kaelohealth

Kaelo MyHealth Plus

Primary healthcare for UCT staff

INDIVIDUAL EMPLOYEE INFORMATION SHEET & MEMBERSHIP APPLICATION FORM

UCT Staff in permanent and & T2 capacity
PAYCLASSES 2-6 ONLY

HEALTHCARE OFFICE ONLY

STAFF NO		PAYCLASS		PERMANENT / T2		CONTRACT START	
PERSONNEL AREA						COST CENTRE	
ORG UNIT						CAMPUS LOCATION	

SUPPORTING DOCUMENTS REQUIRED

- **Section A:** Proof of cover on a registered SA medical aid scheme. Only a current certificate of membership is accepted.
- **Section B:** A clear copy of the main member's ID/Passport document.
- **Section C:**
  - Clear copies of the ID/passport or birth certificate for all dependants named in the application.
  - Affidavit or proof of guardianship is required for grandchildren and fostered or adopted children.
  - Adult children between the ages of 21 and 26 will be billed at the child dependant rate if they are registered for studies. Please provide current proof of registration for studies. If no proof is provided the dependant will be charged at the adult dependant rate.

SECTION A: EMPLOYEE CONFIRMATION OF COVER

I, ……, declare that

Tick	Statement	Confirmation Required	Additional info	Tick applicable line / box
	I DO NOT HAVE COVER on a registered South African medical aid scheme as either the main member or spouse/partner dependant	I confirm my compulsory membership with the UCT primary healthcare insurance, Kaelo MyHealth Plus, is applicable.	My Kaelo MyHealth Plus membership will start from: ……	☐ Main member only *(below)* OR ☐ Add dependants (+ page 2) Complete details and include supporting documents
	I HAVE COVER on a registered South African medical aid scheme as either the main member or spouse/partner dependant.	I am continuing this medical aid cover. I acknowledge I am required to provide proof of cover annually or I will be required to belong to the UCT primary health care insurance, Discovery Flexicare Plus.	Medical Aid Scheme name …… Membership number ……	☐ Proof of cover: A current Certificate of Membership to be attached.

EMPLOYEE NAME: _____ EMPLOYEE SIGNATURE _____DATE _____

Return to: Gaynor Pekeur Email: HR.Healthcare@uct.ac.za HR Healthcare office: 021 650-3519

Forms must be returned by the 10th of the month.

2023/10/20

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SECTION B: EMPLOYEE APPLICATION - MAIN MEMBER DETAILS *(Complete all details)*

SURNAME		FIRST NAMES		TITLE	
ID / PASSPORT NO		GENDER		LANGUAGE	
CELL NUMBER		EMAIL ADDRESS			
PHYSICAL ADDRESS & POST CODE (HOME)					
TELEPHONE (H)		TELEPHONE (W)			
EMPLOYEE SIGNATURE		DATE	COPY OF ID / PASSPORT INCLUDED		

SECTION C: ADDITION OF DEPENDANTS

DEPENDANT'S START DATE OF COVER: _____

FIRST NAMES	SURNAME	ID NUMBER	RELATIONSHIP TO MAIN MEMBER	GENDER	CELL NUMBER

Relationship to main member e.g., spouse, partner, child, adult child (from 21 years of age).

MAIN MEMBER NAME: _____ SIGNATURE: _____

DATE _____

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