

LIBERTY MEDICAL SCHEME

We care. For you

Private Bag X35
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Membership fax 021 673 9587
www.libmed.co.za

2012 Dependant Registration Form

Important:

- Please write clearly using capital and block letters.
- It is compulsory for fields marked with * to be completed.
- Backdating will NOT be permitted.
- It is compulsory to provide copies of supporting documentation.
- The granting of dependant membership is strictly subject to the rules and approval of the Scheme.
- Please complete ID numbers in full.

SECTION 1 – DETAILS OF PRINCIPAL MEMBER

* Denotes compulsory information

Membership number*	<input type="text"/>
Member name(s)*	<input type="text"/>
Member surname*	<input type="text"/>
Employer Group number* (if applicable)	<input type="text"/>
Current option*	<input type="text"/>

SECTION 2 - DEPENDANTS TO BE REGISTERED

Join Scheme from

Please indicate the Dependant type in the blocks below

<input type="checkbox"/> Lawful spouse	<input type="checkbox"/> Child under 21	<input type="checkbox"/> Child over 21
<input type="checkbox"/> Newborn/Adopted child/Stepchild	<input type="checkbox"/> Biological Sibling under 21	<input type="checkbox"/> Life Partner

- It is compulsory to complete this section if you have any dependants you would like to add and provide copies of supporting documentation.
- The granting of dependant membership is strictly subject to the rules and approval of the Scheme.
- Please complete ID numbers in full.
- Please leave a space between names.

* Denotes Compulsory Information

Dependant 1		
Title* <input type="text"/>	Initial(s)* <input type="text"/>	Surname* <input type="text"/>
First name(s)* (as per identity document) <input type="text"/>		
Marital status <input type="text"/>	Gender* <input type="text"/>	Date of birth* <input type="text"/>
Relationship to Principal member* <input type="text"/> <small>(For example mother, child. Where your child is not your biological child, please state relationship. For example adopted child, foster child. Please provide legal proof)</small>		
ID number* <input type="text"/>	Smoker* <input type="text"/>	Weight* <input type="text"/> kg
Is your dependant: married? <input type="text"/>	financially dependent on you? <input type="text"/>	disabled <input type="text"/>
Does your dependant earn an income? <input type="text"/>	How much does your dependant earn each month? <input type="text"/>	a full-time student? <input type="text"/>

DEPENDANTS ACCEPTED BY LMS AND DOCUMENTS REQUIRED FOR REGISTRATION									
Document(s) Required	Lawful Spouse	Life Partner	Biological Parent of Member ***	Biological Siblings of Member ***	Member's Own Minor Children *****	Adult Children, Incl. Stepchildren ***	Permanently Disabled Children	Stepchildren ***	Adopted Children *****
Copy of ID/Birth Certificate/hospital confirmation reflecting the baby's name	✓	✓	✓	✓	✓	✓	✓	✓	✓
Copy of Marriage Certificate	✓								
Copy of Membership Certificate(s)/Affidavit detailing previous membership history*	✓	✓	✓	✓		✓	✓		
Affidavit confirming financial dependency of Biological Parent(s)**			✓	✓					
Proof of income if employed****			✓	✓		✓			
Proof of studies (current proof of registration at a recognised educational institution)						✓			
Affidavit confirming financial dependency of Adult Dependant(s)**				✓		✓			
Copy of the Doctor's disability report							✓		
Proof of legal adoption									✓

* **Copy of Membership Certificate(s)/Affidavit detailing previous membership history** (registration date, benefit date, resignation date, any/all waiting periods and exclusions, all registered dependants). Membership cards or copies thereof will not be accepted. If not attached, the Late Joiner Penalty may apply.

** **LMS Affidavit templates are available on www.libmed.co.za.**

*** **Subject to Annual Review**

- **Biological Parents of Member:** Fathers-in-law and mothers-in-law are not accepted
- **Biological Siblings:** Biological siblings > 21 will be charged adult rates
- **Adult Children, incl. Stepchildren:** > 21 and up to and including the age of 26 will be charged adult rates unless a full-time student at a recognised institution or disabled.

**** **Proof of income must be provided as follows:**

- Copy of dependant's most recent payslip or salary advice or government grant card
- Commission statements for the last 12 months
- Copy of dependant's latest SARS income tax return
- Written confirmation of income from dependant's human resources department, on a company letterhead
- If unemployed, your Unemployment Insurance Fund (UIF) blue book or a discharge certificate from your previous employer or affidavit stating "zero income".

***** **Member's own newborn children:** If registration with LMS takes place within 30 days of the birth no waiting period is imposed. (The "Dependant Registration form" is available on the website: www.libmed.co.za).

***** **Adopted Children:** No waiting period is imposed if registration with LMS is completed within 30 days of the adoption. (The "Dependant Registration form" is available on the website: www.libmed.co.za).

4. Reproductive Organs		Endometriosis; Infertility; Ovarian Cysts; Hysterectomy; Abnormal Pap Smears; Laser treatment; Cervix and Breast Biopsies; Fibro-adenosis of the Breast; Laparoscopies; receiving Hormone Replacement Therapy (HRT); Prostate infections or surgery; Prostate enlargement or any other reproductive problems						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:
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 system problems						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:
6. Ear, Nose & Throat		Deafness; Ear infections; Sinus problems; Nasal surgery; Throat surgery; Orthodontics; Dental surgery; Speech impairments; Harelip; Cleft Palate or any other nose or throat problems						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:
7. Eyes		Blindness (partial or full); Eye surgery; Lens implants; Cataracts; Glaucoma; Retinitis Pigmentosa; Retinal Detachment; Impaired vision or any other eye or eyesight problems						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:
8. Endocrine		Diabetes ("high blood sugar"); Underactive Thyroid; Overactive Thyroid; Thyroid surgery; Cushing's Syndrome; Addison's Disease; Pituitary Gland problems or any other glandular problems						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N									Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N									Tel:
9. Back & Muscles		Neck or back problems or operations; Recurrent back pain; Osteoporosis; Ankylosing Spondylitis; Rheumatoid Arthritis; Osteo-Arthritis; Paget's Disease or any other bone or skeletal disorders						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:
10. Neurological		Epilepsy; Stroke (CVA); Migraine; Brain injuries; Spinal Cord injuries; Paralysis; Cerebral Palsy; Multiple Sclerosis; Mental retardation; Narcolepsy; Motor Neurone Disease; Parkinson's Disease; Alzheimer's Disease or any other neurological problems						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:
11. Psychological		Depression; Anxiety; Psychosis; Suicide attempts; Bipolar Disorders; Manic Depression; "Stress"; Schizophrenia; Tourette's Syndrome; Anorexia Nervosa; Received advice, counselling or hospitalisation for Alcohol or Drug abuse; Attention Deficit Disorder; Bulimia or any other psychological problems						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:
12. Tumours & Growths		Benign or Malignant growths or lumps or tumours including: Melanoma; Lymph Gland Cancer; Leukaemia and Breast Cancer or any other tumours, growths and cancers						<input type="checkbox"/> Y <input type="checkbox"/> N				
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist				
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:

13. Blood		Blood or bleeding disorders e.g. Haemophilia; Christmas factor deficiency; Platelet or any other blood clotting disorders						<input type="checkbox"/> Y <input type="checkbox"/> N					
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist					
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:	
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:	

14. Skin		Eczema; Acne; Dermatomyositis; Pemphigus; Psoriasis; Scleroderma or any other skin disorders						<input type="checkbox"/> Y <input type="checkbox"/> N					
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist					
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:	
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:	

15. Sexually Transmitted Diseases		Advice, treatment or counselling for any of the following: HIV/AIDS; Syphilis; Gonorrhoea; Herpes; Genital Ulcers; Pelvic Infectious Disease (PID); Genital Warts; Hepatitis B or any other sexually transmitted disease or disorder						<input type="checkbox"/> Y <input type="checkbox"/> N					
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist					
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:	
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:	

16. Treatment		Are any of your dependants expecting any treatment/procedures/hospitalisation within the next 12 months?						<input type="checkbox"/> Y <input type="checkbox"/> N					
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist					
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:	
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:	

17. Hospitalisation		Have any of your new dependants to be registered been hospitalised in the last five (5) years?						<input type="checkbox"/> Y <input type="checkbox"/> N					
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist					
			<input type="checkbox"/> Y <input type="checkbox"/> N									Name:	
			<input type="checkbox"/> Y <input type="checkbox"/> N									Tel:	

18. Pregnancy		Are any of your new dependants to be registered currently pregnant? If the answer to this question is "Yes", when is the expected date of delivery?						<input type="checkbox"/> Y <input type="checkbox"/> N					
		<input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D											
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist					
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:	
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:	

19. Disabilities		Do any of your new dependants to be registered have disabilities not mentioned in the above questions 1 to 18?						<input type="checkbox"/> Y <input type="checkbox"/> N					
Dependant	Condition	Medication	Receiving treatment	Date of treatment/hospitalisation				Practitioner/Specialist					
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Name:	
			<input type="checkbox"/> Y <input type="checkbox"/> N	Y	Y	Y	Y	M	M	D	D	Tel:	

DECLARATION FOR HEALTH INFORMATION:

1. I warrant that the information I have provided pertaining to me and my dependants is true, correct and complete and that I have not concealed, withheld or misstated any material facts. Should there be any non-disclosure or material misrepresentations, I accept that my membership may be terminated and that I may forfeit my contributions to the Scheme. Liberty Medical Scheme also has the right to claim damages in respect of any loss or damage it may suffer due to my non-disclosure or misrepresentation.
2. I undertake to promptly advise the Scheme of any change in status of health of myself or any of my dependants that occurs prior to my receiving acceptance of this application. I acknowledge that not doing so may lead to the Scheme reconsidering the basis of my membership application.
3. I accept that waiting periods or late joiner penalties may be applied, based on prior medical scheme membership information I supplied, as provided for in the Medical Schemes Act (Act No.131 of 1998).

Signature of Principal member

Date

SECTION 5 – DECLARATION BY PRINCIPAL MEMBER

I, the undersigned, _____ declare that I am under legal obligation to maintain the dependants listed on this form.

I declare that my dependants (except spouse/partner) are not in receipt of a regular remuneration of more than the tax threshold per annum for persons below the age of 65.

I declare that my dependants are permanent residents of South Africa.

I agree to allow the Scheme to conduct a periodic review of the financial dependency of my dependants and that I will comply with the requirements.

I consent to Liberty Medical Scheme sharing my contact details with any contracted Third Party Provider in order to allow the Scheme to fulfill its functions, duties and obligations. I consent to the use of all contact details given in this application, by Liberty Medical Scheme, or any appointed agent/s of the Scheme, to send me information pertaining to my membership (confidential or other).

In an effort to keep you updated on activities at Liberty Medical Scheme (LMS), we have been sending you various types of marketing and health related product communications in the form of e-mails, sms's and post. We would like to ensure receiving these communications are more convenient for you and we request that you complete the section below and return it to the Scheme.

Do you wish to continue receiving LMS marketing communications?

 Y N

If yes, how would you like to receive them?

Email Y N

SMS Y N

Post Y N

I consent to LMS marketing products, services and special offers being sent to me from time to time.

 Y N

I consent to LMS sharing my membership information with any Third Party Provider contracted to LMS for the delivery of healthcare services to allow the Scheme to fulfil its functions.

 Y N

I consent that such contracted Third Party may contact me from time to time regarding their products, services and special offers.

 Y N

Signature of Principal member

Date

Please return the form by fax to 021 673 9587 or alternatively email a scanned version to updates@libertyhealth.co.za.

For any queries, please contact the Liberty Medical Scheme Contact Centre on 0860 002 163.