Topmed Medical Scheme
Amendment Form

Topmed Medical Scheme
PO Box 2338, Durban 4000
Client Services: 086 000 2158
Website: www.topmed.co.za

A Details of the Member

Surname

Full Name(s)

Membership No.

B Change of postal and / or telephone number

Postal Address

Postal Code

E-mail Address

Cellular Phone Number

Telephone Number (h) (w)

C Debit / Credit Order Instruction

To change your banking details, you will need to complete a Debit/Credit Order Instruction form.

D Death of a Member

Date of Death

Widow's / Widower's Private Address

Postal Code

Address of Trustee / Executor

Postal Code

Date of Death

Telephone Number (h) (w)

Cellular Phone Number

Important Note: Please attach a copy of the Member's Death Certificate.

E Addition of Dependant

In order to add a Dependant to your membership, please complete the questionnaire below:

PLEASE ANSWER "YES" OR "NO" FOR EVERY QUESTION ("Y" or "N")

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High blood pressure, high cholestrol or lipids, Ischaemic heart disease, Heart failure, Angina, Stroke (CVA) or Peripheral vascular disease.						
2	Obstructive lung disease (Asthma, Emphysema or COAD)						
3	Diabetes (Insulin or Non-Insulin Dependant Diabetes Mellitus)						
4	Hypo or Hyperthyroidism						
5	Arthritis, i.e. Osteo, Rheumatoid Arthritis or Gout all related musculoskeletal conditions						
6	Osteoporosis						
7	Gastro-Oesophageal Reflux Disease (GORD/heartburn) or stomach or duodenal ulcers (please circle)						
8 *	Immune Deficiency status, i.e. HIV/Aids*, immunoglobulin deficiencies						
9	Anaemia or abnormalities of clotting mechanism						
10	Hormone replacement therapy, Endometriosis or ovarian cysts						
11	Depression and/or anxiety disorders						
12	Any nervous or mental complaint, e.g. Epilepsy, blackouts, paralysis or headaches						
13	Glaucoma, cataracts or any other disorders of the eye						
14	Parkinson's Disease or Multiple Sclerosis (please circle where applicable)						
15	Hyperplasia of Prostate (BPH) or Prostatism						
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)						
17	Urinary tract infection or calculi (stones)						
18	Back or neck related condition (lumbago, sciatica, injury, spasm, etc)						
19	Are you pregnant? If so, how many weeks?						
20	Have you had any surgical procedure during the past 12 months or planning a surgical procedure in the following 12 months?						
21	Are you on any medication at present?						
22	Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, or could potentially result in a medical aid claim within the next 12 months?						
23	Skin conditions/disorders, e.g. Acne, Eczema, Psoriasis, etc						
24	Ear, nose or throat disorders, e.g. ear discharge, recurrent tonsillitis						
25	Infectious diseases, e.g. Tuberculosis, Shingles, measles, etc						
26	Malignant Neoplasms (Cancer, growths or malignant tumours)						
27	Benign Neoplasms (non malignant tumours/growths)						
28	Specialised dentistry /maxillo facial treatment						
29	Have you had or are you expecting to have Plastic or reconstructive surgery?						

* Should you be HIV positive and not wish to disclose this on your application form, please note that once you have received your membership (contract) number we require you to please fax confirmation of your HIV/Aids status to our HIV/Aids Department on (031) 580 0484. Please note that this may result in you receiving a second card from the Scheme pending whether your application will require underwriting as per current legislation.

Question No.	Nature and duration of complaint and full details of treatment being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment ?

NB: Failure to disclose any pre-existing conditions could result in benefits being limited, excluded and /or membership terminated.

F Addition of Dependants (in the case of newborns, within 30 days of birth. Please attach a copy of the birth certificate.)

	Full name(s)	Surname	Gender (M / F)	ID number	Relationship (spouse, son, partner*, etc)
1					
2					
3					
4					
5					

G Cancellation of Dependant

Surname

Initials

Full Name(s)
(Including any commonly used names or nicknames)

Date of resignation D D M M Y Y Y Y

Reason

H Declaration by Member

I hereby declare that the information in this document, whether it is in my own handwriting or not, is complete and correct.

Signature (Main Member) _____

Date signed D D M M Y Y Y Y

I To be completed by Employer if Member has completed sections D, F and G

Name of Employer

Group Number

The above details have been noted and the contribution will be adjusted in terms of the rules, at the end of D D M M Y Y Y Y

for D D M M Y Y Y Y with arrears, if applicable.

Total current contribution R

Total new contribution R

Arrears (if appliable) R

Signature - Employer

Date signed D D M M Y Y Y Y

Stamp - Employer