Comp Care
Medical Scheme

Universal House, 15 Tambach Road, Sunninghill Park, Sandton
PO Box 1411 Rivonia 2128

Tel: 0861 222 777
E-mail: membership@universal.co.za
Website: www.compcare.co.za

Administrated by Universal Healthcare Administrators (Pty) Ltd

MEMBER AMENDMENT / DEPENDANT REGISTRATION FORM

Please ensure that when completing this form you provide complete, up to date and accurate information at all times. Any non-disclosure of material information or any other fraudulent act, may result in cancellation or suspension of your membership. You also may be guilty of an offence as provided for in the Medical Schemes Act 131 of 1998 and liable on conviction to a fine or imprisonment or both.

SECTION 1 - PRINCIPAL MEMBER DETAILS

Surname

First name / s

Title | Medical Aid No

	TYPE OF REQUEST (indicate with tick)	SECTION TO BE COMPLETED
	CHANGE OF ADDRESS	2, 6 and 7
	CHANGE OF BANKING DETAILS	3, 6 and 7
	TERMINATION OF DEPENDANT MEMBERSHIP	4, 6 and 7
	REGISTRATION OF BIRTH (WITHIN 30 DAYS OF BIRTH)	5, 6 and 7
	REGISTRATION OF ADULT OR CHILD DEPENDANTS	5, 6, 7 and 8

CHECKLIST DOCUMENTATION TO ACCOMPANY THIS APPLICATION

*Attach copy of birth certificate — Yes / No

*Attach copy of Identity Document / Birth certificate / Marriage certificate / Proof of previous membership / Student registration / Affidavit confirming relationship if surname is different. — Yes / No

FOR OFFICE USE ONLY

Member number

Company code

Race (for statistical use only)

Language

Subs table

Persal number

Code

SECTION 2 - CHANGE OF ADDRESS / CONTACT DETAILS

Postal address — Postal code

Physical address — Postal code

Email address

Telephone details (B) Code ( ) — (H) Code ( )

Facsimile details (B) Code ( ) — Cell

SECTION 3 - CHANGE OF BANKING DETAILS

PERSONAL BANKING DETAILS
Electronic transfer of payments to you and collection of members portion's (co-payment's) where applicable.
CREDIT CARD AND TRANSMISSION ACCOUNTS ARE NOT ACCEPTED

	PAYMENTS (Claims refunds)	**CONTRIBUTIONS**
Name of account holder		
Account holders ID no		
Name of bank		
Branch		
IBT number	- -	- -
Account number		
Type of account	Current ☐ Savings ☐	Current ☐ Savings ☐

DISCLAIMER: It is the member's responsibility to advise the administrator in writing of any change in banking details.
Neither the Scheme nor its administrators will be held liable should an incorrect account be credited under any circumstances.

I / We hereby authorise the Scheme to debit my / our bank account, the amount necessary for amounts owed by the member to the Scheme to the maximum value of R500 or as arranged with the Scheme.

Authorised Signature / s Date

Member's Signature
(if different from the authorised signature) Date

☐ Use this account for collections (Member's portions)

Authorised Signature / s Date

Member's Signature
(if different from the authorised signature) Date

☐ Use this account for collections (Member's portions)

SECTION 4 - TERMINATION OF DEPENDANT MEMBERSHIP

Name		Date of Birth	
Relationship	Female / Male	Date of Termination	
Reason			

Name		Date of Birth	
Relationship	Female / Male	Date of Termination	
Reason			

Name		Date of Birth	
Relationship	Female / Male	Date of Termination	
Reason			

SECTION 5 - REGISTRATION OF SPOUSE / PARTNER / ADDITIONAL ADULT OR CHILD DEPENDANT

Relationship to member			
First Name		Date of Birth	
Surname	Female / Male	Date Effective	

Relationship to member			
First Name		Date of Birth	
Surname	Female / Male	Date Effective	

Relationship to member			
First Name		Date of Birth	
Surname	Female / Male	Date Effective	

PLEASE ANSWER THE FOLLOWING COMPULSORY QUESTIONS - Mark the appropriate block with an "X"
(not compulsory for registration of a newborn baby)

1. Does the dependant receive a monthly income? Yes No
If yes, complete the following:

Employer's name

Monthly Salary R

Pension:

Old Age Military Disability Other

Annuity R Total R

2. Is the dependant entirely reliant on you for maintenance and support? Yes No

Give reasons

3. Does the dependant live with you? Yes No

Give reasons and attach a certified affidavit

Indicate length of stay

4. Is the dependant a student? Yes No
If yes, complete the following:

Name of academic institution Full Time Part Time

Expected period of study

Attach proof of student registration

5. Has the dependant been a beneficiary of any medical scheme before this application? Yes No
If yes, complete the following:

Name of Scheme Membership Number

Date Joined Date Left

Reason membership terminated

Please attach a copy of membership certificate, reflecting join and exit dates.
Please note that a copy of a membership card is not sufficient.

If no, provide a reason.

SECTION 6 - EMPLOYER

This application form has been scrutinised, and we are not aware of any facts other than those stated which should be made known to the Scheme. We certify that the applicant is on our permanent staff and confirm the salary details are correct.

Contribution amount **R** Date

Employer's name

Employer's signature Capacity

SECTION 7 - DECLARATION BY PRINCIPAL MEMBER

I confirm that to the best of my knowledge that the information given with this document is true and correct.

SIGNATURE OF APPLICANT DATE

SECTION 8 - MEDICAL HISTORY QUESTIONNAIRE (Not compulsory for the registration of a newborn baby registered within 30 days of birth)

It is most important that the questions listed below be answered as thoroughly as possible. The answers to these questions will be treated as confidential. It is important to note that any medical condition, of which you are aware, not disclosed in this application, can be excluded from benefit. Please advise whether you and any of your dependants suffer from, or have suffered from, or received treatment / consultation for any of the following conditions. Please ensure that you **underline** the appropriate condition, tick and complete the appropriate block / s.

			YES	NO	Name of member / dependant
1.	**Heart & Vascular System**	High blood pressure; high cholesterol; angina; heart attack; angiogram; previous coronary artery bypass; rheumatic fever; heart murmurs; valve problems / replacement; arrhythmias – insertion of pacemakers; heart failure; stroke; varicose veins; DVTs (deep vein thrombosis); pulmonary emboli.			
2.	**Lungs**	Asthma; emphysema; chronic bronchitis; TB; chronic infections - bronchitis & pneumonia.			
3.	**Digestive System, Gallbladder; Liver**	Dyspeptic disease (heartburn; hiatus hernia; peptic ulcers; reflux); irritable bowel syndrome (spastic colon; inflammatory bowel disease e.g. chrohn's & ulcerative colitis; chronic diarrhoea / constipation); gallstones & jaundice; hepatitis; pancreatitis; haemorrhoids; incontinence; bowel prolapse.			
4.	**Nervous System**	Persistent headaches; epilepsy; paralysis; degenerative diseases – Alzheimer's; Parkinson's; multiple sclerosis; stroke; neuralgias; ADD (attention deficit disorder).			
5.	**Bone; Muscle & Joints**	Arthritis; rheumatism; gout; back, knee or neck problems; fibromyalgia; previous fractures; deformities; degenerative muscle disease; osteoporosis; previous amputations / artificial limbs; birth defects; joint replacements.			
6.	**Urinary Tract**	Infections; stones; albumin / blood in urine; urinary incontinence; prolapsed bladder.			
7.	**Gynaecological System**	Menopause; female hormone replacement; irregular menses; infertility; breast tumours (benign / malignant); ovarian tumours; cysts; prolapsed uterus / rectum / bladder; miscarriage; caesarean section. Are you or one of your dependants currently pregnant?			
8.	**Male Genital System**	Prostate problems (hypertrophy / cancer or infections); infertility; hernias – groin; scrotal swellings; testicular tumours; abnormalities of the penis; problems with urination.			
9.	**Gland / Hormonal**	Over / under active thyroid; diabetes mellitus; Cushing's syndrome; Addison's disease; pituitary gland abnormality.			
10.	**Blood**	Anaemia; bleeding disorders (haemophilia); leukaemia; Hodgkin's disease.			
11.	**Ear, Nose & Throat**	Allergies (rhinitis, sinusitis); chronic infections (otitis, tonsillitis); nasal reconstruction; snoring; sleep apnoea; deafness – hearing aids.			
12.	**Eyes**	Poor vision; birth defects; degenerative disease (glaucoma; retinitis pigmentosa; cataracts; keratoconus); allergies – pterygiums; anticipated / previous laser surgery; artificial eyes.			
13.	**Emotional (psychological, psychosomatic problems)**	Depression; bipolar disorder; anxiety; stress; previous treatment for post traumatic stress syndrome; eating disorders – bulimia & anorexia; mental retardation; alcoholism; drug abuse. Have you or any of your dependants ever been on sleeping tablets or antidepressants?			
14.	**Infections / Tropical Diseases**	Sexually transmitted diseases; genital warts; HIV / AIDS; hepatitis; ME-Virus (Yuppie Flu); malaria; bilharzias; cholera; typhoid.			
15.	**Skin Disorders**	Acne; eczema; psoriases; lesions (keloid hypertrophic scars); skin rashes; shingles; Kaposi sarcoma – tumours.			
16.	**Connective Tissue Disorders**	Systemic lupus erythromatosis; scleroderma; rheumatoid arthritis.			
17.	**Teeth & Gums**	Impacted molars (wisdoms); previous / current orthodontic treatment; braces; crowns; recurrent infections- gums.			
18.	**Cancer**	Cysts; growths; tumours of any kind.			
19.	**Allergies**	Are you or any of your dependants allergic to any specific type of medication (e.g. penicillin, aspirin, sulphas, morphine, NSAIDS); pollen dust; animals; specific food types (e.g. nuts).			
20.	**Immuno-Suppressive Treatment**	Have you or any of your dependants ever had or expecting to undergo an organ treatment transplant? Have you or any of your dependants ever suffered from any condition requiring Immunosuppressive treatment?			

21. Have you or any of your dependants ever received any form of physiotherapy, occupational therapy or chiropractic treatment?
22. Are you or any of your dependants pregnant? If **yes** - how many weeks? Please give expected date of delivery.
23. Have you or any of your dependants had any previous or pending claims for which any other party may be liable e.g. MVA (Motor Vehicle Accident) claims? If **yes,** please give details.
24. Are you or any of your dependants expecting to undergo any medical treatment, e.g. hospitalisation, operation, specialised dentistry etc, within the next twelve months?
25. Do you or any of your dependants have a chronic condition requiring ongoing medication? If **yes,** please give the name and dosage of all the medication you or any of your dependants are currently taking.
26. Have you or any of your dependants ever received any medical attention of any nature, e.g., hospitalisation, operation, specialised dentistry etc, not mentioned above?
27. Have you and any dependants ever appeared before a medical board in view of early retirement and declared medically unfit?
28. Are you or any of your dependants organ donors?

If any of the questions above have been answered yes, please supply full details below. If there is not enough space, please attach an additional page.

No	Member / Dep	Full details of the disorder, consulting Doctor, type of medication & dosage used	Date of treatment	Degree of recovery

IMPORTANT! The Board may exclude from benefits or terminate the membership of a member or dependant whom the Board finds guilty of abusing the benefits and privileges of the Scheme by presenting false claims or making misrepresentation or the non-disclosure of factual information. In such an event, the member may be required by the Board to refund the Scheme any sum which, but for his abuse of the benefits or privileges of the Scheme, would not have been disbursed on his behalf.

Universal
Administrators