

MEMBER RECORD AMENDMENT FORM

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FOR: CHANGE OF CONTACT & EMPLOYMENT DETAILS • CHANGE OF MARITAL STATUS
REGISTRATION OF BIRTHS AND ADOPTIONS • DELETION OF DEPENDANTS

Renaissance Health
Medical Aid Fund

Section A - Employment Details:

Membership number

Company Name

Nature of Industry

Company Address

Telephone Number ()

Postal Address

Employee Number

Date of Employment

Designation of Employee

Proposed Date of Change

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CB Number			

Section B - Member Details:

Title Initials Full Names

Surname

Physical Address

Postal Address Postal Code

Telephone Numbers (H) Code () (W) Code ()

Cellphone Fax E-mail:

Date of Birth Age I.D. / Passport Number

Copy of ID/Passport book to be attached to the application form - legally required

Marital Status Single Married Divorced Widowed Common Law

Section C - Bank Details:

Mark correct option with an "X"

Contribution payments

Claims refunds

(Please attach a cancelled cheque or confirmation from your bank to ensure accuracy)

Name of Account Holder

Bank

Account Number

Branch Name Branch Code

Account Type Current Cheque Savings

Signature of Account Holder Date

Section D - Member - Advice of Change in Marital Status:

(Please indicate with an "X" in the appropriate box)

Married (refer to section 4 below) Divorced (refer to section 4 below) Widowed (refer to section 4 below)

My spouse is not a member of another Scheme My spouse is employed (Name of Company)

My spouse is a member of a Registered Medical Scheme - Name of Scheme Membership no.

Title Initials New Surname (if applicable)

Date of marriage/divorce/death YEAR MONTH DAY

Section E - Registration:

REGISTRATION OF NEW BORN CHILD AND/OR ADOPTED CHILDREN UNDER THE AGE OF 21 YEARS AND/OR DELETION OF DEPENDANT(S) DUE TO DEATH, DIVORCE, CHILD SELF SUPPORTING ETC.

Dep Code	FULL NAMES (including any commonly used names(s) such as nicknames)	DATE OF BIRTH			BENEFIT DATE			A	B	TERMINATION DATE				
		YEAR	MONTH	DAY	YEAR	MONTH	DAY			YEAR	MONTH	DAY		

Note: 1) In case of adoption, copies of the adoption papers must accompany this form. CODES
2) State reason for registration or termination of the above dependant(s). A - Relationship (S - Spouse) (C - Child)
3) In case of marriage, copies of the marriage certificate must accompany this form. B - Gender (F - Female) (M - Male)
4) In case of birth, copies of the birth certificate must be attached.

Reason for registration/termination

I declare that to the best of my knowledge the information given above is true and correct

Member's signature Date

Section F - Medical History:

Supply full details on questions below. Where an answer to a question is "yes" - provide details in the space provided below
Questions pertain to Applicant and ALL beneficiaries

Have you/your spouse or any one of your beneficiaries ever experienced any of the following?

Please mark (✓) the relevant box

			Answer	
			Yes	No
1	Cardio Vascular	Chest pain/angina, heart attack, heart failure, heart valve disease, rheumatic fever, high blood pressure, (hypertension), high cholesterol, heart murmurs, circulatory problems/disorders, varicose veins, deep vein thrombosis (DVT), or any other heart or circulatory problems.		
2	Respiratory & Breathing	Asthma, difficulty with breathing, bronchospasm, tuberculosis (TB), coughing up blood, emphysema, pneumonia, cystic fibrosis, chronic bronchitis, shortness of breath, any other breathing problems. Smoking		
3	Bladder & Kidneys	Blood in urine, kidney failure, polycystic kidneys, kidney or bladder infections, removal of kidney (nephrectomy), kidney stones, abnormal kidney or urine tests or any other kidney problems.		
4	Reproductive & Gynae	Endometriosis, infertility, ovarian cysts, hysterectomy, abnormal PAP smear, laser treatment, cervix and breast biopsies, fibro-adenosis of the breast, laparoscopies, hormone replacement therapy, prostate infections or surgery, prostate enlargement or any other reproductive problems.		
5	Digestive System	Duodenal ulcers, gastric ulcers, peptic ulcers, hiatus hernia, colon problems, crohn's disease, ulcerative colitis, gall bladder problems, liver problems or any other digestive problems. Obesity		
6	Ear, Nose and Throat	Deafness, ear infections, sinus problems, nasal surgery, throat surgery, tonsils.		
7	Dental	Orthodontic treatment, dental surgery, speech impairment, harelip, cleft palate, or any other such surgery.		
8	Eyes	Blindness (partial or full), eye surgery, lens implant, cataracts, glaucoma, renitis pigmentosa, retinal detachment, impaired vision, or any other eyesight problems.		
9	Endocrine	Diabetes melitus or insipidus, underactive thyroid, overactive thyroid, thyroid surgery, crushing's syndrome, addison's disease, pituitary gland, gland problems or any other glandular problems.		
10	Back and Muscles	Neck or back problems or operations, recurrent back pain, osteoporosis, ankylosing spondylitis, rheumatoid arthritis, osteo-arthritis, disease, or any other bone or skeletal disorders.		
11	Neurological	Epilepsy, stroke (CVA), migraine, brain or head injuries, spinal cord injuries, paralysis, multiple sclerosis, mental retardation, narcolepsy, motor neuron disease, parkinson's disease, alzheimer's disease, or any other neurological problems.		
12	Psychological	Depression, anxiety, psychosis, suicide attempts, bipolar disorders, manic depression, "Stress", schizophrenia, tourete's syndrome, anorexia nervosa, received advice, counselling or hospitalisation for alcohol or drug abuse, attention deficit disorders, Bulimia or any other psychological conditions.		
13	Tumours and Growths	Benign or malignant growths or lumps or tumours including melanoma, lymph gland cancer, leukaemia, breast cancer or any other tumours, growths and cancers.		
14	Blood	Blood or bleeding disorders e.g. haemophilia, christmas factor deficiency, platelet or any other blood clotting disorders.		
15	Skin	Eczema, acne, dermatovositis, psoriasis, scleroderma, or any other skin disorders		
16	Sexually Transmitted Disease	Advice, treatment or counselling for any of the following: HIV/AIDS, syphilis, gonorrhoea, herpes, genital ulcers, pelvic infectious disease, genital warts, hepatitis B or any other sexually transmitted disease or disorders.		
17	Hospitalisation	Have you, your spouse or any dependants ever been hospitalised? If yes how frequently?		
18	Treatment & Surgery	Are you, your spouse or any dependants expecting any medical or dental advice, treatment, or are you planning any such treatment within the next three to six months?		
19	Dangerous Pastimes	Are you, your spouse, or any dependants participating in any hazardous sport or occupations, e.g. motor or motorbike or motorboat racing, dragster racing, bungee jumping, skydiving, scuba diving or any other hazardous pursuits?		
20	Pregnancy	Are you, your spouse, or any dependants currently pregnant? Should the answer be "yes", when is the expected date of delivery (yyyy/mm/dd)		
21	Other	Are there any other factors related to you or your beneficiaries' health that is not disclosed above?		
22	Planned Treatment	During the last 12 months, have you, your spouse or any dependants had any treatment or are you planning any treatment within the next six months?		

If the answer to any of the above questions is "yes", please give a short summary.

Section G - To be Completed by Employer if Member has Completed Section C and/or D:

Company Name

CB Number Monthly contribution **N\$**

Section H - For Office Use Only:

Processed by (Print name)

Signature Date

Employer Stamp