Bonitas

Principal member change form 2018

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Instructions

This form can be used for:

- Change in subsidy conditions
- Change in employment
- Notification of retrenchment
- Notification of retirement

Please attach the following documents to this form:

- Government employees must attach a copy of their latest salary advice
- A copy of your identity document or passport
- A stamped bank statement or letter from your bank confirming your banking details
- A copy of your payslip
- We require proof of registration for child dependants between 21 and 24 years of age who are currently studying

Please note: We cannot process your application if it is incomplete, incorrect or if you have not attached the correct documents.

Section 1: Choosing your option

Please select one option only.

BonComprehensive ☐	BonClassic ☐	BonComplete ☐	BonSave ☐	BonFit ☐	Standard ☐	Standard Select ☐
Primary ☐	Hospital Plus ☐	Hospital Standard ☐	BonEssential ☐	BonCap ☐		

R0 to R7 500 ☐ R7 501 to R12 194 ☐ R12 195 to R16 659 ☐ R16 660+ ☐

BonCap contributions are income based. Please select the income band that applies to your gross monthly salary.

Please note: If you have selected BonCap, you must also complete **Section 7** and attach the required documents. If you fail to do so you will be defaulted to the highest monthly income band. **BonCap:** Subject to a BonCap GP and BonCap network hospital. **Standard Select:** Subject to nomination of a network GP and Standard Select hospital network. **BonFit:** Subject to a GP network and BonFit hospital network.

Name of employer:

Department/Division:

Employee/Persal number: Employment date: Medical aid start date:

Number of child dependants: Number of adult dependants:

Section 2: Employee information

Please complete this section. You must submit the completed application form to your HR Department if your medical aid is through your employer.

Government employees: Please attach a current copy of your latest salary advice.

Section 3: Employer information

Name of company representative:

Title of company representative:

Telephone:

Email:

Bonitas paypoint code:

Employer stamp

If your medical aid is through your employer, this section must be completed by your employer and have your employer's stamp on it.
We, the Employer, confirm that the applicant is employed by us and began employment on the employment date stated in **Section 2**. Contributions will be deducted according to the Scheme Rules and option chosen.

Signature of employer representative: ______________________ **Date:** ______________________

Section 4: Details of proposed main member
Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Title: Surname:
First names:
Identity number:
Date of birth: Tax number:
Marital status: Gender: M F
Ethnic group: Black Coloured Indian White Asian Other
Cellphone: Telephone (h):
Telephone (w):
Email:
Postal address:
Code:
Street address:
Code:

Section 5: Details of dependants
Please enter the details for any dependants you want to be covered on your option. You may register up to four dependants on this form. Please provide identity numbers or passport numbers for all dependants and attach copies of these. You must also attach copies of marriage certificates, birth certificates, adoption papers or foster care court orders where applicable. We require an affidavit for life partners. We also require copies of previous membership certificates with the termination date.

Please note:

- An adult dependant is a person 21 years or older.
- Child rates apply to students between 21 and 24, provided that proof of registration, from a recognised tertiary institution, for the current year is attached to the application.

Dependant 1

Adult: Child: Relationship to main member:
Title: Surname:
First names:
Identity number:
Date of birth: Tax number:
Marital status: Gender: M F
Cellphone: Telephone (h):
Telephone (w):
Email:

Dependant 2

Adult: Child: Relationship to main member:
Title: Surname:
First names:
Identity number:
Date of birth: Tax number:
Marital status: Gender: M F
Cellphone: Telephone (h):
Telephone (w):
Email:

Dependant 3

Adult: [ ] Child: [ ] Relationship to main member:

Title: Surname:

First names:

Identity number:

Date of birth: Tax number:

Marital status: Gender: M F

Cellphone: Telephone (h):

Telephone (w):

Email:

Dependant 4

Adult: [ ] Child: [ ] Relationship to main member:

Title: Surname:

First names:

Identity number:

Date of birth: Tax number:

Marital status: Gender: M F

Cellphone: Telephone (h):

Telephone (w):

Email:

Section 6: GP nomination

If you choose the Standard Select option, you must nominate a GP from the Bonitas GP network for each beneficiary.

	Name	Surname	Doctor's name	Practice number	Doctor's contact number
Main member					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

Section 7: Declaration of income
Please complete this section only if you have selected the BonCap option.

Description of income	Main member R per month	Spouse/partner R per month
Salary or wages		
Commission and other rewards		
Pensions or annuities		
Rental income		
Trust distributions		
Government grants		
UIF payments		
Interest on investments		
Subsidies of any kind		
Maintenance		
Other income		
Total income	R	R

We also require the documents in the table below to be attached to this form for you and your spouse/partner. **If the required documents are not submitted with this form, you will be defaulted to the highest income band.**

If you	We need
Earn a monthly salary or salary with commission	Your latest payslip + Your bank statements for the last three months (showing the monthly income you receive)
Get paid weekly/fortnightly wages	Four latest weekly payslips or two latest fortnightly payslips OR A letter from your employer/company confirming your income + Your bank statements for the last three months (showing the monthly / weekly / fortnightly income you receive)
Earn commission only	Proof of earnings OR Your last three commission statements + Your latest IRP5 + Your bank statements for the last three months (showing the monthly income you receive)
Are self-employed	A copy of your latest IT34A (SARS notice of assessment) + A letter from an external auditor/accounting firm confirming your income + Your bank statements for the last three months (showing the monthly income you receive)
Are unemployed	Your UIF statement OR A retrenchment letter or dismissal letter if you were dismissed/retrenched in the past twelve months + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Are a minor (including children at primary and secondary school)	A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid

If you	We need
Are a full-time student (tertiary education)	Proof of registration from your tertiary institution (student card only will not be accepted) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Are a foreign student	A copy of your passport + Proof of registration from your tertiary institution + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Are a foreign national (a person living in South Africa who is a citizen of another country)	A copy of your passport + A copy of your work permit + A copy of your contract reflecting your contract period and monthly income + Your bank statements for the last three months (showing the monthly income you receive)
Are temporarily disabled	A copy of your IT34A (SARS notice of assessment) + A full medical report from your doctor + Your disability grant letter OR A letter from the Department of Social Development + Your bank statements for the last three months (showing the monthly income you receive)
Are permanently disabled	A full medical report from your doctor + Your disability grant letter + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid
Earn a Government pension (SASSA)	Your most recent SASSA pension statement OR A copy of an ATM slip confirming your monthly pension OR A copy of a withdrawal slip from a SASSA paypoint confirming your monthly pension OR A SASSA pension income letter (that is not older than six months) + Your bank statements for the last three months (showing the monthly income you receive)
Earn any other pension	A copy of your IT34A (SARS notice of assessment) OR Your most recent pension statement OR A pension income letter (not older than 6 months) + Your bank statements for the last three months (showing the monthly income you receive) + A letter from the person paying your contributions, confirming their relationship to you and that they are paying for your medical aid

Please note: Bank statements submitted must clearly show the money earned being deposited into the account.

Section 8: Medical details

Please enter the medical details and history of the main member and dependants below. Failure to disclose medical conditions could limit your benefits, exclude you from receiving some benefits or result in the termination of your membership.

Please note: Benefits are available per option, per year. A change in the principal member will not result in new allocation of benefits. You will therefore, have access to the remaining benefits that the previous principal member did not use.

Current doctor's name: ____________________ Telephone: ____________________

Do you or any of your dependants currently suffer or have suffered from any chronic illnesses? Yes ☐ No ☐

If you or any of your dependants have a history of any of the following illnesses or currently suffer from these, please complete the relevant tables below.

1. Chronic illnesses (for example, raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression or thyroid disorder).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

2. Gastrointestinal disorders (for example, heartburn, stomach disorder, Crohn's disease or ulcerative colitis).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

3. Muscle, bone, skin or nerve disorders (for example, back and neck-related conditions, arthritis, multiple sclerosis, knee or hip ailments and psoriasis).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

4. Urinary and reproductive disorders (for example, kidney stones, prostate disorders, endometriosis, ovarian cysts or menstrual disorders).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

5. Ear, nose or throat disorders (for example, glaucoma, cataracts, visual disorders, deafness or orthodontics).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

6. Blood diseases or cancer (for example, lymphoma or thalassemia).

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

7. Are you or any of your dependants pregnant? If yes, provide details.

Name	Trimester	Has a doctor confirmed the pregnancy?	Expected due date	Complications (if any)	Name of GP or specialist

8. Have you or any of your dependants had surgery in the past, or are you planning to have surgery in the next 12 months? If yes, please provide details.

Name	Surgery type	Date of surgery	Name of medicine	Name of GP or specialist

9. Are there any other conditions or symptoms not listed above, for which medical advice, care or treatment has been recommended or received, or that could potentially result in a medical claim in the next 12 months? If yes, please provide details.

Name	Illness	Are you being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

Section 9: Banking details

Use this account for contribution collections and refunds

Bank name:	
Branch code:	
Branch name:	
Name of account holder:	
Account number:	
Account type:	

Use this account for refunds only

Bank name:	
Branch code:	
Branch name:	
Name of account holder:	
Account number:	
Account type:	

I instruct Bonitas to collect my contributions by debit order using the information above. I understand that transfers cannot be done to and from credit card accounts. I also irrevocably authorise Bonitas to adjust any incorrect transactions and/or correct any electronic transfer or funds errors without prior notice. I, further, instruct Bonitas to deposit claims and savings refunds into my account using the details above.

Account holder's signature: ______________________________

If the account holder's details differ from the main member, we will also require a copy of the account holder's identity document and a bank statement or a letter from the bank confirming the account holder's details.

Section 10: Protection of your information

1. We will keep your information and your dependants' information confidential. We and our administrator have data security measures in place to do this. Personal information refers to information that identifies you or relates specifically to you or your dependants, such as an identity number, name or email address.
2. We have data security measures in place to protect you and your dependants' personal information. This may include access control to restrict the disclosure of personal information to only authorised individuals, confidentiality agreements with service providers and staff members.
3. We will only use your information for the following purposes:
   - Underwriting
   - Assessing and processing medical services claims
   - Fraud prevention and detection
   - Statistical analysis
   - Audit and record-keeping
   - Compliance with legal and regulatory requirements
   - Verifying your identity.
4. We may share your information with the service providers for the purpose of processing it and rendering services to you.
5. You may access the personal information we hold and request us to correct any errors or delete it.

Section 11: Acknowledgement and declaration

1. I, the undersigned, apply to be admitted as a member of Bonitas Medical Fund. If accepted, I agree to follow the rules of Bonitas Medical Fund. I know that the rules are available at www.bonitas.co.za and will be provided to me upon my request to Bonitas.
2. I declare that the information contained in this application form, is correct. I also declare that I have the permission of my dependants to disclose personal information about them to Bonitas and will provide written proof of this, if asked.
3. I declare that any false information in this application form or the non-disclosure of any material information will result in my membership being declared null and void.
4. I accept that Bonitas has the right to claim damages in respect of any loss or damages it may suffer due to my non-disclosure or misrepresentation or fraudulent behaviour. If any of my or my dependants' circumstances change after the date of signing this application or the acceptance of my membership, I will promptly notify Bonitas of the changes. I understand that failure to do so may lead to the termination or amendment of the terms and conditions of my membership and Bonitas shall also be entitled to reclaim any amounts, it may have erroneously paid to any service provider on behalf of me or my dependants, from me.
5. I instruct and allow my employer to deduct and pay over amounts (that may become owing or due on my behalf) to Bonitas from time to time. I also authorise any persons, bodies or institutions that may hold retirement funds for my benefit, to deduct and pay to Bonitas all amounts that may become due and owing to Bonitas.
6. I agree that should Bonitas incur any legal costs or expenses to recover any contributions owed by me or any other amount due by me to Bonitas, for any reason; I shall be responsible for such costs and expenses on the attorney/client scale. I consent to my details being listed with a credit bureau should I default in the payment of my monthly contributions or in respect of any money owed to Bonitas.
7. I understand that it is my responsibility to ensure that the monthly contributions are received by Bonitas. I also understand that if any contributions are unpaid, it may result in me and my dependants being terminated from Bonitas until all arrear contributions have been settled. I also understand that should my membership be suspended or terminated, I will not be entitled to any benefits arising from my membership whatsoever.
8. I will inform Bonitas of any changes to my or my dependants' health or personal status within 30 days of the change as required by Scheme Rules.
9. I authorise my and my dependants' healthcare providers to disclose information to Bonitas and its contracted service providers and partners, provided that the information is treated as confidential.
10. I agree to provide Bonitas with any medical or historical information and grant Bonitas access to medical information reasonably required relating to a specific ailment, disease, disorder, condition or disability.
11. I agree that should I be accepted as a member of Bonitas, I shall provide Bonitas with all information including medical information that Bonitas may reasonably require for the purpose of carrying out its obligations in terms of the Medical Schemes Act No. 131 of 1998 and the Scheme Rules.
12. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.
13. I declare that my dependants and I are not registered on another registered medical scheme.
14. I understand that the following underwriting conditions may be applicable to my membership as prescribed by the Medical Schemes Act No. 131 of 1998:
    i. A 3-month general waiting period in respect of all benefits
    ii. A 12-month exclusion in respect of a pre-existing condition
    iii. A late-joiner contribution penalty.
15. I understand that the underwriting conditions will affect my rights and my dependants' rights to benefits if applied.
16. I allow Bonitas to take all reasonable steps to verify information provided by me in this application form and agree to submit proof of identification to Bonitas on demand.
17. I consent to my telephone conversations with the Bonitas call centre being recorded and forming part of Bonitas' records. I also agree that such records will remain the sole property of Bonitas.
18. I declare that the information provided in this document is true and accurate and if accepted will form the basis of my agreement with Bonitas.
19. I acknowledge that I have read and understood the content of this application form. I confirm that the content of this application form and the implications thereof have been read and explained to me if necessary.
20. I hereby confirm that as the main member on the Scheme I have received permission from my dependants to access and view their healthcare claims made on my membership and deal with all matters relating to the claims on my membership.
21. I hereby authorise the Scheme to share my and my dependants' personal and healthcare information with the Scheme healthcare management facility, the Scheme's administrator or the relevant government authorities for administrative and statistical purposes, provided such information shall be treated as confidential at all times. I agree that my and my dependants' personal healthcare data may be shared with third parties for the purpose of our membership trend analysis (e.g. employer). I have read and understood these statements and my permission and the permission of my dependants are given voluntarily. My signature below confirms that I give permission.

Signature of main member: ______________________ **Date:** ______________________

Please note:

Late-joiner penalties and waiting periods may apply to your membership. This is a requirement of the Medical Schemes Act No. 131 of 1998.

A late-joiner penalty applies to members over 35 years of age or older, who have had a break in medical aid membership for more than 3 months from 1 April 2001. Late-joiner penalties will result in your premium being increased. This is based on a specific calculation considering the number of years you have not been a member of a medical aid.

A general waiting period lasts 3 months. During this period, you and your dependants are not entitled to claim any benefits, except, in some circumstances, Prescribed Minimum Benefits.

A condition-specific waiting period lasts 12 months. During this period, you and your dependants are not entitled to claim benefits related to a specific condition.