory to answer each question. Failure to discuss information is fraud and may result in mebership not being granted, or termination of membership without refund of contributions paid.

**Current family doctor**

| | | | |
|---|---|---|---|
| Name and surname | | | |
| Telephone | | For how long he/she been your doctor | years / months |

## HAS YOUR DEPENDANT/S SOUGHT ANY ADVICE, BEEN DIAGNOSED WITH, OR TREATED FOR, ANY OF FOLLOWING CONDITIONS IN THE PAST 12 MONTHS

1. A chronic illness? (e.g raised cholestrol, heart problems, diabetes, high or low blood pressure, asthma, SLE, depression, anxiety, epilepsy, and/ or thyroid) If yes, provide details. Yes No

| Name of beneficiary | Diagnosis and date | Name of medication | Are you currently receiving treatment? | | Have you been hospitalised? | | Name and contact number of treating general practitioner, dentist or specialist |
|---|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No | |
| | | | Yes | No | Yes | No | |

2. Gastro intestinal disorders? (e.g gastro-oesophageal reflux disease, heartburn, stomach or duodenal disorder, Crohn's disease, ulcerative colitis, diverticulitis and/ or a spastic colon) If yes, provide details. Yes No

| Name of beneficiary | Diagnosis and date | Name of medication | Are you currently receiving treatment? | | Have you been hospitalised? | | Name and contact number of treating general practitioner, dentist or specialist |
|---|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No | |
| | | | Yes | No | Yes | No | |

3. Muscle, bone, skin or nerve illnesses or disorder? (e.g back and neck related conditions including injury, arthritis, gout, multiple scleroris, knee or hipproblems, osteopororis, dermatis ect.) If yes, provide details. Yes No

| Name of beneficiary | Diagnosis and date | Name of medication | Are you currently receiving treatment? | | Have you been hospitalised? | | Name and contact number of treating general practitioner, dentist or specialist |
|---|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No | |
| | | | Yes | No | Yes | No | |

| 4. Urinary or genital disorders? (e.g. kidney stones, prostates, endometriosis, overian cysts, menstrual disorder) If yes, provide details. | | | | | | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Name of beneficiary | Diagnosis and date | Name of medication | Are you currently receiving treatment? | | Have you been hospitalised? | | Name and contact number of treating general practitioner, dentist or specialist | |
| | | | Yes | No | Yes | No | | |
| | | | Yes | No | Yes | No | | |

| 5. Ear, nose or throat disorders? (e.g Glaucoma, catracts, visual disorders, deafness, rhinitis, orthodontics) If yes, provide details. | | | | | | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Name of beneficiary | Diagnosis and date | Name of medication | Are you currently receiving treatment? | | Have you been hospitalised? | | Name and contact number of treating general practitioner, dentist or specialist | |
| | | | Yes | No | Yes | No | | |
| | | | Yes | No | Yes | No | | |

| 6. Blood disorder, immune deficiency state, HIV/AIDS, concer etc? If yes, provide details. | | | | | | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Name of beneficiary | Diagnosis and date | Name of medication | Are you currently receiving treatment? | | Have you been hospitalised? | | Name and contact number of treating general practitioner, dentist or specialist | |
| | | | Yes | No | Yes | No | | |
| | | | Yes | No | Yes | No | | |

| 7. Is the beneficiary pregnant? If yes, provide details. | | Yes | No |
|---|---|---|---|
| Name of beneficiary | Expected delivery date | Attending doctor | |
| | | | |
| | | | |

| 8. Are there any other conditions or systoms not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or that could potentially result in the next 12 months? If yes, provide details. | | | | | | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Name of beneficiary | Diagnosis and date | Name of medication | Are you currently receiving treatment? | | Have you been hospitalised? | | Name and contact number of treating general practitioner, dentist or specialist | |
| | | | Yes | No | Yes | No | | |
| | | | Yes | No | Yes | No | | |

## SECTION 7: EMPLOYER INFORMATION THIS SECTION MUST BE COMPLETED BY YOUR EMPLOYER

| | | | |
|---|---|---|---|
| Name of employer | | | |
| Division number | | Dept. name | |
| Pay point code | | Employee number | |
| Dependant/s subsidised | Yes / No | | |
| The above details have been noted and contribution will be adjust in terms of the scheme rules on and include arrears, if applicable. | | | d d m m y y y y |
| Total current contribution | R | | |
| Total new contribution | R | Company stamp | |
| Arrears (if applicable) | R | | |
| Name of medical scheme/ salary administrator | | | |
| Designation | | | |
| Signature | | Date signed | d d m m y y y y |

## SECTION 8: DECLARATION BY PRINCIPAL MEMBER THIS SECTION MUST BE COMPLETED

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

| | | | |
|---|---|---|---|
| Principal member's signature | | Date signed | d d m m y y y y |