Change of dependants form

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Instructions
This form can be used to add or remove a dependant from your membership. This includes registration of newborns.

Would you like pre-underwriting? Yes ☐ No ☐

Section 1: Membership details

Full name:			
Identity number:		Marital status:	
Membership number:		Date for change:	

Section 2: Registration of spouse/partner/newborn/additional adult or child dependant

An adult dependant is anyone who is 21 years of age or older. Child rates apply to dependants between 21-24 years of age provided the student's proof of registration from a tertiary institution is attached to the application for the current academic year. You can register adult or child dependants on this form. Provide valid ID numbers and/or passport numbers for all beneficiaries. Acceptance of the dependants will be in accordance with the Rules of the Fund. Please attach copies of ID/passport, marriage certificates, birth certificates, legal adoption or foster care court order documents and previous membership certificates with termination date, where appropriate.

	Relationship to main member	First name	Surname	ID number	Marital status	Join Date	contact details
Dependant 1							
Dependant 2							
Dependant 3							
Dependant 4							

Section 3: GP nomination
If you choose the Standard Select, Primary Select or BonCap option you must nominate a GP from the Bonitas GP network for each beneficiary. You can access the GP network list when you log in to www.bonitas.co.za.

Please note: For BonCap you need to nominate a Primary and Secondary GP.

	Name	Surname	First doctor's name	Practice number	Second doctor's name	Practice number
Main member						
Dependant 1						
Dependant 2						
Dependant 3						
Dependant 4						

Section 4: Confirmation or change of address/contact details
Please fill in your details below. Ensure that all fields are marked clearly and can be read easily.

Cellphone:		Telephone (h):	
Telephone (w):			
Email:			
Postal address:			
		Code:	
Street address:			
		Code:	

Section 5: Medical details
Please note: Failure to disclose medical conditions could limit and/or exclude you from receiving certain benefits, or result in the termination of your membership.

Please complete the relevant tables below, should any of the dependant/s that you are registering have a history or are currently suffering from any of the following illnesses.

1. Chronic illnesses (for example, raised cholesterol, heart problems, diabetes, high or low blood pressure, asthma, depression or thyroid disorder). Yes ☐ No ☐

Name	Illness	Is the dependant 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). Yes ☐ No ☐

Name	Illness	Is the dependant 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). Yes ☐ No ☐

Name	Illness	Is the dependant 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). Yes ☐ No ☐

Name	Illness	Is the dependant 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). Yes ☐ No ☐

Name	Illness	Is the dependant 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) Yes ☐ No ☐

Name	Illness	Is the dependant being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

7. Are any of your dependants pregnant? If yes, provide details. Yes ☐ No ☐

Name	Trimester	Has a doctor confirmed the pregnancy	Expected due date	Complications	Name of GP or specialist

8. Have any of your dependants had surgery in the past, or plan to have surgery in the next 12 months? If yes, please provide details. Yes ☐ No ☐

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.

Yes ☐ No ☐

Name	Illness	Is the dependant being treated?	Date of first treatment	Date of last treatment	Name of medicine	Name of GP or specialist

Section 6: Previous medical scheme information

Have any of your dependants had previous medical aid cover? Yes ☐ No ☐

If yes, please give full details of the previous membership. It is important that you specify exact membership join and termination dates for each medical scheme. Please attach a copy of your previous certificate of membership to this form. The certificate must show the termination date.

Member's name	Scheme	Member number	Join date	Termination date

If you need additional space to provide the necessary information, please make a copy of this section and attach it to your application.

Are you changing your dependants' medical scheme due to change in employment? Yes ☐ No ☐
If so, please provide proof of such change.

Have any condition-specific waiting periods been imposed by previous medical scheme? Yes ☐ No ☐

Section 7: Termination of dependant membership due to death, divorce, over-age child dependant etc.

Attach copy of divorce decree/death certificate.

Full name/s as reflected on your fund membership card	Relationship	Date joined	Date terminated

Section 8: Employer information

This section must be completed by your employer. This form will not be processed if it does not have your employer's stamp on it, where applicable.
We, the Employer, confirm that the applicant is employed by us and that contributions will be deducted according to the Scheme Rules and effective date of change in **Section 1**.

Name of company representative: _____

Title of company representative: _____

Telephone: _____

Email: _____

Bonitas paypoint code: _____

Employer stamp

Signature of employer representative: _____ **Date:** _____

Section 9: 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 only to 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
   - Certain marketing and related activities that may be applicable from time to time, subject to such rights as you may have in law.
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.

Section 10: Acknowledgement and declaration

1. 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.
2. 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.
3. 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, 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. 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.
4. 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.
5. 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.
6. 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 Fund Rules.
7. 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.
8. 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.
9. 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 Fund Rules.
10. I also agree and understand that I may be required to attend an examination by Bonitas' medical assessors from time to time.
11. I understand that the underwriting conditions will affect my rights and my dependants' rights to benefits if applied.
12. 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.
13. 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.
14. 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.
15. I hereby confirm that as the main member on Bonitas, 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.
16. I hereby authorise the Fund to share my and my dependants' personal and healthcare information with the Fund healthcare management facility, the Fund's administrator or the relevant government authorities for administrative and statistical purposes, provided such information shall be treated as confidential at all times.
17. I understand that it is my responsibility to provide the Fund with notice of my intention to terminate my membership, according to the Fund Rules, in writing by completing the relevant Termination of Membership form.
18. I agree that my and my dependants' personal healthcare data may be shared with third parties for the purpose of membership trend analysis (e.g. employer) and for any other such purposes as may be related to our membership of the Fund. 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:** _____