Regular Force
Medical Continuation Fund

Tel: 012 679 4200
Fax: 012 679 4460
membership@rfmcf.co.za
PO Box, 3799, Pretoria 0001

APPLICATION TO REGISTER A DEPENDANT

Instructions:

1. Please complete every section below in full. If not applicable, please write N/A in the appropriate field.
2. Kindly complete this application form as accurately as possible and email it, along with the required documentation listed below, to membership@rfmcf.co.za for further action.
3. The Fund requires a copy of each dependant(s) identity document(s).
4. Additional documentation required for this application:

Type of Dependant	Requirements
Spouse	Copy of the spouse's ID document and Marriage Certificate
Life Partner	Copy of the Life Partner ID document and Notarized Partnership Agreement (Section 4)
Newly born child	A copy of the Unabridged Birth Certificate
Legally adopted child	A copy of the Birth Certificate and Adoption letter
Full-Time Student	Proof of full-time registration at a recognised national educational institution
Permanently Medical Disabled Child	A medical report to prove that the child is permanently medically unfit to register as a beneficiary

Section 1: Details of the Principal Member

Member Number V P A -

Title Initials Surname

Full names

ID Number

Marital status

Physical Address

Postal code

Postal Address (if different)

Postal code

Telephone - home ( ) - Cellphone number ( ) -

Telephone - work ( ) - Fax - work ( ) -

Email address

Section 2: Details of the Dependants

First Name	Surname, if different from Principal Member	ID Number	Gender (M/F)	Relationship to Principal Member
1.				
2.				
3.				
4.				

*An applicant may be requested by the Fund to confirm relationship to Principal Member

Section 3: Medical Details Questionnaire

If any dependants have been diagnosed with any of the following conditions, please list them below.

IMPORTANT: Each dependant who has been diagnosed with any of these conditions MUST register on the Disease Risk Management Programme by completing the Chronic Application Form available on the RFMCF website. For more information, contact 012 679 4200 or email chronicregistration@rfmcf.co.za

	Condition	Tick Box	Medicines
1	**Addison's Disease**		
2	**Asthma**		
3	**Bipolar Mood Disorder**		
4	**Bronchiectasis**		
5	**Cardiac Failure**		
6	**Cardiomyopathy**		
7	**Chronic Obstructive Pulmonary Disease (COPD)**		
8	**Chronic Renal Failure**		
9	**Coronary Artery Disease**		
10	**Crohn's Disease**		
11	**Diabetes Insipidus**		
12	**Diabetes Mellitus Type 1**		
13	**Diabetes Mellitus Type 2**		
14	**Dysrhythmias**		
15	**Epilepsy**		

Section 3: Medical Details Questionnaire Continued

	Condition	Tick Box	Medicines
16	Glaucoma		
17	Haemophilia (A + B)		
18	HIV/Aids		
19	Hyperlipidemia		
20	Hypertension		
21	Hypothyroidism		
22	Major Depression		
23	Multiple Sclerosis		
24	Parkinson's Disease		
25	Rheumatoid Arthritis		
26	Schizophrenia		
27	Systemic Lupus Erythematosus		
28	Ulcerative Colitis		

Section 4: ONLY to be completed for Life Partner Application

We, the undersigned, wish to enter into a Life Partnership.

AND WHEREAS we realise and understand that for the purposes of the Regular Force Medical Continuation Fund, it is a specific requirement that any Life Partner relationship shall be described in detail in a Notarial Deed, executed before a registered Notary Public.

NOW THEREFORE we, the parties hereto state as follows:

1. That we hereby pledge a firm commitment towards each other in a Life Partnership, for all intents and purposes the same as the commitment in a legally/binding marriage.

2. That we are not related to each other with the 4th degree of consanguinity and have the full intention to live together in a common household as Life Partners.

3. That we have been in this relationship since (date)_____/_____/_____and regard each other as domestic partners.

4. That we undertake to have this document attested before a Notary Public, at our own cost, upon which the Notary Public will also complete the PARTICULARS NOTARY PUBLIC section at the bottom of the last page hereof.

Section 4: ONLY to be completed for Life Partner Application Continued

AFFIDAVIT:

APPLICATION FOR THE CAPTURING OF A LIFE PARTNER IN MY FAMILY STRUCTURE FOR THE REGULAR FORCE MEDICAL CONTINUATION FUND BENEFITS

1. I, (Full Names)

Identity Number

Request that my Life Partner, with whom I have entered into an agreement with, be captured on my membership VPA _____ for medical benefits.

2. I state the following under oath:

a. Life Partner's full names are

ID number of Life Partner:

b. We are legally bound by an agreement attested before a Notary Public.

c. I commit to inform the Regular Force Medical Continuation Fund immediately in writing of any changes in the Life Partnership Agreement, *inter alia* in order to have my partner withdrawn as a medical beneficiary. I will submit original documentation to substantiate any changes to the relationship.

d. I understand that this relationship can only be dissolved before a Notary Public and that both my life partner and I have to sign the documentation related to the dissolution of the agreement.

3. Certified true copies of all required documentation were attended to support the application.

4. Any other comments:

5. I undertake to inform the Regular Force Medical Continuation Fund within 30 days of any change in the above-mentioned circumstances.

6. In reply to questions put by the Commissioner of Oaths, I further declare that:

a. I know and understand the contents of the above declaration
b. I have no objection to taking the prescribed oath and:
c. I consider the prescribed oath as binding on my conscience

7. Thus, declared and signed by me after pronouncing the prescribed oath on the _____ day of _____ 20 _____

at _____

_____

Signature of Deponent

Section 4: ONLY to be completed for Life Partner Application Continued

8. I certify that the deponent has acknowledged before me that he/she knows and understands the contents of this declaration.

Thus acknowledged, sworn and signed before me after pronouncing the prescribed oath on the

_____ day of _____ 20 _____ at _____

_____

Ex Officio Commissioner of Oaths

Full Names of Commissioner of Oaths: (In his/her own printed handwriting)

Business Address of Commissioner of Oaths: (In his/her own printed handwriting)

Rank of Commissioner of Oaths:
Appointed as ex officio

PARTICULARS NOTARY PUBLIC (Please note that this agreement will not be accepted for processing if the following section is not fully completed)

PROTOCOL NUMBER OF THIS AGREEMENT:

NOTARY:INITIALS AND SURNAME:

CONTACT TELEPHONE NUMBERS:

PHYSICAL ADDRESS:

CHILDREN:
If the following children are brought into the Life Partnership, they would need to be legally adopted by the principal member.
The following children have been adopted by the principal member and the documentation is provided along with this form.

FULL NAMES AND SURNAME OF CHILD

DATE OF BIRTH:

FULL NAMES AND SURNAME OF CHILD

DATE OF BIRTH:

Section 4: ONLY to be completed for Life Partner Application Continued

FULL NAMES AND SURNAME OF CHILD

DATE OF BIRTH:

FULL NAMES AND SURNAME OF CHILD

DATE OF BIRTH:

Thus signed at _____ on this day of _____ 2022

Member: _____ Witness 1: _____

Partner: _____ Witness 2: _____

Section 5: Declaration

5.1 The Fund confirms that:

5.1.1 A member's personal details and medical information (obtained from healthcare providers with the explicit consent of the member) shall be kept confidential;
5.1.2 Member information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes;
5.1.3 The Fund has data security measures in place including anti-virus security, prevention of unauthorised access to members details, eliminating unauthorised e-mails, web-mails and access controls for signing onto the computer system;
5.1.4 The Fund has granted access to certain persons within the organisation and its contracted third parties, to a beneficiariy's personal and health information. This is for the facilitation of normal business processes;
5.1.5 All Fund employees and its contracted third parties is bound by internal confidentiality agreements;
5.1.6 The Fund and its contracted parties will use the medical health/diagnosis/procedure information for the following purposes: processing the application for membership; re-imbursement, determining member entitlement to benefits, and risk management practices.
Risk management practices include: hospital risk management, disease risk management, and medicine risk management;
5.1.7 The Fund has ensured that confidentiality agreements have been entered into with all contracted third parties who have access to beneficiary information for the purposes of data transfer and management, Fund administration and managed care arrangements;
5.1.8 In the event of a breach in confidentiality, the Fund assumes responsibility and the breach will be managed according to the Fund's internal protocols.

5.2 Financial Declaration by the Applicant:

5.2.1 I hereby instruct the and authorise the Fund to draw money against my bank indicated in the application form (or any other bank or branch to which I may transfer my account) the amount necessary for payment of my monthly contribution due in respect of the abovementioned membership on the selected deduction date as indicated in Section 3.1 each and every month continuing until termination of our agreement or until cancelled by me in writing. All such withdrawals from my bank account by the Fund shall be treated as though they had been signed by me personally.
5.2.2 I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher.
5.2.3 I agree to pay any bank charges relating to this debit order instruction.
5.2.4 This authority may be cancelled by me giving you thirty days notice in writing, but I understand that I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my bank (whichever it is or will be).

Section 6: Terms and conditions

Declaration by the Applicant:

6.1. I am applying for membership of the Regular Force Medical Continuation Fund (RFMCF) and warrant and declare that the information given and statements made herein, whether completed by me or on my behalf, are correct and complete in every respect. I understand that acceptance of my membership of RFMCF is subject to the eligibility criteria and the Rules of the Fund.

6.2. I expressly authorise any healthcare service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to RFMCF, or its contracted service providers, on request, also after the death or termination of membership of any of us. I expressly grant RFMCF the right to access our personal information as and when necessary.

6.3. I expressly authorise RFMCF, to the extent that it may be required by law, to process, which includes the collection, usage and storage of, our personal information, comprising amongst others our demographic, health and biometric information, contact details as well as information related to any suspected fraudulent behaviour by me or any of my dependants, and which information has been supplied by us to RFMCF or which RFMCF may lawfully collect from any third party, for the purposes specified above.

6.4. I consent to the recording of all conversations between myself or any of my dependants and RFMCF or any of its contracted service providers and agree that all information so obtained as well as all other information about us may form part of the records of RFMCF, which records may be retained for as long as it is required in terms of the Rules or applicable legislation, for historical, statistical or research purposes, subject to the requirements of the law, or for any other lawful purpose.

6.5. I understand that my dependants and I must ensure that RFMCF is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of our application for membership, underwriting, the administration of our membership, the calculation of contributions, the processing of claims, payment of benefits, communication by RFMCF with us, and other purposes relevant to our membership as stipulated above.

6.6. I understand that my dependants and I may have access to our personal information held by RFMCF and may request RFMCF to correct any inaccurate information subject to the provisions of applicable legislation.

6.7. I understand that should any of my dependants or I have any concern about the processing of our personal information, we may raise the matter with the Principal Officeror lodge a complaint with the Information Regulator.

6.8. I agree that the information supplied on this application form, together with the supporting information, forms the basis of my membership of RFMCF and that my membership of RFMCF is subject to the conditions, exclusions, and limitations of benefits in accordance with the Defence Act 42 of 2002 Regulations and the Rules of the Fund. I also understand that should any information be incorrect or incomplete, my application for membership might not be approved, my membership might be terminated, or it might prevent RFMCF from providing me and my dependants with benefits and services, including payment of claims.

6.9. I agree that my dependants and I shall abide by the Rules of the Fund, as amended from time to time.

6.10. I authorise RFMCF to deal with my dependants and I electronically and treat electronic communication (such as email, fax, telephone, or communication through RFMCF's digital App) as being the same as written authority and confirmation. I agree further that, where I choose to use electronic methods to transact with RFMCF, we will carry the risk of such use.

6.11. I declare that in the event of any amount being paid by RFMCF in respect of me or any of my dependants arising from injuries which may involve a claim against any other party, I undertake to refund RFMCF the whole amount relevant to medical expenses incurred by RFMCF that I recover from any other source.

6.12. I guarantee that, to the extent that it may be required by law, I have the necessary authority from my dependants to provide the consent and permissions contained in this application and to receive communication from RFMCF on their behalf regarding any matter related to their membership and medical cover, including relevant health information.

6.13 I understand that RFMCF will inform me whether my application for membership has been successful.

This application will remain valid until cancelled in terms of the Rules of the Fund

Signature of Principal Member		Print Name and Surname of Principal Member	

Date D D — M M — 2 0 Y Y