spectramed

Spectramed Reg No: 1141

PRINCIPAL MEMBERSHIP AMENDMENT FORM

(TO BE COMPLETED IN BLACK INK)

• CUSTOMER SERVICE CENTRE: 0861 497 497 • NATIONAL FAX LINE: 0861 492 492 •
• EMAIL ADRESS: enquiries@spectramed.co.za • NATIONAL POSTAL ADRESS: Private Bag X1, Gardenview, 2047 •

COMMENCEMENT DATE FOR PRINCIPAL MEMBER AMENDMENT: YYYY/MM/DD

1. NEW PRINCIPAL MEMBER PERSONAL DETAILS

TITLE | FIRST NAME | SURNAME

INITIALS | I.D./PASSPORT NO. | DATE OF BIRTH: YYYY MM DD

DO YOU GRANT SPECTRAMED PERMISSION TO PERFORM I.D. VERIFICATION ON ALL RELATED PARTIES? YES NO

GENDER: M F | PREVIOUS SURNAME IF APPLICABLE

TAX NO. | COUNTRY OF RESIDENCE

RISK EQUALISATION FUND NO.

MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOWED** **CO-HABITING**

HOME LANGUAGE: **ENGLISH** **ZULU** **XHOSA** **AFRIKAANS** **OTHER**

2. CONTACT DETAILS OF PRINCIPAL MEMBER

ADDRESSES	POSTAL ADDRESS	RESIDENTIAL/PHYSICAL ADDRESS
BUILDING NAME & NO.		
STREET ADDRESS/ BOX NO.		
SUBURB		
TOWN/CITY		
PROVINCE		
AREA CODE		

CONTACT DETAILS

WORK TEL. NO. | CELLULAR NO.

FAX NO. | HOME TEL. NO.

EMAIL

CAN SPECTRAMED CONTACT YOU VIA SMS? **YES** **NO**

PREFERRED CORRESPONDENCE CHANNEL? **POSTAL** **EMAIL**

INITIAL

3. INCOME (from all sources) please note: for Spectra Azure and Spectra Cyan only

GROSS MONTHLY SALARY

PRINCIPAL MEMBER R

SPOUSE R

WEEKLY MONTHLY

Contributions will be calculated on the higher of the two gross monthly incomes. In absence of proof you will be defaulted to the highest inome bracket

4. BILLING DETAILS FOR PAYMENT OF CONTRIBUTIONS/DEBIT ORDER CLAIMS REFUNDS

PLEASE NOTE: Billing of contributions is done in advance or in arrears on the 1st calendar day of every month.

Contributions will be paid no later than the 4th day of the same month. Proof of banking details (ie. Recent stamped bank statement or letter from the bank confirming account details) for both Debit Order Collections and Claims Refunds will be required upon application for a principal member amendment with Spectramed.

Upon acceptance by Spectramed of my/our membership of Spectramed, I / we hereby authorise Spectramed, utilising the services of its nominated agent, to draw any contributions against my / our account or any other bank or branch to which I / we may transfer my / our account. I / we acknowledge that the nominated agent acts merely as Spectramed's collecting agent in respect of Debit Orders and, accordingly, all disputes regarding the payment of contributions shall be between Spectramed and me / us. I / we hereby waive any claim which I / we may have against the nominated agent.

BANK NAME

BRANCH NAME

ACCOUNT HOLDER

BRANCH CODE

ACCOUNT NUMBER

TYPE OF ACCOUNT: SAVINGS TRANSMISSION CHEQUE

CONFIRMATION OF AUTHORISED SIGNATORY: **PRINCIPAL MEMBER** **3rd PARTY PAYER** **EMPLOYER GROUP**

I, the undersigned, authorise **Spectramed** to debit my account monthly for the medical aid contribution

NAME

I.D. NUMBER

AUTHORISED SIGNATURE
(Mandated Account Holder)

USE THE ABOVE ACCOUNT FOR CLAIMS REFUNDS
(If No, please provide details below)

YES NO

Should the banking details provided not be that of the principal member, please state account holder's relationship with principal member, e.g. spouse, sibling, etc.

RELATIONSHIP

PLEASE NOTE: Refunds of lawful claims by electronic funds transfer or EFT must be completed by all applicants.
Documents such as an original bank statement or cancelled cheque must be provided to Spectramed before claims will be refunded. Please state whether these documents are attached YES NO

BANK NAME

BRANCH NAME

ACCOUNT HOLDER

BRANCH CODE

ACCOUNT NUMBER

TYPE OF ACCOUNT: SAVINGS TRANSMISSION CHEQUE

AUTHORISED SIGNATURE
(Mandated Account Holder)

SM18/PMA/V1

INITIAL

5. DECLARATION

All information disclosed in this form is subject to the provisions of sections 16(b), 29(2) and 66 of the Medical Schemes Act No. 131 of 1998, as amended (or its successor-in-law) and the rules of Spectramed as amended from time to time.

Kindly note that the "Applicant" for the purposes of this form is the person who signs the declaration of this form.

1. I understand that the statements below apply equally to me and/or my dependants.
2. I, and on behalf of my dependant/s as stated above, hereby complete this application to join Spectramed .
3. I, the undersigned, confirm that we understand that it is illegal to belong to more than one registered medical scheme at a time and that all my dependants and I will terminate our current medical membership with my/our current medical scheme ("the current medical scheme") with effect from _/_ /_
4. Any changes whatsoever to my health or that of any of my dependants will be notified in writing to Spectramed if these changes occur prior to the end of the membership of the current medical scheme or on receipt of a Spectramed Membership Card or on receipt by Spectramed of contributions, whichever is the latest.
5. I declare that the contents of this application are true, correct and complete in every aspect.
6. I declare that any false or misleading statement and/or non-disclosure of all and any material information to Spectramed shall result in the termination of any membership granted to me and any contributions paid by me or on my behalf shall be forfeited.
7. I acknowledge that membership of Spectramed is not valid unless confirmed in writing by Spectramed. I understand that certain waiting periods and/or exclusions may apply as defined in the Medical Schemes Act or in the Rules of Spectramed or both.
8. I irrevocably authorise:
   - 8.1 Spectramed to obtain from any person any information that Spectramed requires to assess the information contained in this application and/or to assess claims in respect of benefits to which this application relates and/or to obtain a second opinion; and
   - 8.2 Spectramed and/or its administrator to provide me with any personal information by means of email and/or cellular phone and/or ordinary post and to pass that information on to any third party in order to allow Spectramed to fulfill its functions, duties, obligations and realize its rights in terms of any law; and
   - 8.3 Spectramed or its contracted 3rd party service providers, or both of them, shall keep confidential, subject to the provisions of South African law, all information received by either one or both of them from a member subject to any obligation on either Spectramed or its contracted 3rd party service providers, or both of them, to utilise such information in order to fulfil their respective obligations pursuant to the registered rules of Spectramed from time to time and the applicable legislation.
9. I acknowledge that it is my sole responsibility to ensure that my contribution is paid to Spectramed by the **4th day of the month.**
10. I hereby agree to advise Spectramed, in writing, of any changes to my banking details and acknowledge that failure to do so will result in me being liable for any subsequent banking charges incurred by Spectramed.
11. I understand that, according to the Rules, I may terminate my membership **of Spectramed on giving one month's calendar written notice and that all rights to beneftis cease after the last day of my membership.**
12. I understand that certain benefits in the first year of my membership, once membership has been confirmed by Spectramed, are pro-rated and that I will not be entitled to a full year's cover if I join or change my existing option after 31 December of each year.
13. I consent to the processing of the information herein for purposes of marketing of value-added or similar products and services.

SIGNED AT

SIGNATURE OF APPLICANT

SIGNATURE OF WITNESS
(Except in the case of a minor)

DATE OF SIGNATURE (YEAR/MONTH/DAY) YYYY MM DD

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