



ADMINISTRATOR WORKSHOP

MARCH 2012



AGENDA
ADMINISTRATOR WORKSHOP MARCH 2012

Duration	Topic
09h30 - 10h00	Tea / registration
10h15 - 10h15	Course objectives
10h15 - 11h00	Annual returns
11h00 - 11h15	Quarterly returns - broad overview
11h15 - 11h30	Circular 38 overview
11h30 - 12h00	Accrediting administrators - evaluation findings
12h00 – 13h00	Lunch



ANNUAL STATUTORY RETURN IN TERMS OF SECTION 37 OF THE MEDICAL
SCHEMES ACT 131 OF 1998

Medical Scheme:

Financial Year End: 31 December 2011



ANNUAL STATUTORY RETURN IN TERMS OF SECTION 37 OF THE MEDICAL SCHEMES ACT 131 OF 1998

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PART 1.1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN

Name of Medical Scheme:	
Type of Scheme:	
Type of Administration:	
Change in Administrator:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Administrator:	
Change in Administrator Effective From:	dd/mm/yyyy
Amalgamated:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Scheme Amalgamated with:	
Amalgamation Effective From:	dd/mm/yyyy
Liquidated:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liquidation Effective From:	dd/mm/yyyy
Under Curatorship:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Curatorship Effective From:	dd/mm/yyyy
Name Change:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Name:	
Name Change Effective From:	dd/mm/yyyy
Financial Period End:	31 December 2011
Ref No.:	
1. Initials and Surname of Principal Officer:	
1.1 Postal Address:	



PART 1.1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN

1.2 Telephone Number:	
1.3 Cell Phone Number:	
1.4 Fax:	
1.5 E-mail Address:	
2. Initials and Surname of Chairperson:	
2.1 Postal Address:	
2.2 Telephone Number:	
2.3 Cell Phone Number:	
2.4 Fax:	
2.5 E-mail Address:	
3. Initials and Surname of Trustee Signatory:	
3.1 Postal Address:	
3.2 Telephone Number:	
3.3 Cell Phone Number:	
3.4 Fax:	
3.5 E-mail Address:	
4. Registered Office of the Medical Scheme in the RSA (Physical Address):	
4.1 Postal Address:	



PART 1.1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN

4.2 Telephone Number:	
4.3 Fax:	
4.4 Website Address:	
4.5 E-mail Address:	
5. Name of Administrator:	
5.1 Postal Address:	
5.2 Telephone Number:	
5.3 Fax:	
5.4 Website Address:	
5.5 E-mail Address:	
6. Name of Co-Administrator:	
6.1 Postal Address:	
6.2 Telephone Number:	
6.3 Fax:	
6.4 Website Address:	
6.5 E-mail Address:	
7. Person (Fund manager) Responsible for the Medical Scheme:	
7.1 Telephone Number:	



PART 1.1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN

7.2 Cell phone Number:	
7.3 Fax:	
7.4 E-mail Address:	
8. Name of Person Responsible for the Completion of the Return:	
8.1 Telephone Number:	
8.2 Cell phone Number:	
8.3 Fax:	
8.4 E-mail Address:	
9.1. Auditors:	
9.1.1 Name of Audit Firm:	
9.1.2 Initials and Surname of the Responsible Partner(s):	
9.1.3 Telephone Number:	
9.1.4 Cell phone Number:	
9.1.5 Fax:	
9.1.6 E-mail Address:	
9.2. Auditors:	
9.2.1 Name of Audit Firm:	
9.2.2 Initials and Surname of the Responsible Partner(s):	



PART 1.1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN

9.2.3 Telephone Number:	
9.2.4 Cell phone Number:	
9.2.5 Fax:	
9.2.6 E-mail Address:	
10. Initials and Surname of the Liquidator:	
10.1 Telephone Number:	
10.2 Cell phone Number:	
10.3 Fax:	
10.4 Email Address:	
10. Initials and Surname of the Curator:	
10.1 Telephone Number:	
10.2 Cell phone Number:	
10.3 Fax:	
10.4 Email Address:	



PART 1.1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN (CONT.)

We, the undersigned, certify that, to the best of our knowledge, the particulars contained in this return are extracted from the books, records and reconcile to the audited Annual Financial Statements of the scheme and that the information is correct.

Principal Officer:	
Signature:	
Date:	
Chairperson:	
Signature:	
Date:	
Trustee Signatory:	
Signature:	
Date:	



PART 1.2

BENEFIT OPTIONS

Number of benefit options reported on:	
List benefit options by name:	



PART 1.3

BOARD OF TRUSTEES

Number of Board of Trustees:	
List Board of Trustees by name:	



PART 1.4

REPORT OF THE BOARD OF TRUSTEES

GENERAL	Answer
1. Has there been a change in accounting policies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
2. Has there been a change in accounting estimates?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
3. Has any company/institution/person to your knowledge received or dealt with the contributions of the scheme otherwise than in terms of Sections 26(6) and 26(7)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
4. Are transfers to and from reserves fully disclosed in the attached financial statements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
5. Does the scheme have fidelity guarantee and professional indemnity insurance cover in terms of the Act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
6. Were any contract(s) in place during the financial year in respect of inter alia the following services provided to the members of the scheme:	
a) Managed care: management services	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) With the administrator	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii) With other third parties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name (specify)	
b) Managed care: healthcare benefits: no transfer of risk	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name (specify)	



PART 1.4

REPORT OF THE BOARD OF TRUSTEES

GENERAL				Answer
c) Risk transfer arrangements during previous and current financial year				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name (specify)	Previous year	Current year		
<i>Details of risk transfer arrangements are pulled through from the "Current year" column in the previous year's return.</i>				
d) Commercial re-insurance				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name (specify)				
e) Administration agreements				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name (specify)				
<i>Details of administrator and co-administrator are pulled through from Part 1.1.</i>				
f) Brokerage agreements				<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Other				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name (specify)				
7. Did the Scheme prepare consolidated annual financial statements?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of consolidated party (specify)	% holding	Nature of relationship	Specify (where applicable)	
Please ensure that copies of all the parties consolidated annual financial statements are submitted to the Council for Medical Schemes.				
8(a). Does the scheme make use of diagnostic coding?				<input type="checkbox"/> Yes <input type="checkbox"/> No
What systems are used?				
8(b). Does the scheme make use of surgical procedure codes?				<input type="checkbox"/> Yes <input type="checkbox"/> No



PART 1.4

REPORT OF THE BOARD OF TRUSTEES

GENERAL	Answer
What systems are used?	
8(c). Did the scheme operate any unregistered options?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
TECHNICAL PROVISIONS AND INTERNAL SYSTEMS	
9(a). Are underwriting, financial and investments results which can be relied upon for making management decisions, available timeously?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9(b). How frequently are these results available?	
10. Are these results generally available for the calculation of provisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
11. Is sufficient reliable data available for the calculation of provisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
12(a). Has the basis for calculating provisions been changed from the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12(b). Are provisions calculated monthly/quarterly/half yearly/annually?	Monthly/Quarterly/Half yearly/Annually
Please provide full details to the methodology used.	
13. Has an independent person verified the adequacy of provisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide name, date and qualification.	
ASSET COVER	



PART 1.4

REPORT OF THE BOARD OF TRUSTEES

GENERAL	Answer
14(a). Are any assets encumbered in terms of section 35 (6)(a)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
14(b). Are any assets held by another person on behalf of the scheme in terms of section 35(6)(b) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
14(c). Has there been any direct or indirect borrowing of money in terms of section 35(6)(c)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
14(d). Has any suretyship been given in terms of section 35(6)(d)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
15(a). Has any asset been revalued during the year under review?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15(b). Name, date and qualification of valuator.	
15(c). Whether it was done internally or externally.	Internally/Externally
15(d). Other detail.	
16. Are all assets of the Scheme or title thereto held by the scheme in terms of section 26 and Regulation 24?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
17(a). Do the notes to the financial statements fully include contingent liabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
17(b). Does the scheme have any issued guarantees?	<input type="checkbox"/> Yes <input type="checkbox"/> No



PART 1.4

REPORT OF THE BOARD OF TRUSTEES

GENERAL	Answer
Please provide full details.	
INVESTMENTS	
18. Are all investments made in accordance with proper authority from the Management Board/Committee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
19. Does the Scheme hold any investment in the business of any other medical scheme, participating employer group, the administrator of the Scheme or any person associated with the parties mentioned?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
20. Did the Scheme grant a loan to any other medical scheme, participating employer group, the administrator of the Scheme or any person associated with the parties mentioned?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
21. Are appropriate systems in place to enable the frequent and effective monitoring of investments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Are the total assets in compliance with Annexure B?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
23. Have there been any developments after the year end, which have a significant effect on the financial soundness of the Scheme?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
24. Have there been any developments in respect of possible amalgamations, liquidations, and de-registrations of the Scheme?	<input type="checkbox"/> Yes <input type="checkbox"/> No



PART 1.4

REPORT OF THE BOARD OF TRUSTEES

GENERAL	Answer
Please provide full details (i.e. the name of scheme (amalgamating with) and the effective date (if finalised).	
25. Did the Board/Committee meet as frequently as determined by the rules of the scheme?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	
26. After having taken all reasonable steps to obtain the necessary information, the Management Board/Committee hereby reports to the Registrar that:	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) The internal controls and systems of the Scheme are designed to provide reasonable assurance as to the integrity and reliability of the published financial statements.	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Such controls and systems are based on established written policies and procedures and are implemented by trained, skilled personnel whose duties have been segregated appropriately.	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) The controls are monitored by the Scheme and that all employees are required to maintain the highest ethical standards in ensuring that the business practices of the Scheme are conducted in a manner that, in all reasonable circumstances, is beyond reproach.	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) It is confirmed that nothing has come to their attention to indicate that any material malfunctioning of the aforementioned controls, procedures or systems had occurred during the year under review.	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) It is confirmed that there is no reason to believe that the medical scheme will not be a going concern in the year ahead.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the answer to any of the above is No, provide full details.	
27. If the administration of the Scheme is contracted to a third party the Management Committee/Board should qualify par.26 (a)-(e) as such and obtain and append a letter of comfort from the Administrator in response to this information.	<input type="checkbox"/> Yes <input type="checkbox"/> No



PART 1.4

REPORT OF THE BOARD OF TRUSTEES

GENERAL	Answer
28. Does the audit committee's composition adhere to the requirements of Sections 37(10) and 37(11)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide full details.	



PART 2 MEMBERSHIP

PART 2.1 MEMBERSHIP AT THE END OF THE FINANCIAL YEAR

	Benefit Options	Members	Adult Dependants	Child Dependants	Beneficiaries	Dependant Ratio
2.1.1						
2.1.2						
2.1.2	<i>Consolidated Total</i>					

Please provide the reasons, should the members and/or adult and/or child dependants be zero for any option:

Please provide the reasons, and action to be taken, should the principal members be less than 6 000 members:



PART 2.2

NUMBER OF REGISTERED MEMBERS AND DEPENDANTS AT THE END OF EACH MONTH

	Month	Members	Adult Dependants	Child Dependants	Beneficiaries	Dependant Ratio
2.2.1	January					
2.2.2	February					
2.2.3	March					
2.2.4	April					
2.2.5	May					
2.2.6	June					
2.2.7	July					
2.2.8	August					
2.2.9	September					
2.2.10	October					
2.2.11	November					
2.2.12	December	Part 2.1.2 - Consolidated total of Members	Part 2.1.2 - Consolidated total of Adult Dependents	Part 2.1.2 - Consolidated total of Child Dependents		
2.2.13	Average					

Please provide the reasons if the members and/or adult dependants and/or child dependants are zero in any month:

--



PART 2.3

AGE ANALYSIS OF BENEFICIARIES AS AT END OF THE FINANCIAL YEAR

		Consolidated Total		Per Benefit Option	Per Benefit Option
		Male	Female	Male	Female
2.3.1	Less than one year				
2.3.2	1-4 years				
2.3.3	5-9 years				
2.3.4	10-14 years				
2.3.5	15-19 years				
2.3.6	20-24 years				
2.3.7	25-29 years				
2.3.8	30-34 years				
2.3.9	35-39 years				
2.3.10	40-44 years				
2.3.11	45-49 years				
2.3.12	50-54 years				
2.3.13	55-59 years				
2.3.14	60-64 years				
2.3.15	65-69 years				
2.3.16	70-74 years				
2.3.17	75-79 years				
2.3.18	80-84 years				
2.3.19	85 years +				



2.3.20	Total				
	Cumulative Total				
	65 Years + Ratio				
	Average Age per Beneficiary				

Please provide the reasons, should the total males or females be zero for any option:



PART 2.4.1

MEMBER MOVEMENT

		Number of New Members Joining the Scheme			Number of New Dependants Joining the Scheme	Number of Members Leaving the Scheme	Number of Dependants Leaving the Scheme
		Number of Members Transferring from Other Schemes	Number of Members not Transferring from Other Schemes	Total			
2.4.1.1	January						
2.4.1.2	February						
2.4.1.3	March						
2.4.1.4	April						
2.4.1.5	May						
2.4.1.6	June						
2.4.1.7	July						
2.4.1.8	August						
2.4.1.9	September						
2.4.1.10	October						
2.4.1.11	November						
2.4.1.12	December						
2.4.1.13	<i>Total</i>						



PART 2.4.2

AGE ANALYSIS OF MEMBER MOVEMENT FOR THE FINANCIAL YEAR

		Number of New Members Joining the Scheme	Number of New Dependants Joining the Scheme	Number of Members Leaving the Scheme	Number of Dependants Leaving the Scheme
2.4.2.1	Less than one year				
2.4.2.2	1-4 years				
2.4.2.3	5-9 years				
2.4.2.4	10-14 years				
2.4.2.5	15-19 years				
2.4.2.6	20-24 years				
2.4.2.7	25-29 years				
2.4.2.8	30-34 years				
2.4.2.9	35-39 years				
2.4.2.10	40-44 years				
2.4.2.11	45-49 years				
2.4.2.12	50-54 years				
2.4.2.13	55-59 years				
2.4.2.14	60-64 years				
2.4.2.15	65-69 years				
2.4.2.16	70-74 years				
2.4.2.17	75-79 years				
2.4.2.18	80-84 years				



2.4.2.19	85 years +				
2.4.2.20	<i>Total</i>				

Please provide the reasons for the inclusion of members in the category: Less than one year



PART 2.5

WAITING PERIODS

		Number of New Beneficiaries to whom General Waiting Periods were Imposed		Number of New Beneficiaries to whom Pre-existing Condition Exclusions were Imposed		Number of New Beneficiaries to whom Late Joiner Penalties were Imposed	
		New Beneficiaries	Transferred Beneficiaries	New Beneficiaries	Transferred Beneficiaries	New Beneficiaries	Transferred Beneficiaries
2.5.1	Less than one year						
2.5.2	1-4 years						
2.5.3	5-9 years						
2.5.4	10-14 years						
2.5.5	15-19 years						
2.5.6	20-24 years						
2.5.7	25-29 years						
2.5.8	30-34 years						
2.5.9	35-39 years						
2.5.10	40-44 years						
2.5.11	45-49 years						
2.5.12	50-54 years						
2.5.13	55-59 years						
2.5.14	60-64 years						
2.5.15	65-69 years						
2.5.16	70-74 years						
2.5.17	75-79 years						



2.5.18	80-84 years						
2.5.19	85 years +						
2.5.20	<i>Total</i>						

Please provide reasons why no general waiting periods were imposed
Please provide reasons why no pre-existing condition exclusions were imposed
Please provide reasons why no late joiner penalties were imposed



PART 2.6

UTILISATION

		Current Year	Previous Year
2.6.1	<i>Primary and emergency care services</i>		Part 2.6 Current year column 2010 return
2.6.1.1	Number of beneficiaries visiting GPs at least once a year		
2.6.1.2	Total number of visits to GPs		
2.6.1.3	Number of beneficiaries visiting dentists at least once a year		
2.6.1.4	Total number of visits to dentists		
2.6.1.5	Number of beneficiaries visiting private nurses at least once a year		
2.6.1.6	Total number of visits to private nurses		
2.6.1.7	Number of beneficiaries enrolled in primary care networks		
2.6.2	<i>Private Hospitals - beneficiaries:</i>		
2.6.2.1	Number of beneficiaries admitted		
2.6.2.2	Number of hospital admissions		
2.6.2.3	Number of same-day admissions		
2.6.2.4	Number of total admissions		
2.6.2.5	Number of beneficiaries admitted for Prescribed Minimum Benefits		
2.6.2.6	Number of beneficiaries admitted at Day clinics/ unattached operating theatres (disciplines 76 and 77)		
2.6.2.7	Number of beneficiaries receiving MRI scans		
2.6.2.8	Number of MRI scans administered		
2.6.2.9	Number of beneficiaries receiving CT scans		
2.6.2.10	Number of CT scans administered		
2.6.2.11	Number of pregnancies		



PART 2.6

UTILISATION

		Current Year	Previous Year
2.6.2.12	Number of births		
2.6.2.13	Number of live births		
2.6.2.14	Number of caesarean sections performed		
2.6.2.15	Number of births to women between 12 and 18 years		
2.6.2.16	Number of mammograms paid for		
2.6.2.17	Number of pap smears paid for		
2.6.2.18	Number of deaths		
2.6.2.19	Number of beneficiaries receiving PET scans		
2.6.2.20	Number of PET scans administered		
2.6.2.21	Number of beneficiaries receiving angiograms		
2.6.2.22	Number of angiograms administered		
2.6.2.23	Number of beneficiaries receiving bone density scans		
2.6.2.24	Number of bone density scans administered		
2.6.2.25	Number of total days in hospital for beneficiaries		
2.6.2.26	Number of admissions to ICU		
2.6.2.27	Number of admissions to High Care		
2.6.2.28	Number of admissions to General Ward		
2.6.2.29	Number of admissions to Emergency Unit		
2.6.2.30	Number of admissions for Renal Dialysis		Part 2.6 Current year column 2010 return
2.6.2.31	Number of beneficiaries enrolled in hospital networks		



PART 2.6

UTILISATION

		Current Year	Previous Year
2.6.3	<i>Public Hospitals - beneficiaries:</i>		
2.6.3.1	Number of beneficiaries admitted		
2.6.3.2	Number of hospital admissions		
2.6.3.3	Number of same-day admissions		
2.6.3.4	Number of total admissions		
2.6.3.5	Number of beneficiaries admitted for Prescribed Minimum Benefits		
2.6.3.6	Number of beneficiaries receiving MRI scans		
2.6.3.7	Number of MRI scans administered		
2.6.3.8	Number of beneficiaries receiving CT scans		
2.6.3.9	Number of CT scans administered		
2.6.3.10	Number of pregnancies		
2.6.3.11	Number of births		
2.6.3.12	Number of live births		
2.6.3.13	Number of caesarean sections performed		
2.6.3.14	Number of births to women between 12 and 18 years		
2.6.3.15	Number of mammograms paid for		
2.6.3.16	Number of pap smears paid for		
2.6.3.17	Number of deaths		
2.6.3.18	Number of beneficiaries receiving PET scans		
2.6.3.19	Number of PET scans administered		



PART 2.6

UTILISATION

		Current Year	Previous Year
2.6.3.20	Number of beneficiaries receiving angiograms		
2.6.3.21	Number of angiograms administered		
2.6.3.22	Number of beneficiaries receiving bone density scans		
2.6.3.23	Number of bone density scans administered		
2.6.3.24	Number of total days in hospital for beneficiaries		
2.6.3.25	Number of beneficiaries admitted in ICU		
2.6.3.26	Number of beneficiaries admitted in High Care		
2.6.3.27	Number of beneficiaries admitted in General Ward		
2.6.3.28	Number of beneficiaries admitted in Emergency Unit		
2.6.3.29	Number of beneficiaries admitted for Renal Dialysis		

Please provide the reasons for any changes made to the prior year data:



PART 2.7

NUMBER OF BENEFICIARIES WITH THE FOLLOWING CHRONIC DISEASES

	Name of disease	Consolidated Previous Year	Consolidated Current Year	Per Benefit Option Previous Year	Per Benefit Option Current Year
2.7.1	Addison's Disease			Part 2.7 Per benefit option Current year column 2010 return	
2.7.2	Asthma				
2.7.3	Bipolar Mood Disorder				
2.7.4	Bronchiectasis				
2.7.5	Cardiac Failure				
2.7.6	Cardiomyopathy Disease				
2.7.7	Chronic Obstructive Pulmonary Disease				
2.7.8	Chronic Renal Disease				
2.7.9	Coronary Artery Disease				
2.7.10	Crohn's Disease				
2.7.11	Diabetes Insipidus				
2.7.12	Diabetes Mellitus Type 1				
2.7.13	Diabetes Mellitus Type 2				
2.7.14	Dysrhythmias				
2.7.15	Epilepsy				
2.7.16	Glaucoma				
2.7.17	Haemophilia				
2.7.18	HIV				



2.7.19	Hyperlipidaemia				
2.7.20	Hypertension				
2.7.21	Hypothyroidism				
2.7.22	Multiple Sclerosis				
2.7.23	Parkinson's Disease				
2.7.24	Rheumatoid Arthritis				
2.7.25	Schizophrenia				
2.7.26	Systemic Lupus Erythematosus				
2.7.27	Ulcerative Colitis				

Please provide the reasons for any changes made to the prior year data:



PART 2.8

UTILISATION OF SERVICES BY MEDICAL AND DENTAL SPECIALISTS

	Health Professional (BHF PCNS Discipline code)	Total Number of Visits to Specialists	Number of Beneficiaries Visiting at Least Once Per Year
	<i>Medical Specialists:</i>		
2.8.1	Dermatologists (12)		
2.8.2	Obstetricians & Gynaecologists (16)		
2.8.3	Pulmonologists (17)		
2.8.4	Specialist Physicians (18)		
2.8.5	Gastroenterologists (19)		
2.8.6	Neurologists (20)		
2.8.7	Cardiologists (21)		
2.8.8	Psychiatrists (22)		
2.8.9	Medical Oncologists (23)		
2.8.10	Neurosurgeons (24)		
2.8.11	Nuclear Medicine Specialists (25)		
2.8.12	Ophthalmologists (26)		
2.8.13	Clinical Haematologists (27)		
2.8.14	Orthopaedic Surgeons (28)		
2.8.15	Otorhinolaryngologists (30)		
2.8.16	Rheumatologists (31)		
2.8.17	Paediatricians (32)		
2.8.18	Paediatric Cardiologists (33)		



PART 2.8

UTILISATION OF SERVICES BY MEDICAL AND DENTAL SPECIALISTS

	Health Professional (BHF PCNS Discipline code)	Total Number of Visits to Specialists	Number of Beneficiaries Visiting at Least Once Per Year
2.8.19	Physical Medicine Specialists (34)		
2.8.20	Plastic & Reconstructive Surgeons (36)		
2.8.21	Radiation Oncologists (40)		
2.8.22	Surgeons (42)		
2.8.23	Cardiothoracic Surgeons (44)		
2.8.24	Urologists (46)		
2.8.25	Specialist Family Medicine (15)		
	<i>Clinical Support Specialists:</i>		
2.8.26	Anaesthetists (10)		
2.8.27	Diagnostic Radiologists (38)		
2.8.28	Pathologists (48)		
2.8.29	Other Medical or Clinical Support Specialists (specify)		
	<i>Dental Professionals:</i>		
2.8.30	Dental Therapists (95)		
2.8.31	Dental Technicians (93)		
2.8.32	Maxilla, Facial & Oral Surgeons (62)		
2.8.33	Oral Pathologists (98)		
2.8.34	Orthodontists (64)		
2.8.35	Periodontists (92)		



PART 2.8

UTILISATION OF SERVICES BY MEDICAL AND DENTAL SPECIALISTS

	Health Professional (BHF PCNS Discipline code)	Total Number of Visits to Specialists	Number of Beneficiaries Visiting at Least Once Per Year
2.8.36	Prosthodontists (94)		



PART 2.9

UTILISATION OF SERVICES BY SUPPLEMENTARY AND ALLIED HEALTH PROFESSIONALS

	Health Professional (BHF PCNS Discipline code)	Total Number of Visits to Supplementary and Allied Health Professionals	Number of Beneficiaries Visiting at Least Once Per Year
2.9.1	Art Therapists (67)		
2.9.2	Audiologists (82)		
2.9.3	Biokineticists (75-009)		
2.9.4	Clinical / Medical / Laboratory Technologists (75)		
2.9.5	Dieticians (84)		
2.9.6	Hearing Aid Acousticians (83)		
2.9.7	Medical Scientists (69)		
2.9.8	Occupational Therapists (66)		
2.9.9	Optometrists (70)		
2.9.10	Orthoptists (74)		
2.9.11	Pharmacists (60)		
2.9.12	Physiotherapists (72)		
2.9.13	Podiatrists / Chiropodists (68)		
2.9.14	Psychologists (86)		
2.9.15	Radiographers (39)		
2.9.16	Registered Nurses (88)		
2.9.17	Social Workers (89)		
2.9.18	Speech Therapists (82)		



	<i>Complementary Medicine Practitioners:</i>		
2.9.19	Acupuncturists & Chinese Medicine Practitioners (105)		
2.9.20	Ayurvedic Practitioners (104)		
2.9.21	Chiropractors & Osteopaths (04 & 102)		
2.9.22	Homeopaths (08)		
2.9.23	Naturopaths & Phytotherapists (101 & 103)		
2.9.24	Therapeutic Aromatherapists (106) / Reflexologists (108) / Massage (107)		
2.9.25	Community Dentistry (96)		
2.9.26	Nurses Institute (80)		
2.9.27	Orthotist and Prosthetist (87)		
2.9.28	Psychometry (85)		
2.9.29	Registered Councillor (81)		
2.9.30	Dispensing Optometrists (71)		
2.9.31	Other Supplementary & Allied Health Professionals (specify)		



PART 2.10

UTILISATION OF OTHER BENEFIT SERVICES

	Benefit Service (BHF PCNS Discipline Code)	Total Number of Claims from Beneficiaries	Number of Beneficiaries Who Submitted at Least One Claim
2.10.1	Ambulance Services - Basic Life Support (13)		
2.10.2	Ambulance Services - Intermediate Life Support (11)		
2.10.3	Ambulance Services - Advanced Life Support (09)		
2.10.4	Blood and Blood Product Couriers (03)		
2.10.5	Blood Transfusion Services (78)		
2.10.6	Clinical Services - Oxygen Supplier (90-001)		
2.10.7	Clinical Services - Appliance Supplier (90-002/007/013/014)		
2.10.8	Clinical Services - Prosthetic Supplier (90-003/004/005/006)		
2.10.9	Clinical Services - Other (90-008/009/010/011/012)		
2.10.10	Community Health Services (97)		
2.10.11	Drug and Alcohol Rehabilitation (47)		
2.10.12	Group Practice (50)		
2.10.13	Hospice (79)		
2.10.14	Mental Health Institutions (55)		
2.10.15	Sub Acute Facilities/Step Down Facilities (49)		
2.10.16	Private Rehabilitation Hospital (Acute) (059)		
2.10.17	Prosthetic Supplier (58, 57, 77)		



2.10.18	Other Benefit Services (specify)		
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PART 2.11

UTILISATION OF MEDICINES

		Total Number of Scripts Filled	Total Number of Items Dispensed
2.11.1	<i>In Hospital:</i>		
2.11.1.1	Medicines dispensed by Pharmacists		
2.11.1.2	Medicines dispensed by General Practitioners		
2.11.1.3	Medicines dispensed by Medical Specialists		
2.11.1.4	Medicines dispensed by Supplementary and Allied Health Professionals		
2.11.1.5	Medicines dispensed by Other Health Professionals		
2.11.2	<i>Out-of-Hospital:</i>		
2.11.2.1	Medicines dispensed by Pharmacists		
2.11.2.2	Medicines dispensed by General Practitioners		
2.11.2.3	Medicines dispensed by Medical Specialists		
2.11.2.4	Medicines dispensed by Supplementary and Allied Health Professionals		
2.11.2.5	Medicines dispensed by Other Health Professionals		



PART 2.12

DISTRIBUTION OF MEMBERSHIP AT END OF FINANCIAL YEAR

	Province	Members	Adult Dependants	Child Dependants	Beneficiaries
2.12.1	Gauteng				
2.12.2	Limpopo				
2.12.3	Mpumalanga				
2.12.4	North West				
2.12.5	Free State				
2.12.6	Kwa-Zulu Natal				
2.12.7	Western Cape				
2.12.8	Eastern Cape				
2.12.9	Northern Cape				
2.12.10	Outside the Republic				
2.12.11	<i>Total</i>				

Please indicate how the scheme is collecting the data for this part:

	Members	Adult Dependants	Child Dependants	
Private Postal Address	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Business Postal Address	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Employer (Pay Point)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Other (specify)				



PART 2.13

UTILISATION OF PRIVATE HOSPITALS BY AGE GROUP AND GENDER

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
	<i>Female:</i>			
2.13.1.1	Less than one year			
2.13.1.2	1-4 years			
2.13.1.3	5-9 years			
2.13.1.4	10-14 years			
2.13.1.5	15-19 years			
2.13.1.6	20-24 years			
2.13.1.7	25-29 years			
2.13.1.8	30-34 years			
2.13.1.9	35-39 years			
2.13.1.10	40-44 years			
2.13.1.11	45-49 years			
2.13.1.12	50-54 years			
2.13.1.13	55-59 years			
2.13.1.14	60-64 years			
2.13.1.15	65-69 years			
2.13.1.16	70-74 years			
2.13.1.17	75-79 years			
2.13.1.18	80-84 years			



PART 2.13

UTILISATION OF PRIVATE HOSPITALS BY AGE GROUP AND GENDER

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
2.13.1.19	85 years +			
2.13.1.20	<i>Subtotal</i>			
	<i>Male:</i>			
2.13.2.1	Less than one year			
2.13.2.2	1-4 years			
2.13.2.3	5-9 years			
2.13.2.4	10-14 years			
2.13.2.5	15-19 years			
2.13.2.6	20-24 years			
2.13.2.7	25-29 years			
2.13.2.8	30-34 years			
2.13.2.9	35-39 years			
2.13.2.10	40-44 years			
2.13.2.11	45-49 years			
2.13.2.12	50-54 years			
2.13.2.13	55-59 years			
2.13.2.14	60-64 years			
2.13.2.15	65-69 years			
2.13.2.16	70-74 years			



PART 2.13

UTILISATION OF PRIVATE HOSPITALS BY AGE GROUP AND GENDER

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
2.13.2.17	75-79 years			
2.13.2.18	80-84 years			
2.13.2.19	85 years +			
2.13.2.20	<i>Subtotal</i>			



PART 2.14

UTILISATION OF PUBLIC HOSPITALS BY AGE GROUP AND GENDER

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
	<i>Female:</i>			
2.14.1.1	Less than one year			
2.14.1.2	1-4 years			
2.14.1.3	5-9 years			
2.14.1.4	10-14 years			
2.14.1.5	15-19 years			
2.14.1.6	20-24 years			
2.14.1.7	25-29 years			
2.14.1.8	30-34 years			
2.14.1.9	35-39 years			
2.14.1.10	40-44 years			
2.14.1.11	45-49 years			
2.14.1.12	50-54 years			
2.14.1.13	55-59 years			
2.14.1.14	60-64 years			
2.14.1.15	65-69 years			
2.14.1.16	70-74 years			
2.14.1.17	75-79 years			
2.14.1.18	80-84 years			



PART 2.14

UTILISATION OF PUBLIC HOSPITALS BY AGE GROUP AND GENDER

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
2.14.1.19	85 years +			
2.14.1.20	<i>Subtotal</i>			
	<i>Male:</i>			
2.14.2.1	Less than one year			
2.14.2.2	1-4 years			
2.14.2.3	5-9 years			
2.14.2.4	10-14 years			
2.14.2.5	15-19 years			
2.14.2.6	20-24 years			
2.14.2.7	25-29 years			
2.14.2.8	30-34 years			
2.14.2.9	35-39 years			
2.14.2.10	40-44 years			
2.14.2.11	45-49 years			
2.14.2.12	50-54 years			
2.14.2.13	55-59 years			
2.14.2.14	60-64 years			
2.14.2.15	65-69 years			
2.14.2.16	70-74 years			



PART 2.14

UTILISATION OF PUBLIC HOSPITALS BY AGE GROUP AND GENDER

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
2.14.2.17	75-79 years			
2.14.2.18	80-84 years			
2.14.2.19	85 years +			
2.14.2.20	<i>Subtotal</i>			



PART 2.15

UTILISATION OF HOSPITALS IN RESPECT OF SELECTED PRINCIPAL DIAGNOSIS TYPES PER ICD10 CODES

	ICD 10 codes	Principal diagnosis	Number of beneficiaries admitted	Number of admissions	Number of days
2.15.1	A00–B99	Certain infectious and parasitic diseases			
2.15.2	C00–D48	Neoplasms			
2.15.3	D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism			
2.15.4	E00–E90	Endocrine, nutritional and metabolic diseases			
2.15.5	F00–F99	Mental and behavioural disorders			
2.15.6	G00–G99	Diseases of the nervous system			
2.15.7	H00–H59	Diseases of the eye and adnexa			
2.15.8	H60–H95	Diseases of the ear and mastoid process			
2.15.9	I00–I99	Diseases of the circulatory system			
2.15.10	J00–J99	Diseases of the respiratory system			
2.15.11	K00–K93	Diseases of the digestive system			
2.15.12	L00–L99	Diseases of the skin and subcutaneous tissue			
2.15.13	M00–M99	Diseases of the musculoskeletal system and connective tissue			
2.15.14	N00–N99	Diseases of the genitourinary system			



PART 2.15

UTILISATION OF HOSPITALS IN RESPECT OF SELECTED PRINCIPAL DIAGNOSIS TYPES PER ICD10 CODES

	ICD 10 codes	Principal diagnosis	Number of beneficiaries admitted	Number of admissions	Number of days
2.15.15	O00–O99	Pregnancy, childbirth and the puerperium			
2.15.16	P00–P96	Certain conditions originating in the perinatal period			
2.15.17	Q00–Q99	Congenital malformations, deformations and chromosomal abnormalities			
2.15.18	R00–R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified			
2.15.19	S00–T98	Injury, poisoning and certain other consequences of external causes			
2.15.20	Z00–Z99	Factors influencing health status and contact with health services			
2.15.21		Not reported			
2.15.22		<i>Total</i>			



PART 3

PART 3.1

ANALYSIS OF BENEFITS ACTUALLY PAID DURING THE FINANCIAL YEAR

		Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member	Discount received
		R	R	R	R	R
3.1.1	General Practitioners					
3.1.2	Medical Specialists	Part 3.2.29 - Total of Analysis of Medical Specialists (Amount charged by supplier column)	Part 3.2.29 - Total of Analysis of Medical Specialists (Risk amount paid by scheme column)	Part 3.2.29 - Total of Analysis of Medical Specialists (Savings amount paid by scheme on behalf of member column)	Part 3.2.29 - Total of Analysis of Medical Specialists (Amount paid by member column)	
3.1.3	Dentists					
3.1.4	Dental Specialists	Part 3.2.37 - Total of Analysis of Dental Specialists (Amount charged by supplier column)	Part 3.2.37 - Total of Analysis of Dental Specialists (Risk amount paid by scheme column)	Part 3.2.37 - Total of Analysis of Dental Specialists (Savings amount paid by scheme on behalf of member column)	Part 3.2.37 - Total of Analysis of Dental Specialists (Amount paid by member column)	



3.1.5	Supplementary and Allied Health Professionals	Part 3.3.26 - Total of analysis of Allied and Support Health Professionals (Amount charged by supplier column)	Part 3.3.26 - Total of Analysis of Allied and Support Health Professionals (Risk amount paid by scheme column)	Part 3.3.26 - Total of Analysis of Allied and Support Health Professionals (Savings amount paid by scheme on behalf of member column)	Part 3.3.26 - Total of Analysis of Allied and Support Health Professionals (Amount paid by member column)	
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PART 3.1

ANALYSIS OF BENEFITS ACTUALLY PAID DURING THE FINANCIAL YEAR

		Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member	Discount received
		R	R	R	R	R
3.1.6	Hospitals					
3.1.6.1	<i>Unattached Operating Theatres/Day Clinics</i>					
3.1.6.1.1	Ward Fees					
3.1.6.1.2	Theatre Fees					
3.1.6.1.3	Consumables					
3.1.6.1.4	Equipment Fees					
3.1.6.1.5	Procedure Fees					



3.1.6.1.6	Medicines dispensed					
3.1.6.1.7	Other (specify)					
3.1.6.1.8	Subtotal 1					
3.1.6.2	<i>Other Private Hospitals</i>					
3.1.6.2.1	<i>Fee for service arrangements</i>					
3.1.6.2.1.1	Ward Fees					
3.1.6.2.1.2	Theatre Fees					
3.1.6.2.1.3	Consumables					
3.1.6.2.1.4	Equipment Fees					
3.1.6.2.1.5	Procedure Fees					
3.1.6.2.1.6	Medicines dispensed					
3.1.6.2.1.7	Other (specify)					
3.1.6.2.1.8	Subtotal 2					
3.1.6.2.2	<i>Managed care arrangements (In hospital benefits)</i>					
3.1.6.2.2.1	Staff model-hospital care					
3.1.6.2.2.2	Global fee					
3.1.6.2.2.3	Per diem fee					
3.1.6.2.2.4	Hospital network					
3.1.6.2.2.5	Other (specify)					
3.1.6.2.2.6	Subtotal 3					
3.1.6.3	<i>State / Provincial Hospitals</i>					
3.1.6.3.1	Ward Fees					
3.1.6.3.2	Theatre Fees					
3.1.6.3.3	Consumables					



PART 3.1

ANALYSIS OF BENEFITS ACTUALLY PAID DURING THE FINANCIAL YEAR

		Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member	Discount received
		R	R	R	R	R
3.1.6.3.4	Equipment Fees					
3.1.6.3.5	Procedure Fees					
3.1.6.3.6	Medicines dispensed					
3.1.6.3.7	Other (specify)					
3.1.6.3.8	Subtotal 4					
3.1.6.4	Total Hospitals					
3.1.7	Medicine					
3.1.7.1	Medicines dispensed by Pharmacists					
3.1.7.2	Medicines dispensed by General Practitioners					
3.1.7.3	Medicines dispensed by Medical Specialists					
3.1.7.4	Medicines dispensed by Supplementary and Allied Health Professionals					
3.1.7.5	Medicines dispensed by Other Health Professionals					
3.1.7.6	Total Medicines					
3.1.8	Ex-gratia-payments					



3.1.9	Other Benefits	Part 3.4.17 - Total of Analysis of Other benefits (Amount charged by supplier column)	Part 3.4.17 - Total of Analysis of Other benefits (Risk amount paid by scheme column)	Part 3.4.17 - Total of Analysis of Other benefits (Savings amount paid by scheme on behalf of member column)	Part 3.4.17 - Total of Analysis of Other benefits (Amount paid by member column)	
3.1.10	Managed care arrangements (Out of hospital benefits)					
3.1.10.1	Primary care network					
3.1.10.2	Staff model - primary care					
3.1.10.3	Other (specify)					
3.1.10.4	Total Managed Care Arrangements (Out of Hospital Benefits)					
3.1.11	<i>Total Risk Benefits</i>					



PART 3.2

ANALYSIS OF MEDICAL AND DENTAL SPECIALISTS

	Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
	<i>Medical Specialists:</i>				
3.2.1	Dermatologists (12)				
3.2.2	Obstetricians & Gynaecologists (16)				
3.2.3	Pulmonologists (17)				
3.2.4	Specialist Physicians (18)				
3.2.5	Gastroenterologists (19)				
3.2.6	Neurologists (20)				
3.2.7	Cardiologists (21)				
3.2.8	Psychiatrists (22)				
3.2.9	Medical Oncologists (23)				
3.2.10	Neurosurgeons (24)				
3.2.11	Nuclear Medicine Specialists (25)				
3.2.12	Ophthalmologists (26)				
3.2.13	Clinical Haematologists (27)				
3.2.14	Orthopaedic Surgeons (28)				
3.2.15	Otorhinolaryngologists (30)				
3.2.16	Rheumatologists (31)				



PART 3.2

ANALYSIS OF MEDICAL AND DENTAL SPECIALISTS

	Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
3.2.17	Paediatricians (32)				
3.2.18	Paediatric Cardiologists (33)				
3.2.19	Physical Medicine Specialists (34)				
3.2.20	Plastic & Reconstructive Surgeons (36)				
3.2.21	Radiation Oncologists (40)				
3.2.22	Surgeons (42)				
3.2.23	Cardiothoracic Surgeons (44)				
3.2.24	Urologists (46)				
	<i>Clinical Support Specialists:</i>				
3.2.25	Anaesthetists (10)				
3.2.26	Diagnostic Radiologists (38)				
3.2.27	Pathologists (48)				
3.2.28	Other Medical or Clinical Support Specialists (specify)				
3.2.29	<i>Total Specialists</i>				
	<i>Dental Professionals:</i>				
3.2.30	Dental Therapists (95)				



PART 3.2

ANALYSIS OF MEDICAL AND DENTAL SPECIALISTS

	Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
3.2.31	Dental Technicians (93)				
3.2.32	Maxilla, Facial & Oral Surgeons (62)				
3.2.33	Oral Pathologists (98)				
3.2.34	Orthodontists (64)				
3.2.35	Periodontists (92)				
3.2.36	Prosthodontists (94)				
3.2.37	<i>Total Dental Professionals</i>				



PART 3.3

ANALYSIS OF SUPPLEMENTARY & ALLIED HEALTH PROFESSIONALS

	Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
3.3.1	Art Therapists (67)				
3.3.2	Audiologists (82)				
3.3.3	Biokineticists (75-009)				
3.3.4	Clinical / Medical / Laboratory Technologists (75)				
3.3.5	Dieticians (84)				
3.3.6	Hearing Aid Acousticians (83)				
3.3.7	Medical Scientists (69)				
3.3.8	Occupational Therapists (66)				
3.3.9	Optometrists (70)				
3.3.10	Orthoptists (74)				
3.3.11	Pharmacists (60)				
3.3.12	Physiotherapists (72)				
3.3.13	Podiatrists / Chiropodists (68)				
3.3.14	Psychologists (86)				
3.3.15	Radiographers (39)				
3.3.16	Registered Nurses (88)				



3.3.17	Social Workers (89)				
3.3.18	Speech Therapists (82)				
	<i>Complementary Medicine Practitioners:</i>				
3.3.19	Acupuncturists & Chinese Medicine Practitioners (105)				
3.3.20	Ayurvedic Practitioners (104)				
3.3.21	Chiropractors & Osteopaths (04 & 102)				
3.3.22	Homeopaths (08)				
3.3.23	Naturopaths & Phytotherapists (101 & 103)				
3.3.24	Therapeutic Aromatherapists (106) / Reflexologists (108) / Massage (107)				
3.3.25	Other Supplementary & Allied Health Professionals (specify)				
3.3.26	<i>Total</i>				



PART 3.4

ANALYSIS OF OTHER BENEFITS

	Other Benefit Services (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
3.4.1	Ambulance Services - Basic Life Support (13)				
3.4.2	Ambulance Services - Intermediate Life Support (11)				
3.4.3	Ambulance Services - Advanced Life Support (09)				
3.4.4	Blood and Blood Product Couriers (03)				
3.4.5	Blood Transfusion Services (78)				
3.4.6	Clinical Services - Oxygen Supplier (90-001)				
3.4.7	Clinical Services - Appliance Supplier (90-002/007/013/014)				
3.4.8	Clinical Services - Prosthetic Supplier (90-003/004/005/006)				
3.4.9	Clinical Services - Other (90-008/009/010/011/012)				
3.4.10	Community Health Services (97)				
3.4.11	Drug and Alcohol Rehabilitation (47)				
3.4.12	Group Practice (50)				
3.4.13	Hospice (79)				
3.4.14	Mental Health Institutions (55)				



3.4.15	Sub Acute Facilities/Step Down Facilities (49)				
3.4.16	Other Benefit Services (specify)				
3.4.17	<i>Total</i>				



PART 3.5

ANALYSIS OF TOTAL BENEFITS PAID IN RESPECT OF SELECTED PRINCIPAL DIAGNOSIS TYPES PER ICD10 CODES

	ICD 10 codes	Other Benefit Services (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
			R	R	R	R
3.5.1	A00–B99	Certain infectious and parasitic diseases				
3.5.2	C00–D48	Neoplasms				
3.5.3	D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism				
3.5.4	E00–E90	Endocrine, nutritional and metabolic diseases				
3.5.5	F00–F99	Mental and behavioural disorders				
3.5.6	G00–G99	Diseases of the nervous system				
3.5.7	H00–H59	Diseases of the eye and adnexa				
3.5.8	H60–H95	Diseases of the ear and mastoid process				
3.5.9	I00–I99	Diseases of the circulatory system				
3.5.10	J00–J99	Diseases of the respiratory system				
3.5.11	K00–K93	Diseases of the digestive system				
3.5.12	L00–L99	Diseases of the skin and subcutaneous tissue				
3.5.13	M00–M99	Diseases of the musculoskeletal system and connective tissue				
3.5.14	N00–N99	Diseases of the genitourinary system				



3.5.15	O00–O99	Pregnancy, childbirth and the puerperium				
3.5.16	P00–P96	Certain conditions originating in the perinatal period				
3.5.17	Q00–Q99	Congenital malformations, deformations and chromosomal abnormalities				
3.5.18	R00–R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified				
3.5.19	S00–T98	Injury, poisoning and certain other consequences of external causes				
3.5.20	Z00–Z99	Factors influencing health status and contact with health services				
3.5.21		Not reported				
3.5.22		<i>Total</i>				



PART 4
NOTES TO THE FINANCIAL STATEMENTS

PART 4.1
PROPERTY, PLANT AND EQUIPMENT

		Total	Land and Buildings	Computer Equipment and Software	Furniture and Fittings	Motor Vehicles	Other
		R	R	R	R	R	R
4.1.1	Gross Carrying Amount						
4.1.1.1	<i>At beginning of year</i>						
4.1.1.1.1	- As previously reported		4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Land &	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Computer equipment and	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Furniture &	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Motor	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Other)



PART 4.1

PROPERTY, PLANT AND EQUIPMENT

		Total	Land and Buildings	Computer Equipment and Software	Furniture and Fittings	Motor Vehicles	Other
		R	R	R	R	R	R
			Buildings)	Software)	Fittings)	Vehicles)	
4.1.1.1.2	- Prior year adjustment						
4.1.1.2	Additions						
4.1.1.3	Disposals						
4.1.1.4	Impairment write down						
4.1.1.5	Revaluation surplus						
4.1.1.6	Other movements (specify)						
4.1.1.7	Other group balances on consolidation						
4.1.1.8	Transfer of assets due to amalgamation						



PART 4.1

PROPERTY, PLANT AND EQUIPMENT

		Total	Land and Buildings	Computer Equipment and Software	Furniture and Fittings	Motor Vehicles	Other
		R	R	R	R	R	R
4.1.1.9	<i>At end of year</i>						

4.1.2	Accumulated Depreciation						
4.1.2.1	<i>At beginning of year</i>						
4.1.2.1.1	- As previously reported		4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Land & Buildings)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Computer Equipment and Software)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Furniture & Fittings)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Motor Vehicles)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Other)



PART 4.1

PROPERTY, PLANT AND EQUIPMENT

		Total	Land and Buildings	Computer Equipment and Software	Furniture and Fittings	Motor Vehicles	Other
		R	R	R	R	R	R
4.1.2.1.2	- Prior year adjustment						
4.1.2.2	Depreciation charges						
4.1.2.3	Impairment charges						
4.1.2.4	Accumulated depreciation on disposals						
4.1.2.5	Other movements (specify)						
4.1.2.6	Other group balances on consolidation						
4.1.2.7	Transfer of assets due to amalgamation						
4.1.2.8	<i>At end of year</i>						



PART 4.1

PROPERTY, PLANT AND EQUIPMENT

		Total	Land and Buildings	Computer Equipment and Software	Furniture and Fittings	Motor Vehicles	Other
		R	R	R	R	R	R
4.1.3	<i>Net carrying amount at end of year</i>						

Please provide the reasons for any prior year restatements/reclassifications:



PART 4.2

INVESTMENTS

		Non-current	Current	Total
		R	R	R
4.2.1	Investment property			
4.2.2	Available-for-sale investments			
4.2.3	Held-to-maturity investments			
4.2.4	Investments held at fair value through profit or loss			
4.2.5	Other (specify)			
4.2.6	Group investments on consolidation			
4.2.7	Less: Transfer of assets due to amalgamation during the year			
4.2.8	<i>Total investments</i>			



PART 4.3 (a)
TRADE AND OTHER RECEIVABLES

		Total
		R
4.3.1	<i>Contributions outstanding:</i>	
4.3.1.1	- current	
4.3.1.2	- 30 days	
4.3.1.3	- 60 days	
4.3.1.4	- 90 days	
4.3.1.5	- 120 days +	
4.3.2	<i>Recoveries from members for co-payments paid and payable (except for contributions, loans and savings plan account advances)</i>	
4.3.2.1	- current	
4.3.2.2	- 30 days	
4.3.2.3	- 60 days	
4.3.2.4	- 90 days	
4.3.2.5	- 120 days +	
4.3.3	<i>Savings plan account advances</i>	
4.3.3.1	- current	
4.3.3.2	- 30 days	
4.3.3.3	- 60 days	
4.3.3.4	- 90 days	
4.3.3.5	- 120 days +	
4.3.4	<i>Risk transfer arrangements</i>	



PART 4.3 (a)

TRADE AND OTHER RECEIVABLES

		Total
		R
4.3.4.1	<i>Commercial reinsurance contracts</i>	
4.3.4.1.1	Share of outstanding claims provision	
4.3.4.1.2	Share of claims reported not yet paid	
4.3.4.1.3	Less: Provision for impaired losses at year end	
4.3.4.2	<i>Other Risk transfer arrangements</i>	
4.3.4.2.1	Share of outstanding claims provision	
4.3.4.2.2	Share of claims reported not yet paid	
4.3.4.2.3	Less: Provision for impaired losses at year end	
4.3.5	Prepaid expenses on risk transfer arrangements	
4.3.6	Prepaid expenses on managed care arrangements	
4.3.7	Prepaid expenses	
4.3.8	<i>Loans to members</i>	
4.3.8.1	Loans to members - Capital	
4.3.8.2	Loans to members - Interest	
4.3.9	Accrued interest	
4.3.10	<i>Member balances</i>	
4.3.10.1	- current	
4.3.10.2	- 30 days	
4.3.10.3	- 60 days	



PART 4.3 (a)

TRADE AND OTHER RECEIVABLES

		Total
		R
4.3.10.4	- 90 days	
4.3.10.5	- 120 days +	
4.3.11	<i>Provider balances</i>	
4.3.11.1	- current	
4.3.11.2	- 30 days	
4.3.11.3	- 60 days	
4.3.11.4	- 90 days	
4.3.11.5	- 120 days +	
4.3.12	<i>Amounts owing by:</i>	
4.3.12.1	- Administrators	
4.3.12.2	- Reinsurer (other than claim recoveries)	
4.3.12.3	- Managed care organisations (other than claim recoveries)	
4.3.12.4	- Brokers	
4.3.12.5	- Other related parties (specify)	
	Description	Relationship
		Specify
4.3.13	Sundry debtors (specify)	
4.3.14	Less: Provision for impaired losses at year end (excluding risk transfer arrangements)	
4.3.15	Trade and other receivables of group companies on consolidation	
4.3.16	Transfer of assets due to amalgamation during the year	

Initials of Principal Officer: _____ Initials of Auditor(s): _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.3 (a)

TRADE AND OTHER RECEIVABLES

		Total
		R
4.3.17	Total trade and other receivables	

Please indicate whether the scheme has any agreements in place with employers / members to pay their contributions after 3 days of it becoming due:

Please indicate the remedial actions taken by the scheme where contributions were received after three days of it becoming due:

What is the nature of/reasons for the amount owed by the administrator?

What is the nature of/reasons for the amount owed by reinsurers (other than claims recoveries)?

What is the nature of/reasons for the amount owed by managed care organisations (other than claims recoveries)?

What is the nature of/reasons for the amount owed by brokers?

What is the nature of/reasons for the amount owed by other related parties?



PART 4.3 (b)

ANALYSIS OF MOVEMENTS IN RESPECT OF RISK TRANSFER ARRANGEMENTS

		Total
		R
4.3.1	<i>Commercial reinsurance contracts</i>	
4.3.1.1	Balance at beginning of year	
4.3.1.2	Less: Payments in respect of current year	
4.3.1.3	(Over)/under provision in respect of prior year	
4.3.1.4	Adjustment for current year	
4.3.2	<i>Other risk transfer arrangements</i>	
4.3.2.1	Balance at beginning of year	
4.3.2.2	Less: Payments in respect of current year	
4.3.2.3	(Over)/under provision in respect of prior year	
4.3.2.4	Adjustment for current year	
4.3.3	<i>Total risk transfer arrangements assets</i>	



PART 4.4

CASH AND CASH EQUIVALENTS

		Total
		R
4.4.1	Call accounts	
4.4.2	Current accounts	
4.4.3	Fixed deposits	
4.4.4	Money market instruments	
4.4.5	Cash and cash equivalents of group companies on consolidation	
4.4.6	Transfer of assets due to amalgamation during the year	
4.4.7	<i>Total cash and cash equivalents per balance sheet</i>	
4.4.8	Outstanding cheques	
4.4.9	<i>Total cash and cash equivalents per part 9 of the return</i>	



PART 4.5

SAVINGS PLAN LIABILITY

		Total
		R
4.5.1	Balance on savings plan liability at the beginning of the year (credit balance)	4.5.16 (2010 annual return) - Savings plan liability credit balance at the end of the year
4.5.2	Prior year adjustment	
4.5.3	Less: Advances on savings plan accounts	4.5.15 * -1 (2010 annual return) - Advances on savings plan accounts included in accounts receivable
4.5.4	Balance on savings plan liability at the beginning of the year (net balance)	
4.5.5	<i>Savings plan account contributions received or receivable</i>	
4.5.5.1	- For the current year	4.10.2 * -1 - Less: Savings plan account contribution income
4.5.5.2	- Received in advance	
4.5.5.3	- Allocated to settle prior year advances	
4.5.6	Transfers from other schemes	
4.5.7	Savings plan liabilities transferred to/(from) the scheme upon amalgamation	
4.5.8	Interest paid on savings plan accounts	4.22.2 Interest paid on savings plan accounts
4.5.9	Less: Transfers to other schemes	
4.5.10	Less: Claims paid on behalf of members	4.11.2 - Less: Savings plan claims paid (Total column)
4.5.11	Less: Administration expenses	4.16.40 current year (fund column only) - Less: Administration expenses recoverable from



PART 4.5

SAVINGS PLAN LIABILITY

		Total
		R
		savings plan accounts
4.5.12	Less: Refunds on death or resignation	
4.5.13	Other (specify)	
4.5.14	Net balance at the end of the year	
4.5.15	Add: Advances on savings plan accounts	
4.5.16	<i>Balance of savings plan liability at the end of the year (credit balance)</i>	
4.5.17	Ageing of savings plan liability at the end of the year	
4.5.17.1	Current Members	
4.5.17.2	Resigned members	
4.5.17.2.1	- 0 - 6 months	
4.5.17.2.2	- 6 months +	

What procedures are in place to follow-up on members that need to be refunded?
Please provide the reasons for any prior year restatements/reclassifications:

PART 4.6
BORROWINGS

		Interest bearing borrowings		Non-interest bearing borrowings		Total
		Current	Non-current	Current	Non-current	
		R	R	R	R	R
4.6.1	Description (specify)					
4.6.2	Borrowings of group companies on consolidation					
4.6.3	Less: Transfer of liabilities due to amalgamation during the year					
4.6.4	<i>Total borrowings</i>					

Were the borrowings approved by Council?

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.7

OTHER NON-CURRENT LIABILITIES

		Total
		R
4.7.1	Other non-current liabilities (specify)	
4.7.2	Less: Current portion included in current liabilities	
4.7.3	Balances of group companies on consolidation	
4.7.4	Less: Transfer of liability due to amalgamation during the year	
4.7.5	<i>Total other non-current liabilities</i>	



PART 4.8

TRADE AND OTHER PAYABLES

		Total
		R
4.8.1	<i>Reported claims not yet paid</i>	
4.8.1.1	Reported claims not yet paid – due to members (including outstanding cheques)	
4.8.1.2	Reported claims not yet paid – due to providers (including outstanding cheques)	
4.8.2.1	Stale cheques for claims expenses	
4.8.2.2	Stale cheques for expenses other than claims	
4.8.3	Net contributions received in advance	
4.8.4	<i>Payments received in advance under risk transfer arrangements</i>	
4.8.4.1	Payments received in advance under commercial reinsurance contracts	
4.8.4.2	Payments received in advance under other risk transfer arrangements	
4.8.5	Bank overdraft (current account)	
4.8.6	<i>Amounts owing to:</i>	
4.8.6.1	- Administrator	
4.8.6.2	- Reinsurer (other than claim recoveries)	
4.8.6.3	- Brokers	
4.8.6.4	- Managed care organisations	
4.8.6.5	- Other related parties (specify)	
	Description	Relationship
		Specify

Initials of Principal Officer: _____ Initials of Auditor(s): _____



PART 4.8

TRADE AND OTHER PAYABLES

4.8.7	Current portion of non-current borrowings and other non-current liabilities	4.6.4 - Current column of interest bearing borrowings + 4.6.4 - Current column of non-interest bearing borrowings + (4.7.2 *-1) - Less: Current portion included in current liabilities
4.8.8	Amounts owing to members	
4.8.9	Unallocated deposits	
4.8.10	Post retirement benefits	
4.8.11	Other payables & accrued expenses (specify)	
4.8.12	Balances of group companies on consolidation	
4.8.13	Less: Transfer of liability due to amalgamation during the year	
4.8.14	<i>Total trade and other payables</i>	

What is the nature of/the reasons for the amount owed to the administrator? The amount owed is larger than the average fee per month.

What is the nature of/the reasons for the amount owed to brokers? The amount owed is larger than the average fee per month.

What is the nature of/the reasons for the amount owed to managed care organisations? The amount owed is larger than the average fee per month.

Initials of Principal Officer: _____ Initials of Auditor(s): _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.8

TRADE AND OTHER PAYABLES

What is the nature of/the reasons for the amount owed to members in line 4.8.8?
What is the nature of/the reasons for the unallocated deposits? The amount owed is larger than the average gross contributions per month.
In respect of which employees are the post retirement benefits due?
Please indicate whether the scheme obtained approval from Council to directly or indirectly borrow money, as is required by section 35(6)(c) of the Medical Schemes Act:



PART 4.9

OUTSTANDING CLAIMS PROVISION

		A Total	B Outstanding claims provision - not covered by risk transfer arrangements	C Outstanding claims provision – covered by commercial reinsurance contracts	D Outstanding claims provision – covered by other risk transfer arrangements
		R	R	R	R
4.9.1	<i>Balance at beginning of year</i>				
4.9.1.1	- As previously reported:	4.9.8 (2010 annual return) - Total outstanding claims provision at end of year	4.9.8 (2010 annual return) - Column B: Total outstanding claims provision at end of year	4.9.8 (2010 annual return) - Column C: Total outstanding claims provision at end of year	4.9.8 (2010 annual return) - Column D: Total outstanding claims provision at end of year
4.9.1.2	- Prior year adjustment				
4.9.1.3	- Transfer of liability due to amalgamation (IN)				
4.9.2	Less: Payments in respect of the prior year				
4.9.3	(Under)/Over provision in respect of the prior year				
4.9.4	Adjustment for the current year				
4.9.5	Liability adequacy test (LAT) provision adjustment				
4.9.6	Total outstanding claims provision at end of year				
4.9.7	Less: Transfer of liability due to amalgamation				

Initials of Principal Officer: _____ Initials of Auditor(s): _____



PART 4.9

OUTSTANDING CLAIMS PROVISION

		A Total	B Outstanding claims provision - not covered by risk transfer arrangements	C Outstanding claims provision – covered by commercial reinsurance contracts	D Outstanding claims provision – covered by other risk transfer arrangements
		R	R	R	R
	(OUT)				
4.9.8	<i>Total outstanding claims provision at end of year</i>				

	<i>Representing:</i>				
4.9.8.1	Estimated gross claims				
4.9.8.2	Less: Estimated recoveries from				
4.9.8.3	- co-payments				
4.9.8.4	- savings plan accounts				
4.9.8.5	<i>Balance at end of year</i>				

Please provide the reasons for any (under)/over provision which is more than 10% of the previous year's provision:

Please provide the reasons for any prior year restatements/reclassifications:

Initials of Principal Officer: _____ Initials of Auditor(s): _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.10
GROSS CONTRIBUTIONS

		Total
		R
4.10.1	Gross contribution income	
4.10.2	Less: Savings plan account contribution income	
4.10.3	<i>Risk contribution income</i>	

Please provide the reasons if the gross contributions are zero:



PART 4.11

RELEVANT HEALTHCARE EXPENDITURE

		A Total	B In respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)	C In respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)
		R	R	R
4.11.1	<i>Gross claims paid and reported</i>			
4.11.1.1	- Direct benefits for the period			
4.11.1.2	- Direct benefits for the previous period			
4.11.1.3	- Direct benefits reported not yet paid			
4.11.1.4	- Managed care: healthcare benefits for the period (no transfer of risk)			0
4.11.1.5	- Managed care: healthcare benefits for the previous period (no transfer of risk)			0
4.11.1.6	- Managed care: healthcare benefits reported not yet paid (no transfer of risk)			0
4.11.1.7	- Services provided to members in own facilities			0
4.11.2	Less: Savings plan claims paid		3.1.11 - Total Benefits (Savings amount paid by scheme on behalf of member column) *-1	0
4.11.3	Less: Discount received on claims		3.1.11 - Total Benefits (Discount received	0



PART 4.11

RELEVANT HEALTHCARE EXPENDITURE

		A Total	B In respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)	C In respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)
		R	R	R
			column) * -1	
4.11.4	Less: Claims recoveries from third parties			0
4.11.5	Net actual claims paid and reported			
4.11.6	Provision for outstanding claims at the end of the financial year	4.9.6 - Total outstanding claims provision at end of year (Column A)	4.9.6 - Total outstanding claims provision at end of year (Column B) + 4.9.6 (Column C)	4.9.6 - Total outstanding claims provision at end of year (Column D)
4.11.7	Less: Provision for outstanding claims at end of the previous year	4.9.1 - Total outstanding claims provision at beginning of year * -1 (column A)	4.9.1 - Total outstanding claims provision at beginning of year * -1 (column B + column C)	4.9.1 - Total outstanding claims provision at beginning of year * -1 (column D)
4.11.8	<i>Net claims incurred (excluding net (income)/expense from other risk transfer arrangements)</i>			
4.11.9	Net (income)/expense from other risk transfer arrangements		0	4.13.4 (Consolidated total) net (income)/expense from

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.11

RELEVANT HEALTHCARE EXPENDITURE

		A Total	B In respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)	C In respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)
		R	R	R
				other risk transfer arrangements
4.11.10	Relevant healthcare expenditure			



PART 4.12

MANAGED CARE: MANAGEMENT SERVICES

		Administrator / Self-administration	Other third parties	Total
		R	R	R
4.12.1	Asthma programme			
4.12.2	Case management			
4.12.3	Chronic medicine management			
4.12.4	Clinical review/auditing			
4.12.5	Dental benefit management			
4.12.6	Disease management			
4.12.7	Disease/prescribed minimum benefit management			
4.12.8	Drug utilisation review			
4.12.9	Female Wellness programme			
4.12.10	Fraud Hotline			
4.12.11	Health advice line			
4.12.12	HIV management			
4.12.13	Managed health services, ambulance and helpline			
4.12.14	Managed hospital care			
4.12.15	Maternity programme			
4.12.16	Medical advisors			
4.12.17	Medicine bag management			
4.12.18	Member counselling, compliance monitoring & risk			



PART 4.12

MANAGED CARE: MANAGEMENT SERVICES

		Administrator / Self-administration	Other third parties	Total
		R	R	R
	assessment			
4.12.19	Mental health programme			
4.12.20	Mothers-to-be programme			
4.12.21	Network management			
4.12.22	Oncology utilisation programme			
4.12.23	Optical management			
4.12.24	Pathology benefit management			
4.12.25	Pharmacy benefit management			
4.12.26	Primary care provider management			
4.12.27	Radiology benefit management			
4.12.28	Specialist, hospital referrals and pre-authorisation			
4.12.29	Other (specify)			
4.12.30	<i>Total managed care: management services</i>			

Why is the amount paid not split between the different services provided?



PART 4.13

NET (INCOME)/EXPENSES FROM OTHER RISK TRANSFER ARRANGEMENTS (EXCLUDING COMMERCIAL REINSURANCE CONTRACTS)

		Consolidated		Per contract	
		total			
		Current year	Previous year	Current year	Previous year
		R	R	R	R
4.13.1	Premiums/fees paid (Capitation fees)				4.13.1 to 4.13.3 (2010 annual return)
4.13.2	Claims recoveries in respect of related risk transfer arrangements				
4.13.3	Other (specify)				
4.13.4	<i>Net (income)/expense from other risk transfer arrangements</i>				

Please provide the basis for the calculation of the estimated claims recoveries in respect of related risk transfer arrangements.



PART 4.13

NET (INCOME)/EXPENSES FROM OTHER RISK TRANSFER ARRANGEMENTS (EXCLUDING COMMERCIAL REINSURANCE CONTRACTS)

		Consolidated total		Per contract	
		Current year	Previous year	Current year	Previous year
		R	R	R	R
Please provide the reasons for any prior year restatements:					



PART 4.14

NET INCOME/(EXPENSES) FROM RISK TRANSFER ARRANGEMENTS: COMMERCIAL REINSURANCE CONTRACTS

		Consolidated total	Per contract
		R	R
4.14.1	Reinsurance premiums paid		
4.14.2	Reinsurance claims recovered		
4.14.3	Provision for reinsurance claims recovered		
4.14.4	Profit/(Loss) on reinsurance arrangements		
4.14.5	Commissions on reinsurance agreements		
4.14.6	Discounts received		
4.14.7	<i>Net income/(expense) from commercial reinsurance</i>		

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.15 (a)

BROKER SERVICE FEES

		Broker service fees
		R
4.15.1	Paid to brokers	
4.15.2	Paid to related party brokers (specify)	
4.15.3	<i>Total broker service fees</i>	

Why does the broker fees per average member per month exceed the statutory limit of R74.84?
Why does the broker fees exceed the statutory limit of 3.42% of gross contributions?

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.15 (b)

OTHER DISTRIBUTION COSTS

		Other distribution costs
		R
4.15.1	Paid to related parties (specify)	
4.15.2	Other (specify)	
4.15.3	<i>Total distribution costs</i>	



PART 4.16

ADMINISTRATION EXPENSES

		Current year		Previous year	
		Fund	Own Facilities	Fund	Own Facilities
		R	R	R	R
4.16.1	Actuarial fees			4.16.1 to 4.16.41 (2010 annual return) (Fund column)	4.16.1 to 4.16.41 (2010 annual return) (Own Facilities column)
4.16.2	Administration fees:				
4.16.2.1	- Fees paid to the administrator			4.16.1 to 4.16.41 (2010 annual return) (Fund column)	4.16.1 to 4.16.41 (2010 annual return) (Own Facilities column)
4.16.2.2	- Indirect fees paid to the administrator				
4.16.3	Advertising				
4.16.4	Annual general meeting costs				
4.16.5	Association fees				
4.16.6	Audit expense:				



PART 4.16
ADMINISTRATION EXPENSES

		Current year		Previous year	
		Fund	Own Facilities	Fund	Own Facilities
		R	R	R	R
4.16.6.1	- Audit services			4.16.1 to 4.16.41 (2010 annual return) (Fund column)	4.16.1 to 4.16.41 (2010 annual return) (Own Facilities column)
4.16.6.2	- Audit expenses				
4.16.6.3	- Audit committees				
4.16.6.4	- Over/(under) provision of prior year's audit fees				
4.16.6.5	- Other non-audit expenses (specify)				
4.16.7	Bank charges				
4.16.8	Call centre fees				
4.16.9	Co-administration fees paid for ongoing services provided by third parties				
4.16.10	Computer expenses				



PART 4.16

ADMINISTRATION EXPENSES

		Current year		Previous year	
		Fund	Own Facilities	Fund	Own Facilities
		R	R	R	R
4.16.11	Consultancy fees (not the contracted administrator)				
4.16.12	Council for Medical Schemes expenses			4.16.1 to 4.16.41 (2010 annual return) (Fund column)	4.16.1 to 4.16.41 (2010 annual return) (Own Facilities column)
4.16.13	Debt collection fees				
4.16.14	Depreciation				
4.16.15	Electronic checking fees				
4.16.16	Entertainment				
4.16.17	Fidelity guarantee insurance premiums				
4.16.18	Insurance fees				
4.16.19	Internal audit fees				



PART 4.16
ADMINISTRATION EXPENSES

		Current year		Previous year	
		Fund	Own Facilities	Fund	Own Facilities
		R	R	R	R
4.16.20	Investigation fees				
4.16.21	Legal fees				
4.16.22	Marketing expenses				
4.16.23	MVA administration fees				
4.16.24	Operating leases and other rentals (incl. property rentals)				
4.16.25	Other levies				
4.16.26	Penalties (including CMS penalties)				
4.16.27	Pharmacy administration fees				
4.16.28	Principal Officer fees & remuneration				



PART 4.16

ADMINISTRATION EXPENSES

		Current year		Previous year	
		Fund	Own Facilities	Fund	Own Facilities
		R	R	R	R
4.16.29	Principal Officer travel and other expenses incurred				
4.16.30	Printing, stationery and postage				
4.16.31	Professional fees				
4.16.32	Professional indemnity insurance premiums				
4.16.33	Repairs and maintenance			16.1 to 4.16.41 (2010 annual return) (Fund column)	4.16.1 to 4.16.41 (2010 annual return) (Own Facilities column)
4.16.34	Staff remuneration and employment costs				
4.16.35	Telephone, postage and fax				
4.16.36	Travel, accommodation and conferences				
4.16.37	Trustees' remuneration and considerations	4.17.2 (Total column) - Total trustee			



PART 4.16
ADMINISTRATION EXPENSES

		Current year		Previous year	
		Fund	Own Facilities	Fund	Own Facilities
		R	R	R	R
		remuneration and considerations			
4.16.38	Water and electricity				
4.16.39	Other administration expenses (specify)				
4.16.40	Less: Administration expenses recoverable from savings plan accounts				
4.16.41	<i>Total administration expenses</i>				

Kindly provide the reasons why no fidelity or professional indemnity insurance was accounted for in the current year.



PART 4.16
ADMINISTRATION EXPENSES

		Current year		Previous year	
		Fund	Own Facilities	Fund	Own Facilities
		R	R	R	R
Kindly provide information on the nature of the co-administration services rendered to the scheme, including the name of the provider.					
Please provide the reasons for any prior year restatements/reclassifications:					



PART 4.17

TRUSTEE REMUNERATION AND CONSIDERATIONS

		Fees for meeting attendance	Fees for holding of office	Fees for consultancy services	Allowances	Training	Conference fees	Telephone expenses	Accommodation, travel and meals	Other disbursements and reimbursements	Total	Fees received in respect of services rendered to related parties
		R	R	R	R	R	R	R	R	R	R	R
4.17.1	Per trustee member											
4.17.2	Total trustee remuneration and considerations											



PART 4.18

PROVISION FOR IMPAIRED LOSSES AT YEAR-END

		Amount recognised in the income statement for the year							
		A	B	C	D	E	F	G	H
		Provision for impaired losses at beginning of year	Unused amounts reversed during the year (credit in income statement)	Additional provisions made during the year (debit in income statement)	Amounts utilised during the year	Provision for impaired losses at year-end	Impaired losses recognised directly in the income statement (debit in income statement)	Previous impairment losses recovered (credit in the income statement)	Total movement in income statement for the year
		R	R	R	R	R	R	R	R
4.18.1	Contributions owed by members that are not collectable								
4.18.2	Amounts owed in respect of member's portions of claims that are not recoverable								



PART 4.18

PROVISION FOR IMPAIRED LOSSES AT YEAR-END

		Amount recognised in the income statement for the year							
		A Provision for impaired losses at beginning of year	B Unused amounts reversed during the year (credit in income statement)	C Additional provisions made during the year (debit in income statement)	D Amounts utilised during the year	E Provision for impaired losses at year-end	F Impaired losses recognised directly in the income statement (debit in income statement)	G Previous impairment losses recovered (credit in the income statement)	H Total movement in income statement for the year
		R	R	R	R	R	R	R	R
4.18.3	Amounts owed by service providers that are not recoverable								
4.18.4	Amounts owed by members in respect of savings plan accounts that are not								



PART 4.18

PROVISION FOR IMPAIRED LOSSES AT YEAR-END

		Amount recognised in the income statement for the year							
		A Provision for impaired losses at beginning of year	B Unused amounts reversed during the year (credit in income statement)	C Additional provisions made during the year (debit in income statement)	D Amounts utilised during the year	E Provision for impaired losses at year-end	F Impaired losses recognised directly in the income statement (debit in income statement)	G Previous impairment losses recovered (credit in the income statement)	H Total movement in income statement for the year
		R	R	R	R	R	R	R	R
	recoverable								
4.18.5	Other (specify)								
4.18.6	Total								

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.19

OTHER INVESTMENT INCOME

		Total
		R
<i>4.19.1</i>	<i>Income from investments and property:</i>	
4.19.1.1	- Interest	
4.19.1.2	- Dividends received	
4.19.1.3	- Rentals	
4.19.1.4	- Policy income	
4.19.2	Other (specify)	
<i>4.19.3</i>	<i>Total other investment income</i>	



PART 4.20

OTHER REALISED AND UNREALISED GAINS/(LOSSES)

		Total
		R
4.20.1	Profit/(loss) on disposal of property, plant and equipment	
4.20.2	Profit/(loss) on disposal of investment property	
4.20.3	Realised gain/(loss) on disposal of available-for-sale investments	
4.20.4	Unrealised gain/(loss) on revaluation of investment property	
4.20.5	Net gain/(loss) on revaluation of investments carried at fair value through the income statement	
4.20.6	Other (specify)	
4.20.7	<i>Total realised and unrealised gains/(losses)</i>	

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.21

OWN FACILITY SURPLUS / (DEFICIT)

		Total
		R
4.21.1	Income from services rendered to third parties	
4.21.2	Less: Total cost incurred in operating own facility	
4.21.2.1	Less: Total healthcare provider costs	
4.21.2.2	Less: Changes in inventories	
4.21.2.3	Less: Administration expenditure	4.16.41 Current year (Own facility column) - Total administration expenses * -1
4.21.2.4	Less: Other costs incurred in operating own facility	
4.21.2.5	Add: Costs relating to members included in claims	4.11.1.7 - Services provided to members in own facilities (Total column)
4.21.3	<i>Total own facility surplus/(deficit)</i>	

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.22

FINANCE COSTS

		Total
		R
4.22.1	Borrowings	
4.22.2	Interest paid on savings plan accounts	
4.22.3	Other (specify)	
4.22.4	<i>Total finance costs</i>	



PART 4.23

NET SURPLUS / (DEFICIT) PER BENEFIT OPTION

		Consolidated total	Other	Per benefit option
		R	R	R
4.23.1	Gross contribution income			
4.23.2	Less: Savings contribution income			
4.23.3	<i>Net contribution income</i>			
4.23.4	<i>Gross claims paid and reported in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)</i>			
4.23.4.1	- Direct benefits for the period			
4.23.4.2	- Direct benefits for the previous period			
4.23.4.3	- Direct benefits reported not yet paid			
4.23.4.4	- Managed care: healthcare benefits for the period (no transfer of risk)			
4.23.4.5	- Managed care: healthcare benefits for the previous period (no transfer of risk)			
4.23.4.6	- Managed care: healthcare benefits reported not yet paid (no transfer of risk)			
4.23.4.7	- Services provided to members in own facilities			
4.23.5	Less: Savings plan claims paid			
4.23.6	Less: Discount received on claims			
4.23.7	Less: Claims recoveries from third parties			
4.23.8	<i>Net actual claims paid and reported in respect of risk carried by the scheme (including claims incurred in respect</i>			



PART 4.23

NET SURPLUS / (DEFICIT) PER BENEFIT OPTION

		Consolidated total	Other	Per benefit option
		R	R	R
	<i>of commercial reinsurance contracts)</i>			
4.23.9	Provision for outstanding claims at the end of the financial year			
4.23.10	Less: Provision for outstanding claims at end of the previous year			
4.23.11	<i>Net claims incurred in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)</i>			
4.23.12	<i>Gross claims paid and reported in respect of related risk transfer arrangement (excluding claims incurred in respect of commercial reinsurance contracts)</i>			
4.23.12.1	- Direct benefits for the period			
4.23.12.2	- Direct benefits for the previous period			
4.23.12.3	- Direct benefits reported not yet paid			
4.23.13	<i>Net actual claims paid and reported in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)</i>			
4.23.14	Provision for outstanding claims at the end of the financial year			
4.23.15	Less: Provision for outstanding claims at end of the previous year			
4.23.16	<i>Net claims incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of</i>			



PART 4.23

NET SURPLUS / (DEFICIT) PER BENEFIT OPTION

		Consolidated total	Other	Per benefit option
		R	R	R
	<i>commercial reinsurance contracts)</i>			
4.23.17	<i>Net income/(expense) on risk transfer arrangements</i>			
4.23.17.1	Premiums/fees paid (Capitation fees)			
4.23.17.2	Less: Estimated claims recoveries			
4.23.17.3	Other (specify)			
4.23.18	<i>Relevant healthcare expenditure</i>			
4.23.19	Gross healthcare result			
4.23.20	Net income/(expense) on commercial reinsurance contracts			
4.23.21	Less: Managed care: management services			
4.23.22.1	Less: Broker service fees			
4.23.22.2	Less: Other distribution costs			
4.23.23	Administration expenses			
4.23.24	Net impairment losses: Trade and other receivables			
4.23.25	Net healthcare result			
4.23.26	Net impairment losses: Other (specify)			
4.23.27	Other investment income			
4.23.28	Less: Investment management fees			
4.23.29	Less: Operating expenses on rental of investment property			



PART 4.23

NET SURPLUS / (DEFICIT) PER BENEFIT OPTION

		Consolidated total	Other	Per benefit option
		R	R	R
4.23.30	Other realised and unrealised gains/(losses)			
4.23.31	Other income (specify)			
4.23.32	Own facility surplus/(deficit)			
4.23.33	Less: Other expenses (specify)			
4.23.34	Less: Finance costs			
4.23.35	<i>Surplus/(Deficit) for the year before consolidation</i>			
4.23.36	Consolidation results			
4.23.37	<i>Surplus/(Deficit) for the year after consolidation</i>			
4.23.38	Members at the end of the financial year			2.1.1 Number of members per option.
4.23.39	Beneficiaries at the end of the financial year			2.1.1 Number of beneficiaries per option.

What procedures are in place to refund the savings plan liability to members, and what is the timing thereof?

Medical Scheme:
Ref No.:
Financial Year End:



PART 4.24

GUARANTEES SUPPLIED TO REGISTRAR IN TERMS OF THE ACT

		Total
		R
4.24.1	Name of institution	
4.24.2	Total guarantees	



PART 4.25

GUARANTEES AND SURETYSHIPS FOR THIRD PARTY LIABILITIES (INCLUDING CONTINGENT LIABILITIES)

		Guarantees	Suretyships	Encumbered Assets	Other
		R	R	R	R
4.25.1	To whom				
4.25.2	<i>Total</i>				

Were the guarantees, suretyship for third party liabilities or encumbered assets approved by Council? Please also indicate the date of approval.

--



PART 4.26

RELATED PARTY TRANSACTIONS

		Name	Nature of related party relationship	Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arm's-length ?	Amount
					(Y/N)	R
STATEMENT OF COMPREHENSIVE INCOME						
4.26.1	Transactions for the year (statement of comprehensive income)		Nature of relationship	Specify		
4.26.1.1	Trustee remuneration & considerations	Board of Trustees	Key management personnel	Trustee remuneration		4.17.2 - Total trustee remuneration expense: Total
4.26.1.2	Trustees: Fees received in respect of services rendered to related parties	Board of Trustees	Key management personnel	Services rendered to related parties		4.17.2 - Total trustee remuneration expense: Fees received in respect of services rendered to related parties



PART 4.26

RELATED PARTY TRANSACTIONS

		Name	Nature of related party relationship		Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arm's-length ?	Amount
						(Y/N)	R
4.26.1.3	Principal Officer remuneration & considerations	Principal Officer	Key management personnel		Principal Officer remuneration		4.16.27 - Principal Officer fees and remuneration (current year: fund + own facilities) + 4.16.28 - Principal Officer travel and other expenses (current year: fund + own facilities)
4.26.1.4	Name of consolidated party (specify)		Nature of relationship	Specify			
STATEMENT OF FINANCIAL POSITION							



PART 4.26

RELATED PARTY TRANSACTIONS

		Name	Nature of related party relationship		Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arm's-length ?	Amount
						(Y/N)	R
4.26.2	Balances at year end (statement of financial position)		Nature of relationship	Specify			
4.26.2.1	Name of consolidated party (specify)		Nature of relationship	Specify			

Please provide the reasons for the transactions/balances at year-end not at arm's-length:

--



PART 5

STATEMENT OF FINANCIAL POSITION

		Current year	Previous year
		R	R
5.1	ASSETS		
5.1.1	Non-current assets		
5.1.1.1	Property, plant and equipment	4.1.3 - Total net carrying amount at end of year (Total column)	4.1.1.1 Total Gross carrying amount at beginning of year + 4.1.2.1 - Total accumulated depreciation at beginning of year
5.1.1.2	Investments	4.2.8 - Non-current column: Total investments	5.1.1.2 - Investments: current year column 2010 return
5.1.1.3	Other non-current assets (specify)		5.1.1.3 - Other non-current assets: current year column 2010 return
5.1.2	Current assets		
5.1.2.1	Inventories		5.1.2.1 - Inventories: current year column 2010 return
5.1.2.2	Trade and other receivables	4.3.17 - Total trade and other receivables	5.1.2.2 - Trade and other receivables: current year column 2010 return
5.1.2.3	Investments	4.2.8 - Current column: Total investments	5.1.2.3 - Investments: current year column 2010 return
5.1.2.4	Cash and cash equivalents	4.4.7 - Total cash and cash equivalents per balance sheet	5.1.2.4 - Cash and cash equivalents: current year column 2010 return



PART 5

STATEMENT OF FINANCIAL POSITION

		Current year	Previous year
		R	R
5.1.2.5	Other current assets (specify)		5.1.2.5 Other current assets (specify) (current year column 2010 return)
5.1.3	Total assets		
5.2	FUNDS AND LIABILITIES		
5.2.1	Members' funds		
5.2.1.1	Accumulated funds	7.1.5 - Accumulated funds: Balance at the end of the year (current year column)	7.1.5 - Accumulated funds: Balance at the end of the year (previous year column)
5.2.1.2	Revaluation Reserve - Investments	7.2.7 - Revaluation Reserve - Investments: Balance at the end of the year (current year column)	7.2.7 - Revaluation Reserve - Investments: Balance at the end of the year (previous year column)
5.2.1.3	Revaluation Reserve - Property, plant and equipment	7.3.6 - Revaluation Reserve - Property, plant and equipment: Balance at the end of the year (current year column)	7.3.6 - Revaluation Reserve - Property, plant and equipment: Balance at the end of the year (previous year column)
5.2.1.4	Reserves set aside for specific purposes	7.4.4 - Reserves set aside for specific purposes: Consolidated balance at the end of the year (current year column)	7.4.4 - Reserves set aside for specific purposes: Consolidated balance at the end of the year (previous year column)
5.2.1.5	Other reserves	7.5.4 - Other reserves: Consolidated balance at the end	7.5.4 - Other reserves: Consolidated balance at the



PART 5

STATEMENT OF FINANCIAL POSITION

		Current year	Previous year
		R	R
		of the year (current year column)	end of the year (previous year column)
5.2.1.6	Minority interest		5.2.1.6 - Minority interest: current year column 2010 return
5.2.2	Non-current liabilities		
5.2.2.1	Borrowings	4.6.4 - Total non-current borrowings: interest bearing borrowings + 4.6.4 - Total non-current borrowings: non-interest bearing borrowings	5.2.2.1 - Borrowings: current year column 2010 return
5.2.2.2	Other non-current liabilities	4.7.5 - Total other non-current liabilities	5.2.2.2 - Other non-current liabilities: current year column 2010 return
5.2.3	Current liabilities		
5.2.3.1	Savings plan liability	4.5.16 - Balance of savings plan liability at the end of the year (credit balance)	4.5.1 - Savings plan liability (balance at the beginning of the year) + 4.5.2 - Prior year adjustment
5.2.3.2	Trade and other payables	4.8.14 - Total trade and other payables	5.2.3.2 - Trade and other payables: current year column 2010 return
5.2.3.3	Outstanding claims provision	4.9.8 - Total column: Total outstanding claims provision at	4.9.1.1 Total column - As previously reported + 4.9.1.2 Total column - Prior year

Medical Scheme:
Ref No.:
Financial Year End:



PART 5

STATEMENT OF FINANCIAL POSITION

		Current year	Previous year
		R	R
		end of year	adjustment
5.2.3.4	Other current liabilities (specify)		5.2.3.4 - Other current liabilities: current year column 2010 return
5.2.4	<i>Total funds and liabilities</i>		

Please provide the reasons for any prior year restatements/reclassifications:

--



PART 6.1

STATEMENT OF COMPREHENSIVE INCOME

		Current year	Previous year
		R	R
6.1.1	Gross contribution income	4.23.1 - Consolidated gross contribution income	Part 6 Current year column 2010 return
6.1.2	Less: Savings contribution income	4.23.2 - Consolidated savings contribution income	
6.1.3	<i>Net contribution income</i>		
6.1.4	<i>Relevant healthcare expenditure</i>		
6.1.4.1	Net claims incurred	[4.23.11 Net claims incurred in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts) + 4.23.16 Net claims incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance)] * -1	Part 6 Current year column 2010 return
6.1.4.2	Net income/(expense) on risk transfer arrangements	4.23.17 Net (income)/expense on risk transfer arrangements * -1	4.13.4 Net (income)/expense from other risk transfer arrangements consolidated total previous year column * -1
6.1.5	Gross healthcare result		
6.1.6	Net income/(expense) on commercial reinsurance	4.23.20 Consolidated Net income/(expense) on commercial reinsurance contracts	Part 6 Current year column 2010 return
6.1.7	Less: Managed care: management services	4.23.21 - Consolidated Less: Managed care: management services	



PART 6.1

STATEMENT OF COMPREHENSIVE INCOME

		Current year	Previous year
		R	R
6.1.8.1	Less: Broker service fees	4.23.22.1 - Consolidated Less: Broker service fees	
6.1.8.2	Less: Other distribution costs	4.23.22.2 - Consolidated Less: Other distribution costs	
6.1.9	Less: Administration expenses	4.23.23 Consolidated Less: Administration expenses	4.16.41 Previous Year Fund Total administration expenses *-1
6.1.10	Net impairment losses: Trade and other receivables	4.23.24 Consolidated Net impairment losses: Trade and other receivables	Part 6 Current year column 2010 return
6.1.11	Net healthcare result		
6.1.12	Net impairment losses: Other (specify)	4.23.26 Consolidated Net impairment losses: Other (specify)	Part 6 Current year column 2010 return
6.1.13	Other investment income	4.23.27 Consolidated other investment income	
6.1.14	Less: Investment management fees	4.23.28 Consolidated Less: Investment management fees	Part 6 Current year column 2010 return
6.1.15	Less: Operating expenses on rental of investment property	4.23.29 Consolidated Less: Operating expenses on rental of investment property	
6.1.16	Other realised and unrealised gains/(losses)	4.23.30 Consolidated Other realised and unrealised gains/(losses)	
6.1.17	Other income (specify)	4.23.31 Consolidated Other operating income (specify)	



PART 6.1

STATEMENT OF COMPREHENSIVE INCOME

		Current year	Previous year
		R	R
6.1.18	Own facility surplus/(deficit)	4.23.32 Consolidated Own facility surplus/(deficit)	
6.1.19	Less: Other expenses (specify)	4.23.33 Consolidated Less: Other operating expenses (specify)	
6.1.20	Less: Finance costs	4.23.34 Consolidated Less: Finance costs	
6.1.21	Surplus/(Deficit) for the year before consolidation		
6.1.22	Consolidation results	4.23.36 Consolidated Consolidation results	Part 6 Current year column 2010 return
6.1.23	<i>Surplus/(Deficit) for the year after consolidation</i>		
6.1.24	Other comprehensive income		
6.1.25	Fair value adjustment on available-for-sale investments		Part 6 Current year column 2010 return
6.1.26	Reclassification adjustment		
6.1.27	Land and buildings revaluation		
6.1.28	Other (specify)		
6.1.29	<i>Total comprehensive income for the year</i>		

Please provide the reasons for any prior year restatements/reclassifications:



PART 6.2

MONTHLY STATEMENT OF NET HEALTHCARE RESULT

		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD
		R	R	R	R	R	R	R	R	R	R	R	R	R
6.2.1	Gross contribution income													
6.2.2	Less: Savings contribution income													
6.2.3	<i>Net contribution income</i>													
6.2.4	<i>Relevant healthcare expenditure</i>													
6.2.4.1	Net claims incurred													
6.2.4.2	Net income/(expense) on risk transfer arrangements													
6.2.5	Gross healthcare result													
6.2.6	Net income/(expense) on commercial reinsurance													
6.2.7	<i>Less: Managed care: management services</i>													
6.2.7.1	Managed care: management services: paid to													



PART 6.2

MONTHLY STATEMENT OF NET HEALTHCARE RESULT

		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD
		R	R	R	R	R	R	R	R	R	R	R	R	R
	administrator and its related parties													
6.2.7.2	Managed care: management services: paid to other third parties													
6.2.8.1	Less: Broker service fees													
6.2.8.2	Less: Other distribution costs													
6.2.9	<i>Less: Administration expenses</i>													
6.2.9.1	Administration fees and indirect fees paid to the administrator													
6.2.9.2	Co-administration fees													
6.2.9.3	Other administration expenditure													
6.2.10	Net impairment losses: Trade and other receivables													

Medical Scheme:
Ref No.:
Financial Year End:



PART 6.2

MONTHLY STATEMENT OF NET HEALTHCARE RESULT

		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD
		R	R	R	R	R	R	R	R	R	R	R	R	R
6.2.11	<i>Net healthcare result</i>													
6.2.12	<i>Surplus/(Deficit) for the year after consolidation</i>													



PART 7

STATEMENT OF CHANGES IN FUNDS AND RESERVES

PART 7.1

ACCUMULATED FUNDS

		Current year	Previous year
		R	R
7.1.1	<i>Balance at the beginning of the year:</i>		
7.1.1.1	- As previously reported	7.1.5 - Accumulated funds: Balance at the end of the year (previous year column)	7.1.1 (2010 annual return) - Accumulated funds balance at the beginning of the year (current year column)
7.1.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)		
7.1.2	Surplus/(Deficit) for the year	6.1.23 - Surplus/(deficit) for the year (current year columns)	6.1.23 - Surplus/(deficit) for the year (previous year columns)
7.1.3	<i>Transfer to/(from) accumulated funds</i>		
7.1.3.1	- Due to amalgamation		
7.1.3.2	- Due to re-measurement of property, plant and equipment		
7.1.3.3	- Other transfers		
7.1.4	Other (specify)		
7.1.5	<i>Balance at the end of the year</i>		

Medical Scheme:
Ref No.:
Financial Year End:



PART 7

STATEMENT OF CHANGES IN FUNDS AND RESERVES

PART 7.1

ACCUMULATED FUNDS

		Current year	Previous year
		R	R
Please provide the reasons for any prior year restatements/reclassifications:			



PART 7.2

REVALUATION RESERVES (INVESTMENTS)

		Current year	Previous year
		R	R
7.2.1	<i>Balance at the beginning of the year:</i>		
7.2.1.1	- As previously reported	7.2.7 - Revaluation reserve (investments): Balance at the end of the year (previous year column)	7.2.1 (2010 annual return) - Revaluation reserves (investments): Balance at the beginning of the year (current year column)
7.2.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)		
7.2.2	Unrealised gains/(losses) on revaluation of investments	6.1.25 - Fair value adjustment on available-for-sale investments Current year	6.1.25 - Fair value adjustment on available-for-sale investments Previous year
7.2.3	Realised gains/(losses) on derecognition of investments	6.1.26 - Reclassification adjustment current year	6.1.26 - Reclassification adjustment Previous year
7.2.4	Revaluation adjustment		
7.2.5	<i>Transfer (to)/from reserves</i>		
7.2.5.1	- Due to amalgamation		
7.2.5.2	- Other (specify)		
7.2.6	<i>Balance at the end of the year</i>		

Medical Scheme:
Ref No.:
Financial Year End:



PART 7.2

REVALUATION RESERVES (INVESTMENTS)

		Current year	Previous year
		R	R
Please provide the reasons for any prior year restatements/reclassifications:			



PART 7.3

REVALUATION RESERVE (PROPERTY, PLANT AND EQUIPMENT)

		Current year	Previous year
		R	R
7.3.1	<i>Balance at the beginning of the year:</i>		
7.3.1.1	- As previously reported	7.3.6 - Revaluation reserve (property, plant and equipment): Balance at the end of the year (previous year column)	7.3.1 - (2010 annual return) Revaluation reserve (property, plant and equipment): Balance at the beginning of the year (current year column)
7.3.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)		
7.3.2	Unrealised gains/(losses) on revaluation of property, plant and equipment	6.1.27 - Land and buildings revaluation Current year	6.1.27 - Land and buildings revaluation Previous year
7.3.3	Revaluation adjustment		
7.3.4	<i>Transfer (to)/from reserves</i>		
7.3.4.1	- Due to amalgamation		
7.3.4.2	- Other (specify)		
7.3.5	<i>Balance at the end of the year</i>		

Please provide the reasons for any prior year restatements/reclassifications:

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PART 7.4

RESERVES SET ASIDE FOR SPECIFIC PURPOSES

		Current year		Previous year	
		Consolidated	Per reserve	Consolidated	Per reserve
		R	R	R	R
7.4.1	<i>Balance at the beginning of the year:</i>				
7.4.1.1	- As previously reported		7.4.4 - Per Reserve: Reserves set aside for specific purposes: Balance at the end of the year (previous year)		7.4.1 (2010 annual return) Per reserve: Reserves set aside for specific purposes: Balance at the beginning of the year (current year column)
7.4.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)				
7.4.2	<i>Transfer (to)/from reserves</i>				
7.4.2.1	- Due to amalgamation				
7.4.2.2	- Other (specify)				
7.4.3	<i>Balance at the end of the year</i>				

Please provide the reasons for any prior year restatements/reclassifications:



PART 7.5

OTHER RESERVES

		Current year		Previous year	
		Consolidated	Per reserve	Consolidated	Per reserve
		R	R	R	R
7.5.1	<i>Balance at the beginning of the year:</i>				
7.5.1.1	- As previously reported		7.5.4 - Per reserve: Other reserves: Balance at the end of the year (previous year column)		7.5.1 - (2010 annual return): Per reserve: Other reserves: Balance at the beginning of the year (current year column)
7.5.1.2	- Prior year adjustment (including effect of first time adoption of IFRS)				
7.5.2	<i>Transfer (to)/from reserves</i>				
7.5.2.1	- Due to amalgamation				
7.5.2.2	- Other (specify)				
7.5.3	<i>Balance at the end of the year</i>				

Please provide the reasons for any prior year restatements/reclassifications:



PART 8

CASH FLOW STATEMENT

		Current year	Previous year
		R	R
8.1	CASH FLOWS FROM OPERATING ACTIVITIES		
8.1.1	<i>Cash receipts from members and providers</i>		
8.1.1.1	Cash receipts from members – contributions		
8.1.1.2	Cash receipts from members and providers – other		
8.1.2	<i>Cash paid to providers, employees and members</i>		
8.1.2.1	Cash paid to providers and members – claims		
8.1.2.2	Cash paid to providers and employees – non-healthcare expenditure		
8.1.2.3	Cash paid to members – savings plan refunds		
8.1.3	<i>Cash generated from operations</i>		
8.1.4	Interest paid		
8.1.5	Other (specify)		
8.1.6	Net cash from operating activities		
8.2	CASH FLOWS FROM INVESTING ACTIVITIES		
8.2.1	Purchase of property, plant and equipment		
8.2.2	Proceeds on disposal of property, plant and equipment		
8.2.3	Purchase of investment property		
8.2.4	Proceeds on disposal of investment property		



PART 8

CASH FLOW STATEMENT

		Current year	Previous year
		R	R
8.2.5	Purchase of investments		
8.2.6	Proceeds on disposal of investments		
8.2.7	Interest received		
8.2.8	Dividend received		
8.2.9	Rentals received		
8.2.10	Other (specify)		
8.2.11	Net cash from/(used) in investing activities		
8.3	CASH FLOWS FROM FINANCING ACTIVITIES		
8.3.1	(Repayments)/Increase in borrowings		
8.3.2	Other (specify)		
8.3.3	Net cash used in financing activities		
8.4	NET INCREASE IN CASH AND CASH EQUIVALENTS		
8.5	<i>Cash and cash equivalents at the beginning of the year</i>		
8.5.1	- As previously reported	8.8 - Cash and cash equivalents at the end of the year (previous year column)	8.5 (2010 annual return) - Cash and cash equivalents at beginning of period (current year column)

Medical Scheme:
Ref No.:
Financial Year End:



PART 8

CASH FLOW STATEMENT

		Current year	Previous year
		R	R
8.5.2	- Prior year adjustment		
8.6	Other (specify)		
8.7	Transfer of cash and cash equivalents due to amalgamation		
8.8	CASH AND CASH EQUIVALENTS AT THE END OF THE YEAR		

Please provide the reasons for any prior year restatements/reclassifications:



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
9.1	CATEGORY ONE - Deposits and balances in current and savings accounts, negotiable deposits, money market instruments, structured bank notes, margin deposits with SAFEX and collateralised deposits.				
1(a)(i)	BANKS with net qualifying capital and reserve funds > R5 billion				
	Per Bank - Name (specify)				
	Other (specify)				
	SUB-TOTAL: CATEGORY 1(a)(i)				
1(a)(ii)	BANKS with net qualifying capital and reserve funds > R100 million				
	Per Bank - Name (specify)				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	Other (specify)				
	SUB-TOTAL: CATEGORY 1(a)(ii)				
1(a)(iii)	DEPOSITS COLLATERALISED with securities issued by the government of the RSA where an appropriate ISMA has been concluded				
	Name (specify)				
	SUB-TOTAL: CATEGORY 1(a)(iii)				
	SUB-TOTAL: CATEGORY 1(a)				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
1(b)	<i>TERRITORIES OUTSIDE THE REPUBLIC - Deposits and balances in current and savings accounts, negotiable deposit and money market instruments with a foreign bank</i>				
	Per Bank - Name (specify)				
	Description	Specify			
	Other (specify)				
	SUB-TOTAL: CATEGORY 1(b)				
9.2	CATEGORY TWO - Bills, bonds and securities issued or guaranteed by and loans to or guaranteed by:				
2(a)	<i>INSIDE THE REPUBLIC</i>				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
2(a)(i)	Instruments guaranteed by the government of the RSA				
2(a)(ii)	Local Authorities authorized by law to levy rates upon immovable property				
2(a)(iii)	Development Bank				
2(a)(iv)	Industrial Development Corporation (IDC)				
2(a)(v)	Infrastructure Finance Corporation Limited (INCA)				
2(a)(vi)	Land and Agricultural Bank				
2(a)(vii)	Trans-Caledonian Tunnel Authority (TCTA)				
2(a)(viii)	SA Roads Board				
2(a)(ix)	ESKOM				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
2(a)(x)	Transnet				
2(a)(xi)	Per Bank with net qualifying capital and reserve funds > R5 billion - Name (specify)				
2(a)(xii)	Per Bank with net qualifying capital and reserve funds > R100 million - Name (specify)				
2(a)(xiii)	Per corporate institution not included in above categories, where debt is traded on the Bond Exchange				
2(a)(xiv)	Per other approved by Registrar institution not included in above categories				
	Description	Specify			
	SUB-TOTAL: CATEGORY 2(a)				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description		Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
			R	R	R	R
2(b)	TERRITORIES OUTSIDE THE REPUBLIC					
2(b)(i)	Per Foreign institution - Name (specify)					
	Description	Specify				
	SUB-TOTAL: CATEGORY 2(b)					
9.3	CATEGORY THREE - Immovable property, units in unit trust schemes in property shares, shares & loans to & debentures in property companies					
3(a)	INSIDE THE REPUBLIC					
3(a)(i)	Per Single property - Name (specify)					
	Description	Specify				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	SUB-TOTAL: CATEGORY 3(a)				
3(b)	TERRITORIES OUTSIDE THE REPUBLIC				
	Per Foreign institution - Name (specify)				
	Description	Specify			
	SUB-TOTAL: CATEGORY 3(b)				
9.4	CATEGORY FOUR - Shares, convertible debentures, exchange traded funds, units in equity unit trust schemes, linked policies of insurance				
4(a)(i)	UNLISTED SHARES, UNLISTED DEBENTURES, LISTED SHARES AND CONVERTIBLE DEBENTURES IN THE DEVELOPMENT CAPITAL AND VENTURE CAPITAL SECTORS OF				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description		Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
			R	R	R	R
	THE JSE					
	Name (specify)					
	Description	Specify				
	SUB-TOTAL: CATEGORY 4(a)(i)					
4(a)(ii)	SHARES AND CONVERTIBLE DEBENTURES LISTED ON JSE (Other than DEVELOPMENT CAPITAL SECTOR):					
4(a)(ii)(i)	Per Company with market capitalisation of more than R50 billion					
	Per company - Name (specify)					



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	SUB-TOTAL: CATEGORY 4(a)(ii)(i)				
4(a)(ii)(ii)	Per Company with market capitalisation of between R5 billion and R50 billion				
	Per company - Name (specify)				
	SUB-TOTAL: CATEGORY 4(a)(ii)(ii)				
4(a)(ii)(iii)	Per Company with market capitalisation of less than R5 billion				
	Per company - Name (specify)				
	SUB-TOTAL: CATEGORY 4(a)(ii)(iii)				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
4(a)(iii)	EXCHANGE TRADED FUNDS TRADED ON THE JSE:				
4(a)(iii)(i)	Per fund with diversified holdings across the component sectors of the JSE				
	Per fund - Name (specify)				
	SUB-TOTAL: CATEGORY 4(a)(iii)(i)				
4(a)(iii)(ii)	Per fund with holdings focused in sub-sectors of the JSE				
	Per fund - Name (specify)				
	SUB-TOTAL: CATEGORY 4(a)(iii)(ii)				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
4(a)(iv)	UNITS IN EQUITY UNIT TRUSTS OR POOLED EQUITY MANAGED FUNDS				
4(a)(iv)(i)	Per unit trust with diversified holdings across the component sectors of the JSE				
	Per unit trust - Name (specify)			0	
	SUB-TOTAL: CATEGORY 4(a)(iv)(i)			0	
4(a)(iv)(ii)	Per fund with holdings focused in sub-sectors of the JSE				
	Per fund - Name (specify)			0	
	SUB-TOTAL: CATEGORY 4(a)(iv)(ii)			0	



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
4(a)(v)	<i>POLICIES OF INSURANCE LINKED TO THE PERFORMANCE OF UNDERLYING EQUITIES OR EQUITY INDICES:</i>				
4(a)(v)(i)	<i>Per policy of insurance with diversified holdings across the component sectors of the JSE</i>				
	Per policy of insurance - Name (specify)		0		
	SUB-TOTAL: CATEGORY 4(a)(v)(i)		0		
4(a)(v)(ii)	<i>Per policy of insurance with holdings focused in sub-sectors of the JSE</i>				
	Per policy of insurance - Name (specify)		0		



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	SUB-TOTAL: CATEGORY 4(a)(v)(ii)		0		
	SUB-TOTAL: CATEGORY 4(a)				
4(b)	<i>TERRITORIES OUTSIDE THE REPUBLIC</i>				
	Per Foreign institution - Name (specify)				
	Description	Specify			
	SUB-TOTAL: CATEGORY 4(b)				
9.5	CATEGORY FIVE - Listed and unlisted debentures				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description		Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
			R	R	R	R
5(a)	INSIDE THE REPUBLIC					
	Name (specify)					
	Description	Specify				
	SUB-TOTAL: CATEGORY 5(a)					
5(b)	TERRITORIES OUTSIDE THE REPUBLIC					
	Per Foreign institution - Name (specify)					
	SUB-TOTAL: CATEGORY 5(b)					



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
9.6	CATEGORY SIX - Policies of insurance not directly linked and directly linked to market value of underlying assets				
6(a)(i)	<i>POLICY PROCEEDS ARE NOT DIRECTLY LINKED TO THE MARKET VALUE OF THE UNDERLYING ASSETS</i>				
	Per registered insurer (specify)		0		
	SUB-TOTAL: CATEGORY 6(a)(i)		0		
6(a)(ii)	<i>POLICY PROCEEDS ARE DIRECTLY LINKED TO THE MARKET VALUE OF THE UNDERLYING ASSETS</i>				
	Per registered insurer (specify)		0		
	SUB-TOTAL: CATEGORY 6(a)(ii)		0		



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	SUB-TOTAL: CATEGORY 6(a)		0		
6(b)	<i>TERRITORIES OUTSIDE THE REPUBLIC</i>				
	Per Foreign insurer - Name (specify)		0		
	SUB-TOTAL: CATEGORY 6(b)		0		
9.7	CATEGORY SEVEN - Other assets not referred to elsewhere in this Annexure				
7(a)(i)	<i>INVENTORIES</i>				
	Name (specify)		0	0	



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	SUB-TOTAL: CATEGORY 7(a)(i)		0	0	
7(a)(ii)	<i>DERIVATIVES:</i>				
	Per asset class category - Name (specify)				
	Description	Specify			
	SUB-TOTAL: DERIVATIVES 7(a)(ii)				
7(a)(iii)	<i>OTHER ASSETS</i>				
	Per asset - Name (specify)				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	Property, plant and equipment: computer equipment and software	4.1.3 - Net Carrying amount at end of year (Computer Equipment and Software)	0	0	
	Property, plant and equipment: furniture and fittings	4.1.3 - Net Carrying amount at end of year (Furniture and Fittings)	0	0	
	Property, plant and equipment: motor vehicles	4.1.3 - Net Carrying amount at end of year	0	0	



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
		(Motor Vehicles)			
	Property, plant and equipment: other	4.1.3 - Net Carrying amount at end of year (Other)	0	0	
	SUB-TOTAL: OTHER ASSETS 7(a)(iii)				
	SUB-TOTAL: CATEGORY 7(a)				
7(b)	TERRITORIES OUTSIDE THE REPUBLIC				
	Per Foreign institution - Name (specify)				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
	Description	Specify			
	SUB-TOTAL: CATEGORY 7(b)				
9.8	Less: assets encumbered	4.25.2 - (Total encumbered assets + Total suretyships) *-1	0	0	
9.9	Total net assets per Regulation 30				



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
9.10	Assets encumbered	9.8 - Direct investment: Less: Assets Encumbered *-1	0	0	
9.11	Intangible assets		0	0	
9.12	Trade and other receivables	5.1.2.2 - Trade and other receivables (current year column)	0	0	
9.13	Less: transfer of assets due to amalgamation during the year		0	0	



PART 9(a)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
		R	R	R	R
9.14	Total assets		0	0	

Medical Scheme:
Ref No.:
Financial Year End:



PART 9(b)

ASSETS HELD IN THE REPUBLIC IN TERMS OF REGULATION 30 IN CONJUNCTION WITH ANNEXURE B TO THE REGULATIONS

	Name of the person / company / institution managing the investments	Person/company/institution managing the investments		
		Managed on behalf of the scheme	Managed by the scheme	Total
		R	R	R
9.2.1	Name (specify)			
9.2.2	<i>Total net assets per Regulation 30</i>			



PART 10

MINIMUM ACCUMULATED FUNDS TO BE MAINTAINED BY A MEDICAL SCHEME IN TERMS OF REGULATION 29

PART 10.1

CUMULATIVE NET GAINS ON RE-MEASUREMENT OF PROPERTIES AND INVESTMENTS THROUGH THE INCOME STATEMENT

		Year to date
		R
10.1.1	Balance at beginning of period	10.1.7 (2010 annual return) - Cumulative net gain on re-measurement to fair value of properties and investments included in accumulated funds
10.1.2	Prior year adjustment	
10.1.3	Net gains/(losses) on revaluation of investments and property, plant and equipment included in the income statement	4.20.4 - Unrealised gain/(loss) on revaluation of investment property + 4.20.5 - Unrealised gain/(loss) on revaluation of investments carried at fair value through the income statement + 7.1.3.2 - Due to re-measurement of investments and property, plant and equipment (current year column)
10.1.4	Impairment losses and reversal of impairment losses on revaluation of investments and property, plant and equipment included in the income statement	

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10.1.5	Realisation of cumulative gains or losses on disposal of investments	
10.1.6	Consolidation results	6.1.22 - Total Consolidation results
10.1.7	Realisation of assets upon amalgamation during the year	
10.1.8	Other (Specify)	
10.1.9	<i>Cumulative net gain on revaluation of investments and property, plant and equipment included in the income statement</i>	

Please indicate the reasons for the prior year adjustment:



PART 10.2

SOLVENCY RATIO

		Total
		R
10.2.1	Total members' funds per balance sheet	5.2.1 (current year column) - Members' funds
10.2.2	Less: Unrealised non-distributable reserve	{5.2.1.2 (current year column) - Revaluation reserve (investments) + 5.2.1.3 (current year column) - Revaluation reserve (property, plant & equipment)} > 0 * -1
10.2.3	Less: Funds set aside for specific purposes	5.2.1.4 (current year column) - Reserves set aside for specific purposes * -1
10.2.4	Less: Cumulative net gains on revaluation of investments and property, plant and equipment included in the income statement	10.1.9 - Cumulative net gain on revaluation of investments and Property, plant and equipment included in the income statement > 0 * -1; however if 10.2.2 < 0 AND 10.1.9 < 0 then 10.2.4 = 10.1.9 * -1, limited to 10.2.2 * -1
10.2.5	Less: Specific assets encumbered for third party liabilities	4.25.2 - Total encumbered assets + Total suretyships * -1
10.2.6	Less: Minority interest	5.2.1.6 - Minority interest * -1
10.2.7	Add: Sub-ordinated loan as approved by the Council	
10.2.8	<i>Total net assets</i>	
10.2.9	Total net assets	10.2.8 - Total net assets

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10.2.10	Annualised gross contributions	6.1.1 - Total gross contribution income (current year)
10.2.11	<i>Solvency ratio</i>	

Please indicate the reasons for not meeting 25% solvency:
How many days were the solvency less than 25%?
When was/will the business plan be submitted to the Council for Medical Schemes (in terms of section 35(11) and Regulation 29(4))?

Part 11(a)

Circumstances:

- Work performed is regarded as sufficient to satisfy the requirement for the auditor to report as required by Sections 36(8), 37(3) read in conjunction with 37(2), and 39(3);
- The auditor's opinion on the annual financial statements for the current year / period is unmodified; and
- The auditor has not identified any regulatory matter to report (for example, a Reportable Irregularity) in terms of the Auditing Professions Act.

REPORT OF THE INDEPENDENT AUDITOR OF <NAME OF SCHEME> TO THE REGISTRAR OF MEDICAL SCHEMES ON PARTS 4 TO 10 OF THE ANNUAL STATUTORY RETURN AS REQUIRED BY SECTIONS 36, 37 AND 39 OF THE MEDICAL SCHEMES ACT NO. 131 OF 1998¹

We have audited Parts 4 to 10 of the annual statutory return (the Return) of <Name of Scheme> (the Scheme) for the year ended <insert date>, comprising information from the annual financial statements, prepared in accordance with International Financial Reporting Standards, and additional historical financial information extracted from the underlying accounting records of the Scheme for the purpose of reporting to the Registrar of Medical Schemes (the Registrar), as required by Sections 36, 37 and 39 of the Medical Schemes Act No. 131 of 1998 (the Act), whether Parts 4 to 10 of the Return have been prepared in all material respects, in accordance with the provisions of the Act, related Regulations, the Guidance Manual for the completion of the Return and the applicable Circulars issued by the Council for Medical Schemes (the "Act and related Regulations").

Trustees' Responsibility for the Return

The trustees are responsible for the preparation of Parts 4 to 10 of the Return from the annual financial statements and information contained in the underlying accounting records of the Scheme and for such internal control as they determine is necessary to ensure Parts 4 to 10 of the Return is prepared in accordance with the Act and related Regulations, and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility as required by Sections 36(8), 37(3) read in conjunction with 37(2), and 39(3) of the Act is to express our opinion on whether Parts 4 to 10 of the Return have been prepared in all material respects in compliance with the provisions of the Act and related Regulations based on our audit. We completed our audit of the annual financial statements of the Scheme for the year ended <insert date> on which we issued an <unmodified / modified>² opinion on <insert date of audit report>. Our audit of the annual financial statements was conducted in accordance with *International Standards on Auditing*.

Our audit involved performing procedures to obtain audit evidence about the amounts and disclosures in Parts 4 to 10 of the Return. The procedures selected depended on our judgment, including the assessment of the risks of material misstatement of the Return, whether due to fraud or error. In making those risk assessments we considered evidence obtained during our audit of the annual financial statements of the Scheme relevant to the

¹ The Office of the Registrar requires auditors to submit this report on the auditor's letterhead.

² Where a modified opinion has been expressed on the annual financial statements, the auditor considers the implications for the opinion to be expressed in the auditor's report on Parts 4 to 10 of the Return.



entity's preparation and presentation of the annual financial statements, in order to design such additional audit procedures relevant to the preparation of Part 4 to 10 of the Return that are appropriate in the circumstances. Our audit also included obtaining evidence that the Parts 4 to 10 of the Return have been prepared in accordance with the provisions of the Act and related Regulations from information in the annual financial statements and additional historical financial information extracted from the underlying accounting records of the Scheme.

We believe that our evidence obtained is sufficient and appropriate to provide a reasonable basis for our audit opinion.

Opinion

In our opinion, Parts 4 to 10 of the Return of the Scheme have been prepared in all material respects, in accordance with the provisions of the Act and related Regulations.

Restriction on Distribution or Use of the Auditor's Report

Our report is presented solely for the purpose set out in the first paragraph of the report and for the information of the Registrar, and is not to be used for any other purpose, nor to be distributed to any other parties without our prior written permission. Our report relates only to the information included in Parts 4 to 10 of the Return.

Registered audit firm

Per <Name of director / partner>

Registered Auditor

<Director / Partner >

<Date>



Part 11(b)

ASSURANCE REPORT OF THE INDEPENDENT AUDITOR OF <NAME OF SCHEME> TO THE REGISTRAR OF MEDICAL SCHEMES IN ACCORDANCE WITH THE REQUIREMENTS OF SECTIONS 36(5) AND 36(8) OF THE MEDICAL SCHEMES ACT NO. 131 OF 1998³

We have performed our assurance engagement in accordance with the requirements of Sections 36(5) and 36(8) of the Medical Schemes Act No. 131 of 1998 (the Act) in order to provide the Registrar of Medical Schemes (the Registrar) with limited assurance regarding compliance by <Name of Scheme> (the Scheme) with the Sections of the Act and related Regulations specified below:

1. Section 24(5) and/or Regulation 2 (1)(j); and/or sections 33(3) and 44(9)(b) as applicable, relating to the furnishing of financial guarantees;
2. Section 26(1)(c) relating to the establishment of a bank account under the scheme's direct control;
3. Sections 26(4) relating to the restriction of payments made from the scheme's bank account; and 26(5) relating to the prohibition on any dividend, rebate or bonus payment by a Scheme;
4. Section 26(7) relating to the period within which all subscriptions or contributions are to be paid directly to the Scheme;
5. Section 26(11) relating to the prohibition on a registered medical Scheme from carrying on any other business;
6. Section 37(4)(d) relating to disclosures in the annual financial statements in respect of benefit options offered, read together with section 33 relating to approval and withdrawal of benefit options;
7. Sections 35(4), 35(5), 35(7) and 35(8) relating to assets and investments held by the Scheme, as well as Regulation 30 relating to limitations on assets held, read together with Annexure B of the Regulations which specifies the limitations on percentages of different categories of assets that may be held;
8. Section 35(6) relating to prohibition on encumbrances of Scheme assets without the prior approval of the Medical Council;
9. Sections 36(10) and 36(11) relating to the appointment of an audit committee and the composition of the majority of its members;
10. Section 57(4)(f) regarding the duties of the Trustees to take out and maintain an appropriate level of professional indemnity and fidelity insurance⁴;
11. Sections 59(2) relating to the payment within 30 days of a benefit to be paid to a member or supplier of service, read together with Regulations 6(1), 6(2), 6(3) and 6(4) relating to the manner of payment of benefits;
12. Regulation 9A relating to a prohibition on any provision in the rules of a Scheme that permits an accumulation of unexpended benefits by a beneficiary from one year to the next, other than as provided for in personal medical savings accounts;

³ The Office of the Registrar requires auditors to submit this report on the auditor's letterhead

⁴ • Inspect the fidelity guarantee and professional indemnity policy and confirm the policy number and R value of the cover taken out by the scheme in accordance with Section 57(4)(f) of the Act.

- Inspected appropriate documentation and enquired from the scheme's administrator and management whether the premiums were fully paid up.
- Inspected minutes of meetings to confirm that cover was assessed for appropriateness by Board of Trustees.



13. Section 30(1)(e) relating to Scheme Rules allocating a personal medical savings account to a member within the limit and in the manner prescribed from time to time for payment of any relevant health service;
14. Regulations 10(1), 10(4), 10(5) and 10(6) relating to personal medical savings accounts;
15. Regulations 15 relating to the provision of managed health care; 18 relating to provisions to be included in administration agreements; and 19 relating to requirements of the parties on termination of an administration agreement;
16. Section 65 relating to broker services and commission, read together with Regulations 28(1), 28(2), 28(5) relating to compensation of brokers by a Scheme and 28B relating to requirements for accreditation of brokers by the Medical Council; and
17. Regulation 29 relating to the minimum accumulated funds to be maintained by a Scheme.

Trustees' responsibility

The trustees are responsible for compliance by the Scheme with all Sections of the Act and related Regulations and for such internal control as they determine is necessary to ensure compliance in all material respects with those Sections and Regulations specified above.

Auditor's responsibility

Our responsibility, in accordance with Sections 36(5)(b) and 36(8)(b) of the Act, is to express our limited assurance conclusion whether, based on our work performed, anything has come to our attention that causes us to believe that the Scheme has not complied with the Sections of the Act and related Regulations specified above. We conducted our assurance engagement in accordance with the International Standard on Assurance Engagements (ISAE) 3000, *Assurance Engagements Other Than Audits or Reviews of Historic Financial Information*. That standard requires us to comply with ethical requirements and to plan and perform our assurance engagement to obtain sufficient appropriate evidence to support our limited assurance conclusion expressed below.

We completed our audit of the annual financial statements of the Scheme for the year ended <insert date>, prepared in accordance with International Financial Reporting Standards (IFRS), on which we issued an <unmodified/modified>⁵ opinion on <insert date of audit report>. Our audit was performed in accordance with *International Standards on Auditing*. Where appropriate, we have drawn on evidence obtained regarding instances of non-compliance with the above Sections and Regulations identified during the course of our audit that might materially affect the annual financial statements, and have performed such additional procedures as we considered necessary which included:

- Making inquiries of the Scheme's management primarily responsible for financial and accounting matters and regulatory compliance;
- Re-performance of calculations, substantive analytical review procedures; and
- Inspection of supporting documentation considered necessary to assess compliance with the sections specified above.

⁵ Where a modified opinion has been expressed on the annual financial statements, the auditor considers the implications for the *Limited Assurance Conclusion* expressed in this report.



In a limited assurance engagement the evidence gathering procedures are more limited than for a reasonable assurance engagement and therefore less assurance is obtained than in a reasonable assurance engagement. We believe that our evidence obtained is sufficient and appropriate to provide a basis for our limited assurance conclusion.

Limited assurance conclusion

Based on our work performed, nothing has come to our attention that causes us to believe that the Scheme has not complied with the Sections of the Act and related Regulations specified above⁶.

Restriction on use and distribution

Our report is presented solely in compliance with Sections 36(5)(b) and 36(8)(b) of the Act for the purpose set out in the first paragraph of the report, and for the information of the Registrar and is not to be used for any other purpose, nor to be distributed to any other parties without our prior written consent. Our report relates only to instances of non-compliance by the Scheme with those Sections of the Act and related Regulations specified above identified in the course of our compliance engagement.

Registered audit firm

Per <Name of director/partner>

Registered Auditor

<Director / Partner >

<Date>

⁶ Where the auditor identifies instances of non-compliance with any of the sections specified, the assurance report should contain, within the limited assurance conclusion section of the report, a clear description of all such instances of non-compliance as illustrated in the Appendix to this report. Also refer to the guidance in paragraphs 51 – 53 of ISAE 3000, *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information*.



APPENDIX

Instances of non-compliance that may be identified which, if material may result in a modified conclusion and are to be reported to the Registrar, may include:

1. The guarantee supplied to the Registrar in terms of section 24(5) of the Act and/or Regulation 2 (1)(j); and/or sections 33(3) and 44(9)(b) of the Act, may be invalid;
2. The scheme's bank account may not be under the scheme's direct control or in its name in accordance with section 26(1)(c);
3. Invoices may not be prepared and payments may not be made in accordance with sections 26(4) and 26(5) of the Act;
4. Contributions may not be received within three days after payment thereof became due in accordance with section 26(7) of the Act;
5. The scheme is carrying on any business other than the business of a medical scheme in accordance with section 26(11) of the Act;
6. Accounting records may not be maintained for each benefit option in accordance with section 37(4)(d) of the Act, read together with section 33 of the Act;
7. Investments may not be made in accordance with sections 35(4), 35(5), 35(7) and 35(8) of the Act, as well as Regulation 30, read together with Annexure B of the Regulations.
8. The Scheme may have entered into financial arrangements that may not be in accordance with section 35(6) of the Act;
9. That the Scheme *<had/ did not have>* an audit committee in operation for the entire financial year, and if it did have an audit committee, the constitution of the audit committee was not in terms of the requirements of sections 36(10) and 36(11) of the Act;
10. The Scheme either failed to take out fidelity guarantee and professional indemnity, or the cover provided in policy *<insert policy number>* to the value of *<insert sum insured>*, was not in accordance with section 57(4)(f) of the Act, and / or the premiums for the policy were not fully paid up;
11. Benefits were not paid in accordance with the requirements of section 59(2) of the Act, read together with Regulations 6(1), 6(2), 6(3) and 6(4);
12. The Scheme failed to comply with Regulation 9A and provided for the accumulation of unexpended benefits;
13. The rules of the Scheme did not allow for medical savings accounts to be operated by the Scheme in terms of section 30(1)(e) of the Act;
14. Medical savings accounts operated were not in accordance with Regulations 10(1), 10(4), 10(5) and 10(6);
15. Written agreements entered into by the Scheme with administrator(s) and/or managed care organisation(s) did not comply with Regulations 15, 18 and 19;
16. Payments to brokers in terms of section 65 were not made in terms of Regulations 28(1), 28(2), 28(5) and 28B; and
17. The solvency of the Scheme was not correctly calculated in terms of Regulation 29.

Validation rules for the 2011 Annual Statutory Return

Part	Description	Validation rule words
1.4	If "yes" selected in nr. 1, full details need to be provided	Part 1.4.1: Details were not provided
1.4	If "yes" selected in nr. 2, full details need to be provided	Part 1.4.2: Details were not provided
1.4	If "yes" selected in nr. 3, full details need to be provided	Part 1.4.3: Details were not provided
1.4	If "no" selected in nr. 4, full details need to be provided	Part 1.4.4: Details were not provided
1.4	If "no" selected in nr. 5, full details need to be provided	Part 1.4.5: Details were not provided
1.4	If "yes" selected in nr. 6 a ii), names of third parties should be specified	Part 1.4.6 a ii: Details were not provided
1.4	If "yes" selected in nr. 6b, details need to be provided	Part 1.4.6b: Details were not provided
1.4	If "yes" selected in nr. 6c, details need to be provided	Part 1.4.6c: Details were not provided
1.4	If "yes" selected in nr. 6d, details need to be provided	Part 1.4.6d: Details were not provided
1.4	If "yes" selected in nr. 6e, details need to be provided	Part 1.4.6e: Details were not provided
1.4	If a self-administered scheme entered amounts in part 4.16 lines 4.16.1 or 4.16.9, "Yes" should have been selected in question 6e.	Part 1.4.6e: The scheme is a self-administered scheme, and had entered amounts in part 4.16 lines 4.16.1 (administration fees) or 4.16.9 (co-administration fees paid for ongoing services provided by third parties). "Yes" should have been selected in part 1.4 question 6e.
1.4	If "yes" selected in nr. 6g, details need to be provided	Part 1.4.6g: Details were not provided
1.4	If "yes" selected in nr. 7, details need to be provided	Part 1.4.7: Details were not provided

Validation rules for the 2011 Annual Statutory Return

Medical Scheme:
Ref No.:
Financial Year End:



1.4	If "yes" selected in nr. 8a, full details need to be provided	Part 1.4.8a: Details were not provided
1.4	If "yes" selected in nr. 8b, full details need to be provided	Part 1.4.8b: Details were not provided
1.4	If "yes" selected in nr. 8c, full details need to be provided	Part 1.4.8c: Details were not provided
1.4	Full details need to be provided in respect of nr 9b.	Part 1.4.9b: Details were not provided
1.4	If "no" selected in nr. 10, full details need to be provided	Part 1.4.10: Details were not provided
1.4	If "no" selected in nr. 11, full details need to be provided	Part 1.4.11: Details were not provided
1.4	Full details need to be provided in respect of nr 12b.	Part 1.4.12b: Details were not provided
1.4	If "yes" selected in nr. 13, full details need to be provided	Part 1.4.13: Details were not provided
1.4	If "yes" selected in nr. 14a, full details need to be provided	Part 1.4.14a: Details were not provided
1.4	If "yes" selected in nr. 14b, full details need to be provided	Part 1.4.14b: Details were not provided
1.4	If "yes" selected in nr. 14c, full details need to be provided	Part 1.4.14c: Details were not provided
1.4	If "yes" selected in nr. 14d, full details need to be provided	Part 1.4.14d: Details were not provided
1.4	If "yes" selected in nr. 15a, other detail needs to be provided in nr 15b and 15d	Part 1.4.15b: Other detail was not provided
1.4	If "yes" selected in nr. 15a, other detail needs to be provided in nr 15d	Part 1.4.15d: Other detail was not provided
1.4	If "no" selected in nr. 16, full details need to be provided	Part 1.4.16: Details were not provided
1.4	If "no" selected in nr. 17a, full details need to	Part 1.4.17a: Details were not provided

Validation rules for the 2011 Annual Statutory Return

Medical Scheme:
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	be provided	
1.4	If "yes" selected in nr. 17b, full details need to be provided	Part 1.4.17b: Details were not provided
1.4	If "no" selected in nr. 18, full details need to be provided	Part 1.4.18: Details were not provided
1.4	If "yes" selected in nr. 19, full details need to be provided	Part 1.4.19: Details were not provided
1.4	If "yes" selected in nr. 20, full details need to be provided	Part 1.4.20: Details were not provided
1.4	If "no" selected in nr. 22, full details need to be provided	Part 1.4.22: Details were not provided
1.4	If "yes" selected in nr. 23, full details need to be provided	Part 1.4.23: Details were not provided
1.4	If "yes" selected in nr. 24, full details need to be provided	Part 1.4.24: Details were not provided
1.4	If "no" selected in nr. 25, full details need to be provided	Part 1.4.25: Details were not provided
1.4	If "no" selected in nr. 26, full details need to be provided	Part 1.4.26: Details were not provided
1.4	If "no" was selected in nr. 27, but an administration contract was indicated in nr.6(e).	Part 1.4.27: The scheme has indicated that an administration agreement exists in question 6(e), but did not append a letter of comfort.
1.4	If "no" selected in nr. 28, full details need to be provided	Part 1.4.28: Details were not provided
2.1	Members per option should be > 1.	Part 2.1: Please provide the reasons, should the number of members be zero for any option.
2.1	Adult dependants per option should be > 1.	Part 2.1: Please provide the reasons, should the number of adult dependants be zero for any option.
2.1	Child dependants per option should be > 1.	Part 2.1: Please provide the reasons, should the number of child dependants be zero for any option.

Validation rules for the 2011 Annual Statutory Return

Medical Scheme:
Ref No.:
Financial Year End:



2.1	Total principle members should be > 6 000 members for open schemes	Part 2.1: Please provide the reasons, and actions to be taken, should the principle members be less than 6 000 members.
2.2	Members per month should be > 1.	Part 2.2: Please provide the reasons should the number of members be zero in any month.
2.2	Adult dependants per month should be > 1.	Part 2.2: Please provide the reasons should the number of adult dependants be zero in any month.
2.2	Child dependants per month should be > 1.	Part 2.2: Please provide the reasons should the number of child dependants be zero in any month.
2.3	The cumulative total for the consolidated males and females in part 2.3. must agree with the consolidated total of beneficiaries in part 2.1.2.	The cumulative total for the consolidated males and females in part 2.3. does not agree with the consolidated total of beneficiaries in part 2.1.2.
2.3	The cumulative total beneficiaries per option (males and females) in part 2.3.20 must agree with the total beneficiaries per option in part 2.1.	The cumulative total beneficiaries per option-(males and females) in part 2.3.20 does not agree with the total beneficiaries per option in part 2.1.
2.3	Total males for any option should be >1.	Part 2.3: Please provide the reasons, should the number of males be zero for any option.
2.3	Total females for any option should be >1.	Part 2.3: Please provide the reasons, should the number of females be zero for any option.
2.4.1	2.2.1 - beneficiaries <u>less:</u> 2.1.2 - Beneficiaries (2010 annual return) = 2.4.1.1's 'Total' column + 'Number of New Dependants Joining the Scheme' column - 'Number of Members Leaving the Scheme' column - 'Number of Dependants Leaving the Scheme' column.	The January member movement in part 2.4.1.1 does not agree with the beneficiary movement from December (last year) to January (current year) as captured in part 2.2 of the return.

Validation rules for the 2011 Annual Statutory Return

Medical Scheme:
Ref No.:
Financial Year End:



2.4.1	2.2.2 - beneficiaries <u>less</u> : 2.2.1 - beneficiaries = 2.4.1.2's- 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The February member movement in part 2.4.1.2 does not agree with the beneficiary movement from January-to February as captured in part 2.2 of the return.
2.4.1	2.2.3 - beneficiaries <u>less</u> : 2.2.2 - beneficiaries = 2.4.1.3's 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The March member movement in part 2.4.1.3 does not agree with the beneficiary movement from February-to March as captured in part 2.2 of the return.
2.4.1	2.2.4 - beneficiaries <u>less</u> : 2.2.3 - beneficiaries = 2.4.1.4's- 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The April member movement in part 2.4.1.4 does not agree with the beneficiary movement from March-to April as captured in part 2.2 of the return.
2.4.1	2.2.5 - beneficiaries <u>less</u> : 2.2.4 - beneficiaries = 2.4.1.5's- 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The May member movement in part 2.4.1.5 does not agree with the beneficiary movement from April to May as captured in part 2.2 of the return.
2.4.1	2.2.6 - beneficiaries <u>less</u> : 2.2.5 - beneficiaries = 2.4.1.6's- 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The June member movement in part 2.4.1.6 does not agree with the beneficiary movement from May to June as captured in part 2.2 of the return.

Validation rules for the 2011 Annual Statutory Return

Medical Scheme:
Ref No.:
Financial Year End:



2.4.1	2.2.7 - beneficiaries <u>less</u> : 2.2.6 - beneficiaries = 2.4.1.7's 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The July member movement in part 2.4.1.7 does not agree with the beneficiary movement from June to July as captured in part 2.2 of the return.
2.4.1	2.2.8 - beneficiaries <u>less</u> : 2.2.7 - beneficiaries = 2.4.1.8's 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The August member movement in part 2.4.1.8 does not agree with the beneficiary movement from July-to August as captured in part 2.2 of the return.
2.4.1	2.2.9 - beneficiaries <u>less</u> : 2.2.8 - beneficiaries = 2.4.1.9's 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The September member movement in part 2.4.1.9 does not agree with the beneficiary movement from August to September as captured in part 2.2 of the return.
2.4.1	2.2.10 - beneficiaries <u>less</u> : 2.2.9 - beneficiaries = 2.4.1.10's 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The October member movement in part 2.4.1.10 does not agree with the beneficiary movement from September to October as captured in part 2.2 of the return.
2.4.1	2.2.11 - beneficiaries <u>less</u> : 2.2.10 - beneficiaries = 2.4.1.11's 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The November movement in part 2.4.1.11 does not agree with the beneficiary movement from October to November as captured in part 2.2 of the return.

Validation rules for the 2011 Annual Statutory Return

Medical Scheme:
Ref No.:
Financial Year End:



2.4.1	2.2.12 - beneficiaries <u>less</u> : 2.2.11 - beneficiaries = 2.4.1.12's 'Total' column + 'Number of new dependants joining the scheme' column - 'Number of members leaving the scheme' column - 'Number of dependants leaving the scheme' column.	The December movement in part 2.4.1.12 does not agree with the beneficiary movement from November to December as captured in part 2.2 of the return.
2.4.2	The number of new members joining the scheme in part 2.4.2.20 must agree with the total number of new members joining the scheme in part 2.4.1.13 (column 3).	The number of new members joining the scheme in part 2.4.2.20 does not agree with the total number of new members joining the scheme in part 2.4.1.13.
2.4.2	The number of new dependants joining the scheme in part 2.4.2.20 must agree with the total number of new dependants joining the scheme in part 2.4.1.13.	The number of new dependants joining the scheme in part 2.4.2.20 does not agree with the total number of new dependants joining the scheme in part 2.4.1.13.
2.4.2	If the number of members at the end of January in part 2.2.1 >0, then the number of members leaving the scheme in part 2.4.2.20 must agree with the total number of members leaving the scheme in part 2.4.1.13.	The number of members leaving the scheme in part 2.4.2.20 does not agree with the total number of members leaving the scheme in part 2.4.1.13.
2.4.2	If the number of dependants at the end of January in part 2.2.1 >0, then the number of dependants leaving the scheme in part 2.4.2.20 must agree with the total number of dependants leaving the scheme in part 2.4.1.13.	The number of dependants leaving the scheme in part 2.4.2.20 does not agree with the total number of dependants leaving the scheme in part 2.4.1.13.
2.4.2	Principle members in the category "less than one year" exists.	Part 2.4.2: Please provide the reasons for the inclusion of members in the category: Less than one year .
2.5.20	No general waiting periods were imposed. (line 2.5.20 = 0)	Part 2.5: Please provide reasons why no general waiting periods were imposed.

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2.5.20	No pre-existing condition exclusions were imposed. (line 2.5.20 = 0)	Part 2.5: Please provide reasons why no pre-existing condition exclusions were imposed.
2.5.20	No late joiner penalties were imposed. (line 2.5.20 = 0)	Part 2.5: Please provide reasons why no late joiner penalties were imposed.
2.6	The utilisation data must be completed. (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column 2.6.1.1 - 2.6.3.24 > 0.)	Part 2.6 must be completed
2.6.1.1	Current year: The number of beneficiaries visiting GPs at least once a year (2.6.1.1) must be less than or equal to the total number of visits to GPs (2.6.1.2).	Current year: The number of beneficiaries visiting GPs at least once a year (2.6.1.1) is not less than or equal to the total number of visits to GPs (2.6.1.2).
2.6.1.1	Current year: The number of beneficiaries visiting GPs at least once a year (2.6.1.1) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries visiting GPs at least once a year (2.6.1.1) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.1.3	Current year: The number of beneficiaries visiting Dentists at least once a year (2.6.1.3) must be: less than or equal to the total number of visits to Dentists (2.6.1.4).	Current year: The number of beneficiaries visiting Dentists at least once a year (2.1.6.3) is not less than or equal to the total number of visits to Dentists (2.6.1.4).
2.6.1.3	Current year: The number of beneficiaries visiting Dentists at least once a year (2.6.1.3) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries visiting Dentists at least once a year (2.6.1.3) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.6.1.5	Current year: The number of beneficiaries visiting private nurses at least once a year (2.6.1.5) must be: less than or equal to the total number of visits to private nurses (2.1.6.6).	Current year: The number of beneficiaries visiting private nurses at least once a year (2.6.1.5) is not less than or equal to the total number of visits to private nurses (2.1.6.6).
2.6.1.5	Current year: The number of beneficiaries visiting private nurses at least once a year (2.1.6.5) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries visiting private nurses at least once a year (2.6.1.5) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.2.1	Current year: The number of beneficiaries admitted during the year (2.6.2.1) must be less than or equal to the total number of admissions (2.6.2.4).	Current year: The number of beneficiaries admitted during the year (2.6.2.1) is not less than or equal to the total number of admissions (2.6.2.4).
2.6.2.1	Current year: The number of beneficiaries admitted during the year (2.6.2.1) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries admitted during the year (2.6.2.1) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.2.5	Current year: The number of beneficiaries admitted during the year for PMBs (2.6.2.5) must be less than or equal to the total number beneficiaries admitted (2.6.2.1).	Current year: The number of beneficiaries admitted during the year for PMBs (2.6.2.5) is not less than or equal to the total number of beneficiaries admitted (2.6.2.1).

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2.6.2.5	Current year: The number of beneficiaries admitted during the year for PMBs (2.6.2.5) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries admitted during the year for PMBs (2.6.2.5) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.2.6	Current year: The number of beneficiaries admitted during the year at day clinics/unattached operating theaters (2.6.2.6) must be less than or equal to the total number admissions (2.6.2.1).	Current year: The number of beneficiaries admitted during the year at day clinics/unattached operating theaters (2.6.2.6) is not less than or equal to the total number of beneficiaries admitted (2.6.2.1).
2.6.2.6	Current year: The number of beneficiaries admitted during the year at day clinics/unattached operating theatres (2.6.2.6) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries admitted during the year at day clinics/unattached operating theatres (2.6.2.6) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.2.7	Current year: The number of beneficiaries receiving MRI scans at least once a year (2.6.2.7) must be less than or equal to the total number of MRI scans administered (2.6.2.8).	Current year: The number of beneficiaries receiving MRI-scans at least once a year (2.6.2.7) is not less than or equal to the total number of MRI scans administered (2.6.2.6).
2.6.2.7	Current year: The number of beneficiaries receiving MRI scans at least once a year (2.6.2.7) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving MRI scans at least once a year (2.6.2.7) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.6.2.9	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.2.9) must be less than or equal to the total number of CT scans administered (2.6.2.10).	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.2.9) is not less than or equal to the total number of CT scans administered (2.6.2.6).
2.6.2.9	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.2.9) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.2.9) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.2.13	Current year: The number of live births (2.6.2.13) should be less than or equal to the number of births (2.6.2.12).	Current year: The number of live births (2.6.2.13) is not less than or equal to the number of births (2.6.2.12).
2.6.2.14	Current year: The number of caesarean sections performed (2.6.2.14) should be less than or equal to the number of births (2.6.2.12).	Current year: The number of caesarean sections performed (2.6.2.14) is not less than or equal to the number of births (2.6.2.12).
2.6.2.15	Current year: The number of births to women between 12 and 18 years (2.6.2.15) should be less or equal to the number of births (2.6.2.12).	Current year: The number of births to women between 12 and 18 years (2.6.2.15) is not less than or equal to the number of births (2.6.2.12).
2.6.2.19	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.2.19) must be less than or equal to the total number of PET scans administered (2.6.2.20).	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.2.19) is not less than or equal to the total number of PET scans administered (2.6.2.20).

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2.6.2.19	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.2.19) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.2.19) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.2.21	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.2.21) must be less than or equal to the total number of angiograms administered (2.6.2.22).	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.2.21) is not less than or equal to the total number of angiograms administered (2.6.2.22).
2.6.2.21	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.2.21) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.2.21) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.2.23	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.2.23) must be less than or equal to the total number of bone density scans administered (2.6.2.24).	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.2.23) is not less than or equal to the total number of bone density scans administered (2.6.2.24).
2.6.2.23	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.2.23) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.2.23) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.6.2.26	Current year: The total number of admissions to ICU (2.6.2.26) must be less than or equal to the total number of admissions (2.6.2.4)	Current year: The total number of admissions to ICU (2.6.2.26) is not less than or equal to the total number of admissions (2.6.2.4)
2.6.2.27	Current year: The total number of admissions to High Care (2.6.2.27) must be less than or equal to the total number of admissions (2.6.2.4)	Current year: The total number of admissions to High Care (2.6.2.27) is not less than or equal to the total number of admissions (2.6.2.4)
2.6.2.28	Current year: The total number of admissions to General Ward (2.6.2.28) must be less than or equal to the total number of admissions (2.6.2.4)	Current year: The total number of admissions to General Ward (2.6.2.28) is not less than or equal to the total number of admissions (2.6.2.4)
2.6.2.29	Current year: The total number of admissions to Emergency Unit (2.6.2.29) must be less than or equal to the total number of admissions (2.6.2.4)	Current year: The total number of admissions to Emergency Unit (2.6.2.29) is not less than or equal to the total number of admissions (2.6.2.4)
2.6.2.30	Current year: The total number of admissions for Renal Dialysis (2.6.2.30) must be less than or equal to the total number of admissions (2.6.2.4)	Current year: The total number of admissions for Renal Dialysis (2.6.2.30) is not less than or equal to the total number of admissions (2.6.2.4)
2.6.3.1	Current year: The number of beneficiaries admitted during the year (2.6.3.1) must be less than or equal to the total number of admissions (2.6.3.4).	Current year: The number of beneficiaries admitted during the year (2.6.3.1) is not less than or equal to the total number of admissions (2.6.3.4).
2.6.3.1	Current year: The number of beneficiaries admitted during the year (2.6.3.1) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries admitted during the year (2.6.3.1) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.6.3.5	Current year: The number of beneficiaries admitted during the year for PMBs (2.6.3.5) must be less than or equal to the total number beneficiaries admitted (2.6.3.1).	Current year: The number of beneficiaries admitted during the year for PMBs (2.6.3.5) is not less than or equal to the total number of beneficiaries admitted (2.6.3.1).
2.6.3.5	Current year: The number of beneficiaries admitted during the year for PMBs (2.6.3.5) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries admitted during the year for PBM (2.6.3.5) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.3.6	Current year: The number of beneficiaries receiving MRI scans at least once a year (2.6.3.6) must be less than or equal to the total number of MRI scans administered (2.6.3.7).	Current year: The number of beneficiaries receiving MRI scans at least once a year (2.6.3.6) is not less than or equal to the total number of MRI scans administered (2.6.3.7).
2.6.3.6	Current year: The number of beneficiaries receiving MRI scans at least once a year (2.6.3.6) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving MRI-scans at least once a year (2.6.3.6) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.3.8	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.3.8) must be less than or equal to the total number of CT scans administered (2.6.3.9).	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.3.8) is not less than or equal to the total number of CT scans administered (2.6.3.9).

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2.6.3.8	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.3.8) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving CT scans at least once a year (2.6.3.8) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.3.12	Current year: The number of live births (2.6.3.12) should be less than or equal to the number of births (2.6.3.11).	Current year: The number of live births (2.6.3.12) is not less than or equal to the number of births (2.6.3.11).
2.6.3.13	Current year: The number of caesarean sections performed (2.6.3.13) should be less than or equal to the number of births (2.6.3.11).	Current year: The number of caesarean sections performed (2.6.3.13) is not less than or equal to the number of births (2.6.3.11).
2.6.3.14	Current year: The number of births to women between 12 and 18 years (2.6.3.14) should be less than or equal to the number of births (2.6.3.11).	Current year: The number of births to women between 12 and 18 years (2.6.3.14) is not less than or equal to the number of births (2.6.3.11).
2.6.3.18	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.3.18) must be less than or equal to the total number of PET scans administered (2.6.3.19).	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.3.18) is not less than or equal to the total number of PET scans administered (2.6.3.19).
2.6.3.18	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.3.18) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving PET scans at least once a year (2.6.3.18) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.6.3.20	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.3.20) must be less than or equal to the total number of angiograms administered (2.6.3.21).	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.3.20) is not less than or equal to the total number of angiograms administered (2.6.3.21).
2.6.3.20	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.3.20) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving angiograms at least once a year (2.6.3.20) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.3.22	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.3.22) must be less than or equal to the total number of bone density scans administered (2.6.3.23).	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.3.22) is not less than or equal to the total number of bone density scans administered (2.6.3.23).
2.6.3.22	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.3.22) must be less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).	Current year: The number of beneficiaries receiving bone density scans at least once a year (2.6.3.22) is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.6.3.25	Current year: The total number of admissions to ICU (2.6.3.25) must be less than or equal to the total number of admissions (2.6.3.4)	Current year: The total number of admissions to ICU (2.6.3.25) is not less than or equal to the total number of admissions (2.6.3.4)
2.6.3.26	Current year: The total number of admissions to High Care (2.6.3.26) must be less than or equal to the total number of admissions (2.6.3.4)	Current year: The total number of admissions to High Care (2.6.3.26) is not less than or equal to the total number of admissions (2.6.3.4)

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2.6.3.27	Current year: The total number of admissions to General Ward (2.6.3.27) must be less than or equal to the total number of admissions (2.6.3.4)	Current year: The total number of admissions to General Ward (2.6.3.27) is not less than or equal to the total number of admissions (2.6.3.4)
2.6.3.28	Current year: The total number of admissions to Emergency Unit (2.6.3.28) must be less than or equal to the total number of admissions (2.6.3.4)	Current year: The total number of admissions to Emergency Unit (2.6.3.28) is not less than or equal to the total number of admissions (2.6.3.4)
2.6.3.29	Current year: The total number of admissions for Renal Dialysis (2.6.3.29) must be less than or equal to the total number of admissions (2.6.3.4)	Current year: The total number of admissions for Renal Dialysis (2.6.3.29) is not less than or equal to the total number of admissions (2.6.3.4)
2.6.	Part 2.6: Changes were made to the previous year column.	Part 2.6: Please provide the reasons for any changes made to the prior year data.
2.7.	Current year: The number of beneficiaries with chronic diseases should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column "Consolidated" 2.7.1 - 2.7.27 > 0)	2.7 Current year, Consolidated total: The number of beneficiaries with chronic diseases should not be equal to zero.
2.7.1	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions <= total number of beneficiaries as at the 31st December (2.1.2) or <= average number of beneficiaries as at the 31st December (2.2.13).	2.7.1. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.2	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions <= total number of beneficiaries as at the 31st December (2.1.2) or <= average number of beneficiaries as at the 31st December (2.2.13).	2.7.2. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.7.3	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions <= total number of beneficiaries as at the 31st December (2.1.2) or <= average number of beneficiaries as at the 31st December (2.2.13).	2.7.3. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.4	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions <= total number of beneficiaries as at the 31st December (2.1.2) or <= average number of beneficiaries as at the 31st December (2.2.13).	2.7.4. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.5	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions <= total number of beneficiaries as at the 31st December (2.1.2) or <= average number of beneficiaries as at the 31st December (2.2.13).	2.7.5. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.6	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions <= total number of beneficiaries as at the 31st December (2.1.2) or <= average number of beneficiaries as at the 31st December (2.2.13).	2.7.6. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.7.7	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.7. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.8	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.8. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.9	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.9. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.10	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.10. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.7.11	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.11. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.12	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.12. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.13	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.13. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.14	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.14. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.7.15	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.15. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.16	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.16. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.17	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.17. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.18	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.18. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.7.19	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.19. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.20	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.20. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.21	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.21. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.22	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.22. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.7.23	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.23. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.24	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.24. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.25	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.25. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.26	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.26. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.7.27	Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.7.27. Current year, Consolidated total: The number of beneficiaries with any of the chronic conditions is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.7.	Part 2.7: Changes were made to the previous year column.	Part 2.7: Please provide the reasons for any changes made to the prior year data.
2.8.	The number of beneficiaries visiting at least once per year should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0 , then the sum of column "Number of Beneficiaries Visiting at Least Once Per Year" 2.8.1 - 2.8.35 > 0)	2.8: The number of beneficiaries visiting at least once per year should not be equal to zero.
2.8.	The total number of visits to specialists should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0 , then the sum of column "Total Number of Visits to Specialists" 2.8.1 - 2.8.35 > 0)	2.8: The total number of visits to specialists should not be equal to zero.
2.8.1	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.1. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.1	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.1. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.2	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.2. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.2	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.2. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.3	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.3. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.3	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.3. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.4	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.4. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.4	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.4. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.5	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.5. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.5	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.5. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.6	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.6. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.6	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.6. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.8.7	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.7. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.7	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.7. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.8	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.8. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.8	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.8. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.9	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.9. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.9	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.9. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.10	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.10. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.10	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.10. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.11	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.11. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.11	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.11. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.8.12	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.12. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.12	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.12. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.13	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.13. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.13	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.13. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.14	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.14. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.14	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.14. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.15	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.15. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.15	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.15. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.16	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.16. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.16	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.16. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.8.17	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.17. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.17	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.17. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.18	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.18. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.18	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.18. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.19	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.19. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.19	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.19. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.20	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.20. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.20	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.20. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.21	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.21. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.21	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.21. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.8.22	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.22. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.22	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.22. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.23	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.23. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.23	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.23. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.24	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.24. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.24	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.24. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.25	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.25. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.25	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.25. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.26	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.26. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.26	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.26. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.8.27	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.27. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.27	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.27. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.28	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.28. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.28	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.28. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.29	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.29. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.29	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.29. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.30	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.30. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.30	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.30. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.31	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.31. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.31	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.31. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.8.32	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.32. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.32	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.32. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.33	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.33. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.33	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.33. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.34	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.34. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.

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2.8.34	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.34. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.35	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.35. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.35	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.35. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.8.36	The number of beneficiaries visiting a medical specialist at least once a year must be \leq the total number of visits to a medical specialist.	2.8.36. The number of beneficiaries visiting a medical specialist at least once a year is not less than or equal to the total number of visits to a medical specialist.
2.8.36	The number of beneficiaries visiting a medical specialist at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq average number of beneficiaries as at the 31st December (2.2.13).	2.8.36. The number of beneficiaries visiting a medical specialist at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).



2.9.	The number of beneficiaries visiting at least once per year should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column "Number of Beneficiaries Visiting at Least Once Per Year" 2.9.1 - 2.9.25 > 0)	2.9: The number of beneficiaries visiting at least once per year should not be equal to zero.
2.9.	The total number of visits to specialists should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column "Total Number of Visits to Supplementary and Allied Health Professionals" 2.9.1 - 2.9.25 > 0)	2.9: The total number of visits to Supplementary and Allied Health Professionals should not be equal to zero.
2.9.1	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be ≤ total number of beneficiaries as at the 31st December (2.1.2) or ≤ the average number of beneficiaries as at the 31st December (2.2.13).	2.9.1. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.1	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be ≤ the total number of visits to a supplementary & allied health professional.	2.9.1. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.2	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.2. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.2	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.2. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.3	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.3. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.3	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.3. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.4	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.4. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.4	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.4. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.5	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.5. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.5	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.5. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.6	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.6. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.6	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.6. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.7	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.7. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.7	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.7. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.8	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.8. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.8	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.8. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.9	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.9. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.9	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.9. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.10	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.10. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.10	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.10. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.11	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.11. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.11	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.11. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.12	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.12. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.12	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.12. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.13	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.13. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.13	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.13. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.14	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.14. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.14	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.14. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.15	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.15. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.15	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.15. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.16	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.16. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.16	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.16. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.17	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.17. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.17	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.17. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.18	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.18. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.18	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.18. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.19	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.19. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.19	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.19. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.20	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.20. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.20	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.20. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.21	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.21. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.21	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.21. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.22	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.22. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.22	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.22. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.23	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.23. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.23	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.23. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.24	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.24. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.24	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.24. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.25	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.25. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.25	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.25. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.26	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.26. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.26	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.26. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.27	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.27. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.27	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.27. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.28	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.28. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.28	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.28. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.29	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.29. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.29	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.29. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.

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2.9.30	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.30. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.30	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.30. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.9.31	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.9.31. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.9.31	The number of beneficiaries visiting supplementary & allied health professionals at least once a year must be \leq the total number of visits to a supplementary & allied health professional.	2.9.31. The number of beneficiaries visiting supplementary & allied health professionals at least once a year is not less than or equal to the total number of visits to a supplementary & allied health professional.
2.10.	The total number of beneficiaries who submitted at least one claims should not be equal to zero (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column "Number of Beneficiaries who Submitted at Least One Claim " 2.10.1 -	2.10: The total number of beneficiaries who submitted at least one claims should not be equal to zero

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	2.10.16 > 0.)	
2.10.	The total number of claims from beneficiaries should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column "Total Number of Claims from Beneficiaries for" 2.10.1 - 2.10.16 > 0.)	2.10: The total number of claims from beneficiaries should not be equal to zero.
2.10.1	The number of beneficiaries who submitted at least one claim for other benefit services must be <= total number of beneficiaries as at the 31st December (2.1.2) or <= the average number of beneficiaries as at the 31st December (2.2.13).	2.10.1. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.1	The number of beneficiaries who submitted at least one claim for other benefit services must be <= the total number of claims from beneficiaries for other benefit services	2.10.1. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.2	The number of beneficiaries who submitted at least one claim for other benefit services must be <= total number of beneficiaries as at the 31st December (2.1.2) or <= the average number of beneficiaries as at the 31st December (2.2.13).	2.10.2. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.10.2	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.2. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.3	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.3. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.3	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.3. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.4	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.4. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.4	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.4. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services

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2.10.5	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.5. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.5	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.5. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.6	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.6. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.6	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.6. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.7	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.7. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.10.7	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.7. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.8	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.8. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.8	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.8. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.9	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.9. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.9	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.9. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services

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2.10.10	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.10. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.10	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.10. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.11	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.11. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.11	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.11. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.12	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.12. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.10.12	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.12. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.13	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.13. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.13	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.13. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.14	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.14. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.14	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.14. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services

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2.10.15	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.15. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.15	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.15. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.16	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.16. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.16	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.16. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.17	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.17. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.10.17	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.17. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.10.18	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.10.18. The number of beneficiaries who submitted at least one claim for other benefit services is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.10.18	The number of beneficiaries who submitted at least one claim for other benefit services must be \leq the total number of claims from beneficiaries for other benefit services	2.10.18. The number of beneficiaries who submitted at least one claim for other benefit services is not less than or equal to the total number of claims from beneficiaries for other benefit services
2.11.1.1	The total number of scripts filled by Pharmacists must be \leq the total number of items dispensed	2.11.1.1. The total number of scripts filled by Pharmacists is not less than or equal to the total number of items dispensed
2.11.1.2	The total number of scripts filled by General Practitioners must be \leq the total number of items dispensed	2.11.1.2. The total number of scripts filled by General Practitioners is not less than or equal to the total number of items dispensed
2.11.1.3	The total number of scripts filled by Medical Specialists must be \leq the total number of items dispensed	2.11.1.3. The total number of scripts filled by Medical Specialists is not less than or equal to the total number of items dispensed
2.11.1.4	The total number of scripts filled by Supplementary and Allied Health Professionals must be \leq the total number of items dispensed	2.11.1.4. The total number of scripts filled by Supplementary and Allied Health Professionals is not less than or equal to the total number of items dispensed

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2.11.1.5	The total number of scripts filled by Other Health Professionals must be \leq the total number of items dispensed	2.11.1.5. The total number of scripts filled by Other Health Professionals is not less than or equal to the total number of items dispensed
2.11.2.1	The total number of scripts filled by Pharmacists must be \leq the total number of items dispensed	2.11.2.1. The total number of scripts filled by Pharmacists is not less than or equal to the total number of items dispensed
2.11.2.2	The total number of scripts filled by General Practitioners must be \leq the total number of items dispensed	2.11.2.2. The total number of scripts filled by General Practitioners is not less than or equal to the total number of items dispensed
2.11.2.3	The total number of scripts filled by Medical Specialists must be \leq the total number of items dispensed	2.11.2.3. The total number of scripts filled by Medical Specialists is not less than or equal to the total number of items dispensed
2.11.2.4	The total number of scripts filled by Supplementary and Allied Health Professionals must be \leq the total number of items dispensed	2.11.2.4. The total number of scripts filled by Supplementary and Allied Health Professionals is not less than or equal to the total number of items dispensed
2.11.2.5	The total number of scripts filled by Other Health Professionals must be \leq the total number of items dispensed	2.11.2.5. The total number of scripts filled by Other Health Professionals is not less than or equal to the total number of items dispensed
2.11.	The total number of scripts filled should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column "Total Number of Scripts Filled" 2.11.1.1 - 2.11.2.5 > 0)	2.11: The total number of scripts filled should not be equal to zero.
2.11.	The total number of items dispensed should not be equal to zero. (If the number of beneficiaries at the end of January in part 2.2.1 > 0, then the sum of column "Total Number of Items Dispensed " 2.11.1.1 -	2.11: The total number of items dispensed should not be equal to zero.

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	2.11.2.5 > 0)	
2.12	The total members in part 2.12.11 should agree with the consolidated total members in part 2.1.2.	The total members in part 2.12.11 does not agree with the consolidated total members in part 2.1.2.
2.12	The total adult dependants in part 2.12.11 should agree with the consolidated total adult dependants in part 2.1.2.	The total adult dependants in part 2.12.11 does not agree with the consolidated total adult dependants in part 2.1.2.
2.12	The total child dependants in part 2.12.11 should agree with the consolidated total child dependants in part 2.1.2.	The total child dependants in part 2.12.11 does not agree with the consolidated total child dependants in part 2.1.2.
2.12	The scheme should provide an indication on how it is collecting adult dependant data for the completion of part 2.12.	Part 2.12: Please indicate how the scheme is collecting adult dependant data for the completion of this part.
2.12	The scheme should provide an indication on how it is collecting child dependant data for the completion of part 2.12.	Part 2.12: Please indicate how the scheme is collecting child dependant data for the completion of this part.
2.12	The scheme should provide an indication on how it is collecting member data for the completion of part 2.12.	Part 2.12: Please indicate how the scheme is collecting member data for the completion of this part.
2.13.1.1	2.13.1.1 Females less than one year: The number of beneficiaries admitted to private hospitals must be <= than the number of admissions to private hospitals	2.13.1.1 Females less than one year: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.1.1	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.1. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.1	2.13.1.1 Females less than one year: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.1 Females less than one year: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.2	2.13.1.2 Females 1-4 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.2 Females 1-4 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.2	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.2. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.2	2.13.1.2 Females 1-4 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.2 Females 1-4 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.3	2.13.1.3 Females 5-9 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.3 Females 5-9 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals



2.13.1.3	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.3. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.3	2.13.1.3 Females 5-9 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.3 Females 5-9 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.4	2.13.1.4 Females 10-14 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.4 Females 10-14 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.4	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.4. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.4	2.13.1.4 Females 10-14 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.4 Females 10-14 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.5	2.13.1.5 Females 15-19 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.5 Females 15-19 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals



2.13.1.5	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.5. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.5	2.13.1.5 Females 15-19 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.5 Females 15-19 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.6	2.13.1.6 Females 20-24 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.6 Females 20-24 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.6	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.6. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.6	2.13.1.6 Females 20-24 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.6 Females 20-24 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.7	2.13.1.7 Females 25-29 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.7 Females 25-29 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals



2.13.1.7	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.7. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.7	2.13.1.7 Females 25-29 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.7 Females 25-29 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.8	2.13.1.8 Females 30-34 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.8 Females 30-34 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.8	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.8. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.8	2.13.1.8 Females 30-34 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.8 Females 30-34 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.9	2.13.1.9 Females 35-39 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.9 Females 35-39 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals



2.13.1.9	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.9. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.9	2.13.1.9 Females 35-39 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.9 Females 35-39 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.10	2.13.1.10 Females 40-44 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.10 Females 40-44 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.10	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.10. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.10	2.13.1.10 Females 40-44 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.10 Females 40-44 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.11	2.13.1.11 Females 45-50 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.11 Females 45-50 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals



2.13.1.11	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.11. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.11	2.13.1.11 Females 45-50 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.11 Females 45-50 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.12	2.13.1.12 Females 50-54 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.12 Females 50-54 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.12	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.12. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.12	2.13.1.12 Females 50-54 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.12 Females 50-54 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.13	2.13.1.13 Females 55-59 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.13 Females 55-59 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals



2.13.1.13	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.13. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.13	2.13.1.13 Females 55-59 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.13 Females 55-59 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.14	2.13.1.14 Females 60-64 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.14 Females 60-64 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.14	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.14. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.14	2.13.1.14 Females 60-64 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.14 Females 60-64 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.15	2.13.1.15 Females 65-69 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.15 Females 65-69 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals



2.13.1.15	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.15. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.15	2.13.1.15 Females 65-69 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.15 Females 65-69 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.16	2.13.1.16 Females 70-74 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.16 Females 70-74 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.16	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.16. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.16	2.13.1.16 Females 70-74 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.16 Females 70-74 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.17	2.13.1.17 Females 75-79 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.17 Females 75-79 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.1.17	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.17. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.17	2.13.1.17 Females 75-79 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.17 Females 75-79 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.18	2.13.1.18 Females 80-84 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.18 Females 80-84 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.1.18	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.18. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.18	2.13.1.18 Females 80-84 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.18 Females 80-84 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.1.19	2.13.1.19 Females 85 years +: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.1.19 Females 85 years +: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.1.19	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.1.19. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.1.19	2.13.1.19 Females 85 years +: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.1.19 Females 85 years +: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.1	2.13.2.1 Males less than one year: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.1 Males less than one year: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.1	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.1. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.1	2.13.2.1 Males less than one year: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.1 Males less than one year: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.2	2.13.2.2 Males 1-4 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.2 Males 1-4 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.2	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.2. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.2	2.13.2.2 Males 1-4 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.2 Males 1-4 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.3	2.13.2.3 Males 5-9 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.3 Males 5-9 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.3	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.3. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.3	2.13.2.3 Males 5-9 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.3 Males 5-9 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.4	2.13.2.4 Males 10-14 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.4 Males 10-14 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.4	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.4. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.4	2.13.2.4 Males 10-14 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.4 Males 10-14 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.5	2.13.2.5 Males 15-19 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.5 Males 15-19 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.5	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.5. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.5	2.13.2.5 Males 15-19 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.5 Males 15-19 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.6	2.13.2.6 Males 20-24 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.6 Males 20-24 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.6	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.6. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.6	2.13.2.6 Males 20-24 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.6 Males 20-24 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.7	2.13.2.7 Males 25-29 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.7 Males 25-29 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.7	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.7. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.7	2.13.2.7 Males 25-29 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.7 Males 25-29 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.8	2.13.2.8 Males 30-34 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.8 Males 30-34 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.8	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.8. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.8	2.13.2.8 Males 30-34 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.8 Males 30-34 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.9	2.13.2.9 Males 35-39 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.9 Males 35-39 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.9	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.9. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.9	2.13.2.9 Males 35-39 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.9 Males 35-39 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.10	2.13.2.10 Males 40-44 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.10 Males 40-44 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.10	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.10. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.10	2.13.2.10 Males 40-44 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.10 Males 40-44 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.11	2.13.2.11 Males 45-50 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.11 Males 45-50 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.11	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.11. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.11	2.13.2.11 Males 45-50 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.11 Males 45-50 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.12	2.13.2.12 Males 50-54 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.12 Males 50-54 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.12	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.12. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.12	2.13.2.12 Males 50-54 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.12 Males 50-54 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.13	2.13.2.13 Males 55-59 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.13 Males 55-59 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.13	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.13. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.13	2.13.2.13 Males 55-59 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.13 Males 55-59 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.14	2.13.2.14 Males 60-64 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.14 Males 60-64 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.14	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.14. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.14	2.13.2.14 Males 60-64 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.14 Males 60-64 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.15	2.13.2.15 Males 65-69 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.15 Males 65-69 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.15	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.15. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.15	2.13.2.15 Males 65-69 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.15 Males 65-69 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.16	2.13.2.16 Males 70-74 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.16 Males 70-74 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.16	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.16. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.16	2.13.2.16 Males 70-74 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.16 Males 70-74 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.17	2.13.2.17 Males 75-79 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.17 Males 75-79 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.17	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.17. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.17	2.13.2.17 Males 75-79 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.17 Males 75-79 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.18	2.13.2.18 Males 80-84 years: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.18 Males 80-84 years: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals

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2.13.2.18	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.18. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.18	2.13.2.18 Males 80-84 years: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.18 Males 80-84 years: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13.2.19	2.13.2.19 Males 85 years +: The number of beneficiaries admitted to private hospitals must be \leq than the number of admissions to private hospitals	2.13.2.19 Males 85 years +: The number of beneficiaries admitted to private hospitals is not less than or equal to the number of admissions to private hospitals
2.13.2.19	The number of beneficiaries who was admitted at least once to a private hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.13.2.19. The number of beneficiaries who was admitted at least once to a private hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.13.2.19	2.13.2.19 Males 85 years +: The number of admissions to private hospitals must be \leq than the number of days admitted to private hospitals	2.13.2.19 Males 85 years +: The number of admissions to private hospitals is not less than or equal to the number of days admitted to private hospitals
2.13	If the number of members at the end of January in part 2.2.1 >0 , then the total number of beneficiaries admitted to private hospitals should not be equal to zero. (2.13.1.20 + 2.13.2.20 > 0)	2.13: The total number of beneficiaries admitted to private hospitals should not be equal to zero.

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2.13	If the number of members at the end of January in part 2.2.1 >0, then the total number of admissions to private hospitals should not be equal to zero. (2.13.1.20 + 2.13.2.20 > 0)	2.13: The total number of admissions to private hospitals should not be equal to zero.
2.13	If the number of members at the end of January in part 2.2.1 >0, then the total number of days admitted to private hospitals should not be equal to zero. (2.13.1.20 + 2.13.2.20 > 0)	2.13: The total number of days admitted to private hospitals should not be equal to zero.
2.14.1.1	2.14.1.1 Females less than one year: The number of beneficiaries admitted to public hospitals must be <= than the number of admissions to public hospitals	2.14.1.1 Females less than one year: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.1	The number of beneficiaries who was admitted at least once to a public hospital must be <= total number of beneficiaries as at the 31st December (2.1.2) or <= the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.1. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.1	2.14.1.1 Females less than one year: The number of admissions to public hospitals must be <= than the number of days admitted to public hospitals	2.14.1.1 Females less than one year: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.2	2.14.1.2 Females 1-4 years: The number of beneficiaries admitted to public hospitals must be <= than the number of admissions to public hospitals	2.14.1.2 Females 1-4 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.2	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.2. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.2	2.14.1.2 Females 1-4 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.2 Females 1-4 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.3	2.14.1.3 Females 5-9 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.3 Females 5-9 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.3	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.3. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.3	2.14.1.3 Females 5-9 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.3 Females 5-9 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.4	2.14.1.4 Females 10-14 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.4 Females 10-14 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.4	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.4. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.4	2.14.1.4 Females 10-14 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.4 Females 10-14 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.5	2.14.1.5 Females 15-19 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.5 Females 15-19 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.5	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.5. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.5	2.14.1.5 Females 15-19 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.5 Females 15-19 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.6	2.14.1.6 Females 20-24 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.6 Females 20-24 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.6	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.6. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.6	2.14.1.6 Females 20-24 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.6 Females 20-24 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.7	2.14.1.7 Females 25-29 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.7 Females 25-29 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.7	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.7. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.7	2.14.1.7 Females 25-29 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.7 Females 25-29 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.8	2.14.1.8 Females 30-34 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.8 Females 30-34 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.8	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.8. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.8	2.14.1.8 Females 30-34 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.8 Females 30-34 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.9	2.14.1.9 Females 35-39 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.9 Females 35-39 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.9	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.9. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.9	2.14.1.9 Females 35-39 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.9 Females 35-39 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.10	2.14.1.10 Females 40-44 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.10 Females 40-44 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.10	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.10. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.10	2.14.1.10 Females 40-44 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.10 Females 40-44 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.11	2.14.1.11 Females 45-50 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.11 Females 45-50 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.11	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.11. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.11	2.14.1.11 Females 45-50 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.11 Females 45-50 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.12	2.14.1.12 Females 50-54 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.12 Females 50-54 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.12	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.12. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.12	2.14.1.12 Females 50-54 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.12 Females 50-54 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.13	2.14.1.13 Females 55-59 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.13 Females 55-59 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.13	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.13. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.13	2.14.1.13 Females 55-59 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.13 Females 55-59 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.14	2.14.1.14 Females 60-64 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.14 Females 60-64 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.14	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.14. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.14	2.14.1.14 Females 60-64 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.14 Females 60-64 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.15	2.14.1.15 Females 65-69 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.15 Females 65-69 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.15	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.15. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.15	2.14.1.15 Females 65-69 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.15 Females 65-69 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.16	2.14.1.16 Females 70-74 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.16 Females 70-74 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.16	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.16. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.16	2.14.1.16 Females 70-74 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.16 Females 70-74 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.17	2.14.1.17 Females 75-79 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.17 Females 75-79 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.17	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.17. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.17	2.14.1.17 Females 75-79 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.17 Females 75-79 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.18	2.14.1.18 Females 80-84 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.18 Females 80-84 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.1.18	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.18. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.18	2.14.1.18 Females 80-84 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.18 Females 80-84 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.1.19	2.14.1.19 Females 85 years +: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.1.19 Females 85 years +: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.1.19	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.1.19. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.1.19	2.14.1.19 Females 85 years +: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.1.19 Females 85 years +: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.1	2.14.2.1 Males less than one year: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.1 Males less than one year: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.1	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.1. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.1	2.14.2.1 Males less than one year: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.1 Males less than one year: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.2	2.14.2.2 Males 1-4 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.2 Males 1-4 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.2	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.2. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.2	2.14.2.2 Males 1-4 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.2 Males 1-4 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.3	2.14.2.3 Males 5-9 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.3 Males 5-9 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.3	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.3. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.3	2.14.2.3 Males 5-9 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.3 Males 5-9 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.4	2.14.2.4 Males 10-14 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.4 Males 10-14 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.4	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.4. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.4	2.14.2.4 Males 10-14 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.4 Males 10-14 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.5	2.14.2.5 Males 15-19 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.5 Males 15-19 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.5	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.5. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.5	2.14.2.5 Males 15-19 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.5 Males 15-19 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.6	2.14.2.6 Males 20-24 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.6 Males 20-24 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.6	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.6. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.6	2.14.2.6 Males 20-24 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.6 Males 20-24 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.7	2.14.2.7 Males 25-29 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.7 Males 25-29 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.7	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.7. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.7	2.14.2.7 Males 25-29 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.7 Males 25-29 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.8	2.14.2.8 Males 30-34 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.8 Males 30-34 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.8	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.8. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.8	2.14.2.8 Males 30-34 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.8 Males 30-34 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.9	2.14.2.9 Males 35-39 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.9 Males 35-39 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.9	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.9. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.9	2.14.2.9 Males 35-39 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.9 Males 35-39 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.10	2.14.2.10 Males 40-44 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.10 Males 40-44 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.10	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.10. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.10	2.14.2.10 Males 40-44 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.10 Males 40-44 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.11	2.14.2.11 Males 45-50 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.10 Males 45-50 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.11	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.11. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.11	2.14.2.11 Males 45-50 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.11 Males 45-50 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.12	2.14.2.12 Males 50-54 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.12 Males 50-54 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.12	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.12. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.12	2.14.2.12 Males 50-54 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.12 Males 50-54 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.13	2.14.2.13 Males 55-59 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.13 Males 55-59 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.13	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.13. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.13	2.14.2.13 Males 55-59 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.13 Males 55-59 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.14	2.14.2.14 Males 60-64 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.14 Males 60-64 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.14	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.14. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.14	2.14.2.14 Males 60-64 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.14 Males 60-64 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.15	2.14.2.15 Males 65-69 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.15 Males 65-69 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.15	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.15. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.15	2.14.2.15 Males 65-69 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.15 Males 65-69 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.16	2.14.2.16 Males 70-74 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.16 Males 70-74 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.16	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.16. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.16	2.14.2.16 Males 70-74 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.16 Males 70-74 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.17	2.14.2.17 Males 75-79 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.17 Males 75-79 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.17	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.17. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.17	2.14.2.17 Males 75-79 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.17 Males 75-79 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.18	2.14.2.18 Males 80-84 years: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.18 Males 80-84 years: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals
2.14.2.18	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.18. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.18	2.14.2.18 Males 80-84 years: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.18 Males 80-84 years: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14.2.19	2.14.2.19 Males 85 years +: The number of beneficiaries admitted to public hospitals must be \leq than the number of admissions to public hospitals	2.14.2.19 Males 85 years +: The number of beneficiaries admitted to public hospitals is not less than or equal to the number of admissions to public hospitals

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2.14.2.19	The number of beneficiaries who was admitted at least once to a public hospital must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.14.2.19. The number of beneficiaries who was admitted at least once to a public hospital is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.14.2.19	2.14.2.19 Males 85 years +: The number of admissions to public hospitals must be \leq than the number of days admitted to public hospitals	2.14.2.19 Males 85 years +: The number of admissions to public hospitals is not less than or equal to the number of days admitted to public hospitals
2.14	If the number of members at the end of January in part 2.2.1 >0 , then the total number of beneficiaries admitted to public hospitals should not be equal to zero. (2.14.1.20 + 2.14.2.20 > 0)	2.14: The total number of beneficiaries admitted to public hospitals should not be equal to zero.
2.14	If the number of members at the end of January in part 2.2.1 >0 , then the total number of admissions to public hospitals should not be equal to zero. (2.14.1.20 + 2.14.2.20 > 0)	2.14: The total number of admissions to public hospitals should not be equal to zero.
2.14	If the number of members at the end of January in part 2.2.1 >0 , then the total number of days admitted to public hospitals should not be equal to zero. (2.14.1.20 + 2.14.2.20 > 0)	2.14: The total number of days admitted to public hospitals should not be equal to zero.
2.15.1	2.15.1: A00–B99 - Certain infectious and parasitic diseases: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.1: A00–B99 - Certain infectious and parasitic diseases: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types

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2.15.1	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.1. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.1	2.15.1: A00–B99 - Certain infectious and parasitic diseases: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.1: A00–B99 - Certain infectious and parasitic diseases: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.2	2.15.2: C00–D48 - Neoplasms: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.2: C00–D48 - Neoplasms: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.2	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.2. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.2	2.15.2: C00–D48 - Neoplasms: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.2: C00–D48 - Neoplasms: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types

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2.15.3	2.15.3: D50–D89 - Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism: The number of beneficiaries admitted in respect of certain principal diagnosis types must be <= than the number of admissions in respect of certain principal diagnosis types	2.15.3: D50–D89 - Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.3	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be <= total number of beneficiaries as at the 31st December (2.1.2) or <= the average number of beneficiaries as at the 31st December (2.2.13).	2.15.3. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.3	2.15.3: D50–D89 - Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism: The number of admissions in respect of certain principal diagnosis types must be <= than the number of days admitted in respect of certain principal diagnosis types	2.15.3: D50–D89 - Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.4	2.15.4: E00–E90 - Endocrine, nutritional and metabolic diseases: The number of beneficiaries admitted in respect of certain principal diagnosis types must be <= than the number of admissions in respect of certain principal diagnosis types	2.15.4: E00–E90 - Endocrine, nutritional and metabolic diseases: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types

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2.15.4	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.4. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.4	2.15.4: E00–E90 - Endocrine, nutritional and metabolic diseases: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.4: E00–E90 - Endocrine, nutritional and metabolic diseases: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.5	2.15.5: F00–F99 - Mental and behavioural disorders: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.5: F00–F99 - Mental and behavioural disorders: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.5	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.5. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.15.5	2.15.5: F00–F99 - Mental and behavioural disorders: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.5: F00–F99 - Mental and behavioural disorders: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.6	2.15.6: G00–G99 - Diseases of the nervous system: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.6: G00–G99 - Diseases of the nervous system: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.6	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.6. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.6	2.15.6: G00–G99 - Diseases of the nervous system: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.6: G00–G99 - Diseases of the nervous system: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.7	2.15.7: H00–H59 - Diseases of the eye and adnexa: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.7: H00–H59 - Diseases of the eye and adnexa: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types

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2.15.7	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.7. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.7	2.15.7: H00–H59 - Diseases of the eye and adnexa: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.7: H00–H59 - Diseases of the eye and adnexa: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.8	2.15.8: H60–H95 - Diseases of the ear and mastoid process: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.8: H60–H95 - Diseases of the ear and mastoid process: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.8	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.8. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.15.8	2.15.8: H60–H95 - Diseases of the ear and mastoid process: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.8: H60–H95 - Diseases of the ear and mastoid process: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.9	2.15.9: I00–I99 - Diseases of the circulatory system: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.9: I00–I99 - Diseases of the circulatory system: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.9	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.9. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.9	2.15.9: I00–I99 - Diseases of the circulatory system: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.9: I00–I99 - Diseases of the circulatory system: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.10	2.15.10: J00–J99 - Diseases of the respiratory system: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.10: J00–J99 - Diseases of the respiratory system: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types

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2.15.10	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.10. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.10	2.15.10: J00–J99 - Diseases of the respiratory system: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.10: J00–J99 - Diseases of the respiratory system: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.11	2.15.11: K00–K93 - Diseases of the digestive system: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.11: K00–K93 - Diseases of the digestive system: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.11	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.11. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.15.11	2.15.11: K00–K93 - Diseases of the digestive system: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.11: K00–K93 - Diseases of the digestive system: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.12	2.15.12: L00–L99 - Diseases of the skin and subcutaneous tissue: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.12: L00–L99 - Diseases of the skin and subcutaneous tissue: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.12	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.12. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.12	2.15.12: L00–L99 - Diseases of the skin and subcutaneous tissue: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.12: L00–L99 - Diseases of the skin and subcutaneous tissue: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types

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2.15.13	2.15.13: M00–M99 - Diseases of the musculoskeletal system and connective tissue: The number of beneficiaries admitted in respect of certain principal diagnosis types must be <= than the number of admissions in respect of certain principal diagnosis types	2.15.13: M00–M99 - Diseases of the musculoskeletal system and connective tissue: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.13	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be <= total number of beneficiaries as at the 31st December (2.1.2) or <= the average number of beneficiaries as at the 31st December (2.2.13).	2.15.13. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.13	2.15.13: M00–M99 - Diseases of the musculoskeletal system and connective tissue: The number of admissions in respect of certain principal diagnosis types must be <= than the number of days admitted in respect of certain principal diagnosis types	2.15.13: M00–M99 - Diseases of the musculoskeletal system and connective tissue: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.14	2.15.14: N00–N99 - Diseases of the genitourinary system: The number of beneficiaries admitted in respect of certain principal diagnosis types must be <= than the number of admissions in respect of certain principal diagnosis types	2.15.14: N00–N99 - Diseases of the genitourinary system: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types

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2.15.14	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.14. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.14	2.15.14: N00–N99 - Diseases of the genitourinary system: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.14: N00–N99 - Diseases of the genitourinary system: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.15	2.15.15: O00–O99 - Pregnancy, childbirth and the puerperium: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.15: O00–O99 - Pregnancy, childbirth and the puerperium: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.15	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.15. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.15.15	2.15.15: O00–O99 - Pregnancy, childbirth and the puerperium: The number of admissions in respect of certain principal diagnosis types must be <= than the number of days admitted in respect of certain principal diagnosis types	2.15.15: O00–O99 - Pregnancy, childbirth and the puerperium: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.16	2.15.16: P00–P96 - Certain conditions originating in the perinatal period: The number of beneficiaries admitted in respect of certain principal diagnosis types must be <= than the number of admissions in respect of certain principal diagnosis types	2.15.16: P00–P96 - Certain conditions originating in the perinatal period: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.16	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be <= total number of beneficiaries as at the 31st December (2.1.2) or <= the average number of beneficiaries as at the 31st December (2.2.13).	2.15.16. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.16	2.15.16: P00–P96 - Certain conditions originating in the perinatal period: The number of admissions in respect of certain principal diagnosis types must be <= than the number of days admitted in respect of certain principal diagnosis types	2.15.16: P00–P96 - Certain conditions originating in the perinatal period: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types

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2.15.17	2.15.17: Q00–Q99 - Congenital malformations, deformations and chromosomal abnormalities: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.17: Q00–Q99 - Congenital malformations, deformations and chromosomal abnormalities: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.17	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.17. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.17	2.15.17: Q00–Q99 - Congenital malformations, deformations and chromosomal abnormalities: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.17: Q00–Q99 - Congenital malformations, deformations and chromosomal abnormalities: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.18	2.15.18: R00–R99 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.18: R00–R99 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types

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2.15.18	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.18. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.18	2.15.18: R00–R99 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.18: R00–R99 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.19	2.15.19: S00–T98 - Injury, poisoning and certain other consequences of external causes: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.19: S00–T98 - Injury, poisoning and certain other consequences of external causes: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.19	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.19. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).

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2.15.19	2.15.19: S00–T98 - Injury, poisoning and certain other consequences of external causes: The number of admissions in respect of certain principal diagnosis types must be <= than the number of days admitted in respect of certain principal diagnosis types	2.15.19: S00–T98 - Injury, poisoning and certain other consequences of external causes: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15.20	2.15.20: Z00–Z99 - Factors influencing health status and contact with health services: The number of beneficiaries admitted in respect of certain principal diagnosis types must be <= than the number of admissions in respect of certain principal diagnosis types	2.15.20: Z00–Z99 - Factors influencing health status and contact with health services: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.20	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be <= total number of beneficiaries as at the 31st December (2.1.2) or <= the average number of beneficiaries as at the 31st December (2.2.13).	2.15.20. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.20	2.15.20: Z00–Z99 - Factors influencing health status and contact with health services: The number of admissions in respect of certain principal diagnosis types must be <= than the number of days admitted in respect of certain principal diagnosis types	2.15.20: Z00–Z99 - Factors influencing health status and contact with health services: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types



2.15.21	2.15.21: - Not reported: The number of beneficiaries admitted in respect of certain principal diagnosis types must be \leq than the number of admissions in respect of certain principal diagnosis types	2.15.21: - Not reported: The number of beneficiaries admitted in respect of certain principal diagnosis types is not less than or equal to the number of admissions in respect of certain principal diagnosis types
2.15.21	The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types must be \leq total number of beneficiaries as at the 31st December (2.1.2) or \leq the average number of beneficiaries as at the 31st December (2.2.13).	2.15.21. The number of beneficiaries who was admitted at least once in respect of certain principal diagnosis types is either not less than or equal to the total number of beneficiaries as at the 31st December (2.1.2) or is not less than or equal to the average number of beneficiaries as at the 31st December (2.2.13).
2.15.21	2.15.21: - Not reported: The number of admissions in respect of certain principal diagnosis types must be \leq than the number of days admitted in respect of certain principal diagnosis types	2.15.21: - Not reported: The number of admissions in respect of certain principal diagnosis types is not less than or equal to the number of days admitted in respect of certain principal diagnosis types
2.15	If the number of members at the end of January in part 2.2.1 >0 , then the total number of beneficiaries admitted in respect of certain principal diagnosis types should not be equal to zero. (2.15.22 > 0)	2.15: The total number of beneficiaries admitted in respect of certain principal diagnosis types should not be equal to zero.
2.15	If the number of members at the end of January in part 2.2.1 >0 , then the total number of admissions in respect of certain principal diagnosis types should not be equal to zero. (2.15.22 > 0)	2.15: The total number of admissions in respect of certain principal diagnosis types should not be equal to zero.

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2.15	If the number of members at the end of January in part 2.2.1 >0, then the total number of days admitted in respect of certain principal diagnosis types should not be equal to zero. (2.15.22 > 0)	2.15: The total number of days admitted in respect of certain principal diagnosis types should not be equal to zero.
3.1	Part 3.1.1 - General Practitioners: Total amount charged by supplier must be >= {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.1 - General Practitioners: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.2 - Medical Specialists: Total amount charged by supplier must be >= {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.2 - Medical Specialists: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.3 - Dentists: Total amount charged by supplier must be >= {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.3 - Dentists: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.4 - Dental Specialists: Total amount charged by supplier must be >= {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.4 - Dental Specialists: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.5 - Supplementary and Allied Health Professionals: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.5 - Supplementary and Allied Health Professionals: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.1.1 - Ward Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.1.1 - Ward Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.1.2 - Theatre Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.1.2 - Theatre Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.1.3 - Consumables: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.1.3 - Consumables: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.1.4 - Equipment Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.1.4 - Equipment Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.6.1.5 - Procedure Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.1.5 - Procedure Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.1.6 - Medicines dispensed: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.1.6 - Medicines dispensed: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.1.7 - Other (specify): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.1.7 - Other (specify): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.1.1 - Ward Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.1.1 - Ward Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.1.2 - Theatre Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.1.2 - Theatre Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.6.2.1.3 - Consumables: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.1.3 - Consumables: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.1.4 - Equipment Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.1.4 - Equipment Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.1.5 - Procedure Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.1.5 - Procedure Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.1.6 - Medicines dispensed: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.1.6 - Medicines dispensed: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.1.7 - Other (specify): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.1.7 - Other (specify): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.6.2.2.1 - Staff model-hospital care: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.2.1 - Staff model-hospital care: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.2.2 - Global fee: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.2.2 - Global fee: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.2.3 - Per diem fee: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.2.3 - Per diem fee: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.2.4 - Hospital network: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.2.4 - Hospital network: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.2.2.5 - Other (specify): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.2.2.5 - Other (specify): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.6.3.1 - Ward Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.3.1 - Ward Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.3.2 - Theatre Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.3.2 - Theatre Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.3.3 - Consumables: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.3.3 - Consumables: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.3.4 - Equipment Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.3.4 - Equipment Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.3.5 - Procedure Fees: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.3.5 - Procedure Fees: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.6.3.6 - Medicines dispensed: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.3.6 - Medicines dispensed: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.6.3.7 - Other (specify): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.6.3.7 - Other (specify): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.7.1 - Medicines dispensed by Pharmacists: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.7.1 - Medicines dispensed by Pharmacists: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.7.2 - Medicines dispensed by General Practitioners: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.7.2 - Medicines dispensed by General Practitioners: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.7.3 - Medicines dispensed by Medical Specialists: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.7.3 - Medicines dispensed by Medical Specialists: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.7.4 - Medicines dispensed by Supplementary and Allied Health Professionals: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.7.4 - Medicines dispensed by Supplementary and Allied Health Professionals: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.7.5 - Medicines dispensed by Other Health Professionals: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.7.5 - Medicines dispensed by Other Health Professionals: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.8 - Ex-gratia-payments: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.8 - Ex-gratia-payments: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.9 - Other Benefits: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.9 - Other Benefits: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.1	Part 3.1.10.1 - Primary care network: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.1.10.1 - Primary care network: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.1	Part 3.1.10.2 - Staff model - primary care: Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.1.10.2 - Staff model - primary care: Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.1	Part 3.1.10.3 - Other (specify): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.1.10.3 - Other (specify): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.2	Part 3.2.1 - Dermatologists (12): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} \}$	Part 3.2.1 - Dermatologists (12): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} \}$
3.2	Part 3.2.2 - Obstetricians & Gynaecologists (16): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.2.2 - Obstetricians & Gynaecologists (16): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.2	Part 3.2.3 - Pulmonologists (17): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.2.3 - Pulmonologists (17): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$

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3.2	Part 3.2.4 - Specialist Physicians (18): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.4 - Specialist Physicians (18): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.5 - Gastroenterologists (19): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.5 - Gastroenterologists (19): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.6 - Neurologists (20): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.6 - Neurologists (20): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.7 - Cardiologists (21): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.7 - Cardiologists (21): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.8 - Psychiatrists (22): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.8 - Psychiatrists (22): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.2	Part 3.2.9 - Medical Oncologists (23): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.9 - Medical Oncologists (23): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.10 - Neurosurgeons (24): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.10 - Neurosurgeons (24): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.11 - Nuclear Medicine Specialists (25): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.11 - Nuclear Medicine Specialists (25): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.12 - Ophthalmologists (26): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.12 - Ophthalmologists (26): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.13 - Clinical Haematologists (27): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.13 - Clinical Haematologists (27): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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3.2	Part 3.2.14 - Orthopaedic Surgeons (28): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.2.14 - Orthopaedic Surgeons (28): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.2	Part 3.2.15 - Otorhinolaryngologists (30): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.2.15 - Otorhinolaryngologists (30): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.2	Part 3.2.16 - Rheumatologists (31): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.2.16 - Rheumatologists (31): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.2	Part 3.2.17 - Paediatricians (32): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.2.17 - Paediatricians (32): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.2	Part 3.2.18 - Paediatric Cardiologists (33): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.2.18 - Paediatric Cardiologists (33): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$

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3.2	Part 3.2.19 - Physical Medicine Specialists (34): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.19 - Physical Medicine Specialists (34): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.20 - Plastic & Reconstructive Surgeons (36): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.20 - Plastic & Reconstructive Surgeons (36): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.21 - Radiation Oncologists (40): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.21 - Radiation Oncologists (40): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.22 - Surgeons (42): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.22 - Surgeons (42): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.23 - Cardiothoracic Surgeons (44): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.23 - Cardiothoracic Surgeons (44): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
Ref No.:
Financial Year End:



3.2	Part 3.2.24 - Urologists (46): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.24 - Urologists (46): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.25 - Anaesthetists (10): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.25 - Anaesthetists (10): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.26 - Diagnostic Radiologists (38): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.26 - Diagnostic Radiologists (38): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.27 - Pathologists (48): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.27 - Pathologists (48): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.28 - Other Medical or Clinical Support Specialists (specify): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.28 - Other Medical or Clinical Support Specialists (specify): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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Financial Year End:



3.2	Part 3.2.30 - Dental Therapists (95): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.30 - Dental Therapists (95): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.31 - Dental Technicians (93): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.31 - Dental Technicians (93): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.32 - Maxilla, Facial & Oral Surgeons (62): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.32 - Maxilla, Facial & Oral Surgeons (62): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.33 - Oral Pathologists (98): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.33 - Oral Pathologists (98): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.34 - Orthodontists (64): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.34 - Orthodontists (64): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.2	Part 3.2.35 - Periodontists (92): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.35 - Periodontists (92): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.2	Part 3.2.36 - Prosthodontists (94): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.2.36 - Prosthodontists (94): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.1 - Art Therapists (67): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.3.1 - Art Therapists (67): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.3	Part 3.3.2 - Audiologists (82): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.2 - Audiologists (82): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.3 - Biokineticists (75-009): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.3 - Biokineticists (75-009): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.3	Part 3.3.4 - Clinical / Medical / Laboratory Technologists (75): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.4 - Clinical / Medical / Laboratory Technologists (75): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.5 - Dieticians (84): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.5 - Dieticians (84): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.6 - Hearing Aid Acousticians (83): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.6 - Hearing Aid Acousticians (83): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.7 - Medical Scientists (69): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.7 - Medical Scientists (69): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.8 - Occupational Therapists (66): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.8 - Occupational Therapists (66): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.3	Part 3.3.9 - Optometrists (70): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.9 - Optometrists (70): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.10 - Orthoptists (74): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.10 - Orthoptists (74): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.11 - Pharmacists (60): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.11 - Pharmacists (60): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.12 - Physiotherapists (72): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.12 - Physiotherapists (72): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.13 - Podiatrists / Chiropodists (68): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.13 - Podiatrists / Chiropodists (68): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.3	Part 3.3.14 - Psychologists (86): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.14 - Psychologists (86): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.15 - Radiographers (39): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.15 - Radiographers (39): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.16 - Registered Nurses (88): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.16 - Registered Nurses (88): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.17 - Social Workers (89): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.17 - Social Workers (89): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.18 - Speech Therapists (82): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.18 - Speech Therapists (82): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.3	Part 3.3.19 - Acupuncturists & Chinese Medicine Practitioners (105): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.19 - Acupuncturists & Chinese Medicine Practitioners (105): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.20 - Ayurvedic Practitioners (104): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.20 - Ayurvedic Practitioners (104): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.21 - Chiropractors & Osteopaths (04 & 102): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.21 - Chiropractors & Osteopaths (04 & 102): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.22 - Homeopaths (08): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.22 - Homeopaths (08): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.3	Part 3.3.23 - Naturopaths & Phytotherapists (101 & 103): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.3.23 - Naturopaths & Phytotherapists (101 & 103): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.3	Part 3.3.24 - Therapeutic Aromatherapists (106) / Reflexologists (108) / Massage (107): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.3.24 - Therapeutic Aromatherapists (106) / Reflexologists (108) / Massage (107): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.3	Part 3.3.25 - Other Supplementary & Allied Health Professionals (specify): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.3.25 - Other Supplementary & Allied Health Professionals (specify): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$
3.4	Part 3.4.1 - Ambulance Services - Basic Life Support (13): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} \}$	Part 3.4.1 - Ambulance Services - Basic Life Support (13): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} \}$
3.4	Part 3.4.2 - Ambulance Services - Intermediate Life Support (11): Total amount charged by supplier must be $\geq \{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$	Part 3.4.2 - Ambulance Services - Intermediate Life Support (11): Total amount charged by supplier is not greater than or equal to $\{ \text{Risk amount paid by scheme} + \text{Savings amount paid by scheme on behalf of member} + \text{Amount paid by member} + \text{Discount received} \}$

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Medical Scheme:
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3.4	Part 3.4.3 - Ambulance Services - Advanced Life Support (09): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.3 - Ambulance Services - Advanced Life Support (09): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.4 - Blood and Blood Product Couriers (03): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.4 - Blood and Blood Product Couriers (03): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.5 - Blood Transfusion Services (78): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.5 - Blood Transfusion Services (78): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.6 - Clinical Services - Oxygen Supplier (90-001): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.6 - Clinical Services - Oxygen Supplier (90-001): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.7 - Clinical Services - Appliance Supplier (90-002/007/013/014): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.7 - Clinical Services - Appliance Supplier (90-002/007/013/014): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.4	Part 3.4.8 - Clinical Services - Prosthetic Supplier (90-003/004/005/006): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.8 - Clinical Services - Prosthetic Supplier (90-003/004/005/006): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.9 - Clinical Services - Other (90-008/009/010/011/012): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.9 - Clinical Services - Other (90-008/009/010/011/012): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.10 - Community Health Services (97): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.10 - Community Health Services (97): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.11 - Drug and Alcohol Rehabilitation (47): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.11 - Drug and Alcohol Rehabilitation (47): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.12 - Group Practice (50): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.12 - Group Practice (50): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}

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Medical Scheme:
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3.4	Part 3.4.13 - Hospice (79): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.13 - Hospice (79): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.14 - Mental Health Institutions (55): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.14 - Mental Health Institutions (55): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.15 - Sub Acute Facilities/Step Down Facilities (49): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.15 - Sub Acute Facilities/Step Down Facilities (49): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.4	Part 3.4.16 - Other Benefit Services (specify): Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}	Part 3.4.16 - Other Benefit Services (specify): Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member + Discount received}
3.5.1	Part 3.5.1: A00–B99 - Certain infectious and parasitic diseases: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.1: A00–B99 - Certain infectious and parasitic diseases: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}

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3.5.2	Part 3.5.2: C00–D48 - Neoplasms: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.2: C00–D48 - Neoplasms: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.3	Part 3.5.3: D50–D89 - Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.3: D50–D89 - Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.4	Part 3.5.4: E00–E90 - Endocrine, nutritional and metabolic diseases: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.4: E00–E90 - Endocrine, nutritional and metabolic diseases: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.5	Part 3.5.5: F00–F99 - Mental and behavioural disorders: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.5: F00–F99 - Mental and behavioural disorders: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.6	Part 3.5.6: G00–G99 - Diseases of the nervous system: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.6: G00–G99 - Diseases of the nervous system: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}

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3.5.7	Part 3.5.7: H00–H59 - Diseases of the eye and adnexa: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.7: H00–H59 - Diseases of the eye and adnexa: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.8	Part 3.5.8: H60–H95 - Diseases of the ear and mastoid process: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.8: H60–H95 - Diseases of the ear and mastoid process: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.9	Part 3.5.9: I00–I99 - Diseases of the circulatory system: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.9: I00–I99 - Diseases of the circulatory system: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.10	Part 3.5.10: J00–J99 - Diseases of the respiratory system: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.10: J00–J99 - Diseases of the respiratory system: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.11	Part 3.5.11: K00–K93 - Diseases of the digestive system: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.11: K00–K93 - Diseases of the digestive system: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}

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3.5.12	Part 3.5.12: L00–L99 - Diseases of the skin and subcutaneous tissue: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.12: L00–L99 - Diseases of the skin and subcutaneous tissue: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.13	Part 3.5.13: M00–M99 - Diseases of the musculoskeletal system and connective tissue: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.13: M00–M99 - Diseases of the musculoskeletal system and connective tissue: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.14	Part 3.5.14: N00–N99 - Diseases of the genitourinary system: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.14: N00–N99 - Diseases of the genitourinary system: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.15	Part 3.5.15: O00–O99 - Pregnancy, childbirth and the puerperium: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.15: O00–O99 - Pregnancy, childbirth and the puerperium: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.16	Part 3.5.16: P00–P96 - Certain conditions originating in the perinatal period: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.16: P00–P96 - Certain conditions originating in the perinatal period: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}

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3.5.17	Part 3.5.17: Q00–Q99 - Congenital malformations, deformations and chromosomal abnormalities: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.17: Q00–Q99 - Congenital malformations, deformations and chromosomal abnormalities: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.18	Part 3.5.18: R00–R99 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.18: R00–R99 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.19	Part 3.5.19: S00–T98 - Injury, poisoning and certain other consequences of external causes: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.19: S00–T98 - Injury, poisoning and certain other consequences of external causes: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.20	Part 3.5.20: Z00–Z99 - Factors influencing health status and contact with health services: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.20: Z00–Z99 - Factors influencing health status and contact with health services: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}
3.5.21	Part 3.5.21: - Not reported: Total amount charged by supplier must be \geq {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}	Part 3.5.21: - Not reported: Total amount charged by supplier is not greater than or equal to {Risk amount paid by scheme + Savings amount paid by scheme on behalf of member + Amount paid by member}

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3.5	If the number of members at the end of January in part 2.2.1 >0, then the total amount charged by suppliers in respect of certain principal diagnosis types should not be equal to zero. (3.5.22 > 0)	3.5: The total amount charged by suppliers in respect of certain principal diagnosis types should not be equal to zero.
4.1	4.1.2.2 - Depreciation charges (total) *-1 = 4.16.14 Depreciation (current year both columns).	The total depreciation charges in part 4.1.2.2 must agree with the depreciation in part 4.16.14(current year both columns).
4.1	Part 4.1: Previous year figures were restated/reclassified in line 4.1.1.1.2 or line 4.1.2.1.2.	Part 4.1: Please provide the reasons for any prior year restatements/reclassifications.
4.3(a)	4.3.3 - Savings plan advances (total) = 4.5.15	The total savings plan account advances in part 4.3.3 must agree with the advances on savings plan accounts in part 4.5.15.
4.3(a)	4.3.4.1.1 - Share of outstanding claims provision + 4.3.4.1.2 - Share of claims reported not yet paid covered by reinsurance contracts = 4.14.3 - Provision for reinsurance claims recovered.	Part 4.3.4.1.1 - Share of outstanding claims provision + Part 4.3.4.1.2 - Share of claims reported not yet paid covered by reinsurance contracts must agree with part 4.14.3 - Provision for reinsurance claims recovered.
4.3(a)	There are values in 4.3.1.2; 4.3.1.3; 4.3.1.4; or 4.3.1.5.	Part 4.3.1: Please indicate whether the scheme has any agreements in place with employers / members to pay their contributions after 3 days of it becoming due.
4.3(a)	There are values in 4.3.1.2; 4.3.1.3; 4.3.1.4; or 4.3.1.5.	Part 4.3.1: Please indicate the remedial actions taken by the scheme where contributions were received after three days of it becoming due.
4.3(a)	There is a value in part 4.3.12.1.	Part 4.3.12.1: What is the nature of/reasons for the amount owed by the administrator?

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4.3(a)	There is a value in part 4.3.12.2.	Part 4.3.12.2: What is the nature of/reasons for the amount owed by reinsurers (other than claim recoveries)?
4.3(a)	There is a value in part 4.3.12.3.	Part 4.3.12.3: What is the nature of/reasons for the amount owed by managed care organisations (other than claim recoveries)?
4.3(a)	There is a value in part 4.3.12.4.	Part 4.3.12.4: What is the nature of/reasons for the amount owed by brokers?
4.3(a)	There is a value in part 4.3.12.5.	Part 4.3.12.5: What is the nature of/reasons for the amount owed by other related parties?
4.3(b)	Part 4.3.4.1(a) Commercial reinsurance contracts = Part 4.3.1(b) Commercial reinsurance contracts	The closing balance on the commercial reinsurance contract in part 4.3.4.1(a) should agree to the closing balance on the commercial reinsurance contract in part 4.3.1(b)
4.3(b)	Part 4.3.4.2(a) Other risk transfer arrangements = Part 4.3.2(b) Other risk transfer arrangements	The closing balance on the other risk transfer arrangements in part 4.3.4.2(a) should agree to the closing balance on the other risk transfer arrangements in part 4.3.2(b)
4.5	4.5.16 - Balance of savings plan liability at the end of the year (credit balance) = 4.5.17 - Ageing of savings plan liability at the end of the year.	The ageing of the savings plan liability at the end of the year in part 4.5.17 must agree with the balance of the savings plan liability at the end of the year in part 4.5.16.
4.5	Part 4.5.17.2.2 > R0	Part 4.5.17.2.2: There are savings plan amounts due to members who resigned longer than 6 months ago. What procedures are in place to follow-up on members that need to be refunded?
4.5	Part 4.5: Previous year figures were restated/reclassified in line 4.5.2.	Part 4.5: Please provide the reasons for any prior year restatements/reclassifications.

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4.6	4.6.1 - Total > R0	Part 4.6: Were the borrowings that existed at year-end approved by Council?
4.8	4.8.6.1 > {4.16.2 (current year both columns) / 12}	Part 4.8.6.1: Administration fees owed is larger than the average fees per month.
4.8	4.8.6.3 > {(6.1.8.1 Total column * -1) / 12}	Part 4.8.6.3: Broker fees owed is larger than the average fees per month.
4.8	4.8.6.4 > {((6.1.7 Total column * -1)+ (4.13.1 Consolidated total current year)) / 12}	Part 4.8.6.4: Fees owed to managed care organisations are larger than the average fees per month.
4.8	If 4.8.8 > (4.8.14 x 10%)	Part 4.8: What is the nature of/the reasons for the amount owed to members in line 4.8.8?
4.8	4.8.9 > {6.1.1 Total column / 12}	Part 4.8.9: Unallocated deposits are larger than average gross contributions per month.
4.8	Third party administered scheme and 4.8.10 > R0	Part 4.8.10: In respect of which employees are the post retirement benefits due?
4.8	Lines 4.8.5 and 4.8.7 > 0	Part 4.8: Please indicate whether the scheme obtained approval from Council to directly or indirectly borrow money, as is required by section 35(6)(c) of the Medical Schemes Act.
4.8	4.8.1 - Reported claims not yet paid = (4.11.1.3 - Total Direct benefits reported not yet paid + 4.11.1.6 - Managed care: healthcare benefits reported not yet paid (no risk transfer)).	Reported claims not yet paid in part 4.8.1 must agree with the sum of 4.11.1.3 - Total Direct benefits reported not yet paid + 4.11.1.6 - Managed care: healthcare benefits reported not yet paid (no risk transfer).
4.9	(4.9.3 / 4.9.1) > 10% or (4.9.3 / 4.9.1) < -10%	Part 4.9: Please provide reasons for any (under)/over provision which is more than 10% of the previous year's provision.

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4.9	4.9.8 - Total outstanding claims provision at end of year = 4.9.8.5 Balance at end of year.	The balance of the outstanding claims provision in part 4.9.8.5 must agree with the total outstanding claims provision at the end of year in part 4.9.8.
4.9	4.9.6 (Column C) Total outstanding claims provision at the end of the year (covered by commercial reinsurance contracts) = 4.3.4.1.1 (a) Commercial reinsurance contracts : Share of outstanding claims provision.	4.9.6 (Column C): The balance of the outstanding claims provision covered by commercial reinsurance contracts at the end of the year must agree with the share of outstanding claims provision (commercial reinsurance contracts) in part 4.3.4.1.1 (a).
4.9	4.9.6 (Column D) Total outstanding claims provision at the end of the year (covered by other risk transfer arrangements) = 4.3.4.2.1 (a) Other risk transfer arrangements : Share of outstanding claims provision.	4.9.6 (Column D): The balance of the outstanding claims provision covered by other risk transfer arrangements at the end of the year must agree with the share of outstanding claims provision (other risk transfer arrangements) in part 4.3.4.2.1 (a).
4.9	Part 4.9: Previous year figures were restated/reclassified in line 4.9.1.2.	Part 4.9: Please provide the reasons for any prior year restatements/reclassifications.
4.10	4.10.1 = R0	Part 4.10: Please provide the reasons if the gross contributions are zero.
4.11	If the number of beneficiaries at the end of January in part 2.2.1 >0, and 4.11.7 column C < 0, then 4.11.1.2 column C > 0.	Part 4.11: Although the scheme had a provision for outstanding claims in respect of related risk transfer arrangements at the end of the previous period in line 4.11.7, no payments in respect of this provision were accounted for in line 4.11.1.2.
4.11	4.11.1.3 Direct benefits reported not yet paid Columnn B >= 4.3.4.1.2 Share of claims reported not yet paid	4.11.1.3 Direct benefits reported not yet paid Columnn B should be greater than or equal to 4.3.4.1.2 Share of claims reported not yet paid
4.11	4.11.1.3 Direct benefits reported not yet paid Column C= 4.3.4.2.2 Share of claims reported not yet paid	4.11.1.3 Direct benefits reported not yet paid Column C should agree to 4.3.4.2.2 Share of claims reported not yet paid

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4.11 / 4.13	4.11.1.4 - (Total column) Managed care: healthcare benefits for the period (no risk transfer) + 4.11.1.5 - Managed care: healthcare benefits for the previous period (no risk transfer) + 4.11.1.6 - Managed care: healthcare benefits reported not yet paid (no transfer of risk) + 4.13.1 - Premiums/fees paid (Capitation fees) consolidated total current year \geq 3.1.6.2.2.6 (risk amount paid by scheme + savings amount paid by scheme on behalf of member + discount received columns) - Sub total of managed care arrangements (in hospital benefits) + 3.1.10.4 (risk amount paid by scheme + savings amount paid by scheme on behalf of member + discount received columns) - Total managed care arrangements (out of hospital benefits).	4.11.1.4 - Managed care: healthcare benefits for the period (no risk transfer) + 4.11.1.5 - Managed care: healthcare benefits for the previous period (no risk transfer) + 4.11.1.6 - Managed care: healthcare benefits reported not yet paid (no transfer of risk) + 4.13.1 - Premiums/fees paid (Capitation fees) consolidated total current year must agree or should be bigger than 3.1.6.2.2.6 (risk amount paid by scheme + savings amount paid by scheme on behalf of member + discount received columns) - Sub total of managed care arrangements (in hospital benefits) + 3.1.10.4 (risk amount paid by scheme + savings amount paid by scheme on behalf of member + discount received columns) - Total managed care arrangements (out of hospital benefits).
4.11 / 1.4.6 b	If in part 1.4.6.b "yes" was selected, 4.11.1.4 (Total) > R0. If in part 1.4.6.b "no" was selected, 4.11.1.4 (Total) should be 0.	Part 1.4 question 6b "Yes" was selected, the value of part 4.11.1.4 should be greater than R0. If "No" was selected, no amounts should have been inputted in part 4.11.1.4.
4.11	If 4.21.3 not equal to zero, then 4.11.1.7 should be > 0.	Part 4.11: the scheme has accounted for own facilities in part 4.21, but no information was provided in line 4.11.1.7 in respect of services provided to members in own facilities.
4.11	4.11.5 - net actual claims paid and reported (Column B) + 4.13.1 - Premiums/fees paid (Capitation fees) [consolidated column current year] = 3.1.11 - Total benefits (risk amount paid by scheme column).	Part 4.11.5 - net actual claims paid and reported (Column B) plus part 4.13.1 - Premiums/fees paid (Capitation fees) [consolidated column current year] must agree with part 3.1.11 - Total benefits (risk amount paid by scheme column).

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4.12	If 4.12.29 > R0, and 4.12.1 to 4.12.28 = R0	Part 4.12: Why are the managed care: management services fees not broken down into the different types of services delivered?
4.13	Part 4.13.2 consolidated total current year *-1 = Part 4.11.1.1 (Column C) + 4.11.1.2 (Column C)+ 4.11.1.3 (Column C) + 4.11.6 (Column C) + 4.11.7(Column C)	Part 4.13.2 - Less: Claims recoveries in respect of related risk transfer arrangements consolidated total current year *-1 should agree with the sum of Part 4.11.1.1 to 4.11.1.3 (Column C) - Direct benefits in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts) plus the difference movement in the provision for outstanding claims in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts) in lines 4.11.6 and 4.11.7(Column C).
4.13	Current Year: (Consolidated Total Part 4.13.1 + Consolidated Total Part 4.13.2)/Consolidated Total Part 4.13.1 x 100 > 50% or if < -50%	Part 4.13: Please provide the basis for the calculation of the estimated claims recoveries in respect of related risk transfer arrangements.
4.13	Part 4.13: Previous year figures were restated.	Part 4.13: Please provide the reasons for any prior year restatements.
4.15	If (4.15.3 / 12 / 2.2.13 (Members)) > R74.84	Part 4.15: Please provide reasons why the broker fees per average member per month exceeds the statutory limit of R74.84.
4.15	If 4.15.3 > (4.10.1 x 3.42%)	Part 4.15: Please provide reasons why the broker fees exceeds the statutory limit of 3.42% of gross contributions.
4.16	Part 4.16.17 + Part 4.16.32 = 0	Part 4.16: Kindly provide the reasons why no fidelity or professional indemnity insurance was accounted for in the current year?

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4.16	Part 4.16: Previous year figures were restated/reclassified.	Part 4.16: Please provide the reasons for any prior year restatements/reclassifications.
4.16	Part 4.16.9 > 0, but no co-administrator exists in part 1.1.	Part 4.16.9: Kindly provide information on the nature of the co-administration services rendered to the scheme, including the name of the provider.
4.18	4.18.6 (Column E - Provision for impaired losses at year-end) = ((4.3.4.1.3 - Less: Provision for impaired losses at year end) + (4.3.4.2.3 - Less: Provision for impaired losses at year end) + (4.3.14 - Less: Provision for impaired losses at year end) (excluding Risk Transfer arrangements))*-1	4.18.6 (Column E - Provision for impaired losses at year-end) = ((4.3.4.1.3 - Less: Provision for impaired losses at year end) + (4.3.4.2.3 - Less: Provision for impaired losses at year end) + (4.3.14 - Less: Provision for impaired losses at year end) (excluding Risk Transfer arrangements))*-1
4.23	4.23.1 - Consolidated Gross contribution income = 4.10.1 - Gross contribution income.	Part 4.23.1 - Consolidated Gross contribution income must agree with part 4.10.1 - Gross contribution income.
4.23	4.23.2 - Consolidated Savings contribution income = 4.10.2 - Less: Savings contribution income.	Part 4.23.2 - Consolidated Savings contribution income must agree with part 4.10.2 - Less: Savings contribution income.
4.23	4.23.4.1 - Consolidated Direct benefits for the period = 4.11.1.1- Direct benefits for the period Column B.	Part 4.23.4.1 - Consolidated Direct benefits for the period must agree with part 4.11.1.1- Direct benefits for the period Column B.
4.23	4.23.4.2 - Consolidated Direct benefits for the previous period = 4.11.1.2- Direct benefits for the previous period Column B.	Part 4.23.4.2 - Consolidated Direct benefits for the previous period must agree with part 4.11.1.2- Direct benefits for the previous period Column B.
4.23	4.23.4.3 - Consolidated Direct benefits reported not yet paid = 4.11.1.3- Direct benefits reported not yet paid Column B.	Part 4.23.4.3 - Consolidated Direct benefits reported not yet paid must agree with part 4.11.1.3 - Direct benefits reported not yet paid Column B.

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4.23	4.23.4.4 - Consolidated Managed care: healthcare benefits for the period (no transfer of risk) = 4.11.1.4 - Total Managed care: healthcare benefits for the period (no transfer of risk).	Part 4.23.4.4 - Consolidated Managed care: healthcare benefits for the period (no transfer of risk) must agree with part 4.11.1.4 - Total Managed care: healthcare benefits for the period (no transfer of risk).
4.23	4.23.4.5 - Consolidated Managed care: healthcare benefits for the previous period (no transfer of risk) = 4.11.1.5 - Total Managed care: healthcare benefits for the previous period (no transfer of risk).	Part 4.23.4.5 - Consolidated Managed care: healthcare benefits for the previous period (no transfer of risk) must agree with part 4.11.1.5 - Total Managed care: healthcare benefits for the previous period (no transfer of risk).
4.23	4.23.4.6 - Consolidated Managed care: healthcare benefits reported not yet paid (no transfer of risk) = 4.11.1.6 - Total Managed care: healthcare benefits reported not yet paid (no transfer of risk).	Part 4.23.4.6 - Consolidated Managed care: healthcare benefits reported not yet paid (no transfer of risk) must agree with part 4.11.1.6 - Total Managed care: healthcare benefits reported not yet paid (no transfer of risk).
4.23	4.23.4.7 - Consolidated Services provided to members in own facilities = 4.11.1.7 - Total Services provided to members in own facilities.	Part 4.23.4.7 - Consolidated Services provided to members in own facilities must agree with part 4.11.1.7 - Total Services provided to members in own facilities.
4.23	4.23.5 - Consolidated Savings plan claims paid = 4.11.2 Total Savings plan claims paid.	Part 4.23.5 - Consolidated Savings plan claims paid must agree with part 4.11.2 Total Savings plan claims paid.
4.23	4.23.6 - Consolidated Discount received on claims = 4.11.3 - Total Discount received on claims.	Part 4.23.6 - Consolidated Discount received on claims must agree with part 4.11.3 - Total Discount received on claims.
4.23	4.23.7 - Consolidated Claims recoveries from third parties = 4.11.4 - Total Claims recoveries from third parties.	Part 4.23.7 - Consolidated Claims recoveries from third parties must agree with part 4.11.4 - Total Claims recoveries from third parties.

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4.23	4.23.9 - Consolidated Provision for outstanding claims at the end of the financial year = 4.11.6 - Provision for outstanding claims at the end of the financial year (Column B).	Part 4.23.9 - Consolidated Provision for outstanding claims at the end of the financial year must agree with part 4.11.6 - Provision for outstanding claims at the end of the financial year (Column B).
4.23	4.23.10 - Consolidated Provision for outstanding claims at the end of the previous year = 4.11.7 - Provision for outstanding claims at end of the previous year (Column B).	Part 4.23.10 - Consolidated Provision for outstanding claims at the end of the previous year must agree with part 4.11.7 - Provision for outstanding claims at end of the previous year (Column B).
4.23	4.23.12.1 - Consolidated Direct benefits for the period = 4.11.1.1- Direct benefits for the period Column C.	Part 4.23.12.1 - Consolidated Direct benefits for the period must agree with part 4.11.1.1- Direct benefits for the period Column C.
4.23	4.23.12.2 - Consolidated Direct benefits for the previous period = 4.11.1.2- Direct benefits for the previous period Column C.	Part 4.23.12.2 - Consolidated Direct benefits for the previous period must agree with part 4.11.1.2- Direct benefits for the previous period Column C.
4.23	4.23.12.3 - Consolidated Direct benefits reported not yet paid = 4.11.1.3- Direct benefits reported not yet paid Column C.	Part 4.23.12.3 - Consolidated Direct benefits reported not yet paid must agree with part 4.11.1.3 - Direct benefits reported not yet paid Column C.
4.23	4.23.14 - Consolidated Provision for outstanding claims at the end of the financial year = 4.11.6 - Provision for outstanding claims at the end of the financial year (Column C).	Part 4.23.14 - Consolidated Provision for outstanding claims at the end of the financial year must agree with part 4.11.6 - Provision for outstanding claims at the end of the financial year (Column C).
4.23	4.23.15 - Consolidated Provision for outstanding claims at the end of the previous year = 4.11.7 - Provision for outstanding claims at end of the previous year (Column C).	Part 4.23.15 - Consolidated Provision for outstanding claims at the end of the previous year must agree with part 4.11.7 - Provision for outstanding claims at end of the previous year (Column C).

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4.23	4.23.17 Consolidated total Net (income)/expense = 4.13.4 Consolidated total current year Net (income)/expense	4.23.17 Consolidated total Net (income)/expense must agree with 4.13.4 Consolidated total current year Net (income)/expense
4.23	4.23.17.1 Consolidated total Premiums/fees paid (Capitation fees) = 4.13.1 - Consolidated total current year Premiums/fees paid (Capitation fees)	4.23.17.1 Consolidated total Premiums/fees paid (Capitation fees) must agree with 4.13.1 - Consolidated total current year Premiums/fees paid (Capitation fees)
4.23	4.23.17.2 - Consolidated total Less: Estimated claims recoveries = 4.13.2 - Consolidated total current year Claims recoveries in respect of related risk transfer arrangements	4.23.17.2 - Consolidated total Less: Estimated claims recoveries must agree with 4.13.2 - Consolidated total current year Claims recoveries in respect of related risk transfer arrangements
4.23	4.23.17.3 Consolidated total Other = 4.13.3 Consolidated total current year Other	4.23.17.3 Consolidated total Other must agree with 4.13.3 Consolidated total current year Other
4.23	4.23.18 - Consolidated Relevant healthcare expenditure * -1= 4.11.10 - Total Relevant healthcare expenditure	4.23.18 - Consolidated Relevant healthcare expenditure *-1= 4.11.10 - Total Relevant healthcare expenditure
4.23	4.23.20 Consolidated total Net income/(expense) from commercial reinsurance = 4.14.7 Consolidated total Net income/(expense) from commercial reinsurance	4.23.20 Consolidated total Net income/(expense) from commercial reinsurance must agree with 4.14.7 Consolidated total Net income/(expense) from commercial reinsurance
4.23	4.23.21 - Consolidated Managed care: management services *-1= 4.12.30 Total - Managed care: management services.	Part 4.23.21 - Consolidated managed care: Management services *-1 must agree with part 4.12.30 Total - Managed care: management services.
4.23	4.23.22.1 - Consolidated Broker service fees *-1 = 4.15.3(a) - Broker service fees	Part 4.23.22.1 - Consolidated Broker service fees *-1 must agree with part 4.15.3(a) - Broker service fees

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4.23	4.23.22.2 - Consolidated Other distribution costs *-1 = 4.15.3(b) - Other distribution costs	Part 4.23.22.2 - Consolidated Other distribution costs *-1 must agree with part 4.15.3(b) - Other distribution costs.
4.23	4.23.23 - Consolidated Administration expenses *-1 = 4.16.41 current year fund - Administration expenses.	Part 4.23.23 - Consolidated Administration expenses *-1 must agree with part 4.16.41 current year fund - Administration expenses.
4.23	[4.23.24 (Consolidated column - Net impairment losses: Trade and other receivables) + 4.23.26 (Consolidated column - Net impairment losses: Other)]*-1 = 4.18.6 (Column H - Total movement in income statement for the year)	[4.23.24 (Consolidated column - Net impairment losses: Trade and other receivables) + 4.23.26 (Consolidated column - Net impairment losses: Other)]*-1 must agree with 4.18.6 (Column H - Total movement in income statement for the year)
4.23	4.23.27 - Consolidated Other investment income = 4.19.3 Total other investment income	Part 4.23.27 - Consolidated Other investment income must agree with part 4.19.3 Total other investment income
4.23	4.23.30 - Consolidated Other realised and unrealised gains/(losses) = 4.20.7 Total realised and unrealised gains/(losses)	Part 4.23.30 - Consolidated Other realised and unrealised gains/(losses) must agree with part 4.20.7 Total realised and unrealised gains/(losses)
4.23	4.23.32 - Consolidated Own facility surplus/(deficit) = 4.21.3 Total own facility surplus/(deficit)	Part 4.23.32 - Consolidated Own facility surplus/(deficit) must agree with part 4.21.3 Total own facility surplus/(deficit)
4.23	4.23.34 - Consolidated Less: Finance costs *-1 = 4.22.4 Total finance costs	Part 4.23.34 - Consolidated Less: Finance costs *-1 must agree with part 4.22.4 Total finance costs
4.23	If part 4.23.2 current year total = R0, and 4.5.16 > R0	No savings contributions were received during the year (4.23.2), but a savings plan liability is still disclosed in part 4.5.16. Please complete the reason box.
4.25	If 4.25.2 Guarantees > R0, or if 4.25.2 Suretyships > R0, or if 4.25.2 Encumbered > R0, or if 4.25.2 Other > R0	There are values in part 4.25, please complete the reason box

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4.25	If selected "Yes" in part 1.4 question 14 (d), 4.25.2 Suretyships > R0	Part 4.25 It was indicated in part 1.4 question 14(d)that suretyships exist.
4.25	If selected "Yes" in part 1.4 question 14 (a), 4.25.2 Encumbered > R0	Part 4.25 It was indicated in part 1.4 question 14(a) that assets are encumbered.
4.25	If selected "Yes" in part 1.4 question 17 (b), 4.25.2 Guarantees > R0	Part 4.25 It was indicated in part 1.4 question 17(b) that guarantees have been issued.
4.26	4.26 - Related party transactions : If "N" was included in the column "Was the transaction/balances at year-end at arms length?", scheme should complete reason box.	Part 4.26: If the transactions/balances at year-end were not at arms length, the reason box must be completed.
5	5.1.3 - Total assets (current year column) = 5.2.4- Total funds and liabilities (current year column)	Part 5.1.3 - Total assets (current year column) must agree with part 5.2.4 - Total funds and liabilities (current year column).
5	5.1.3 -Total assets (previous year column) = 5.2.4 - Total funds and liabilities (previous year column)	Part 5.1.3 - Total assets (previous year column) must agree with part 5.2.4 - Total funds and liabilities (previous year column).
5	Part 5: Previous year figures (lines 5.1.1.2 - 5.1.1.3, 5.1.2.1 - 5.1.2.5, 5.2.1.6, 5.2.2.1 - 5.2.2.2, or 5.2.3.2) were restated/reclassified.	Part 5: Please provide the reasons for any prior year restatements/reclassifications in lines 5.1.1.2 - 5.1.1.3, 5.1.2.1 - 5.1.2.5, 5.2.1.6, 5.2.2.1 - 5.2.2.2, and 5.2.3.2 .

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6.1	<p>6.1.24 - Other comprehensive income current year = 7.1.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year + 7.1.3.2 Transfer to/(from) accumulated funds current year - Due to re-measurement property, plant and equipment + 7.1.3.3 Transfer to/(from) accumulated funds current year - Other transfers + 7.1.4 Other (specify) current year + 7.2.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year + 7.2.2 Unrealised gains/(losses) on revaluation of investments current year + 7.2.3 Realised (gains)/losses on derecognition of investments current year + 7.2.4 Revaluation adjustment current year + 7.2.5.2 Transfer (to)/from reserves: Other (specify) current year + 7.3.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year + 7.3.2 Unrealised gains/(losses) on revaluation of property, plant and equipment current year + 7.3.3 Revaluation adjustment current year + 7.3.4.2 Transfer (to)/from reserves: Other (specify) current year + 7.4.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year + 7.4.2.2 Transfer (to)/from reserves: Other (specify) current year + 7.5.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year + 7.5.2.2 Transfer (to)/from reserves: Other (specify) current year</p>	<p>6.1.24 - Other comprehensive income current year must agree with the total of parts 7.1.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year, 7.1.3.2 Transfer to/(from) accumulated funds current year - Due to re-measurement property, plant and equipment, 7.1.3.3 Transfer to/(from) accumulated funds current year - Other transfers, 7.1.4 Other (specify) current year, 7.2.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year, 7.2.2 Unrealised gains/(losses) on revaluation of investments current year, 7.2.3 Realised (gains)/losses on derecognition of investments current year, 7.2.4 Revaluation adjustment current year, 7.2.5.2 Transfer (to)/from reserves: Other (specify) current year, 7.3.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year, 7.3.2 Unrealised gains/(losses) on revaluation of property, plant and equipment current year, 7.3.3 Revaluation adjustment current year, 7.3.4.2 Transfer (to)/from reserves: Other (specify) current year, 7.4.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year, 7.4.2.2 Transfer (to)/from reserves: Other (specify) current year, 7.5.1.2 - Prior year adjustment (including the first time adoption of IFRS) current year, 7.5.2.2 Transfer (to)/from reserves: Other (specify) current year</p>
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6.1	<p>6.1.24 - Other comprehensive income previous year = 7.1.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year + 7.1.3.2 Transfer to/(from) accumulated funds previous year - Due to re-measurement property, plant and equipment + 7.1.3.3 Transfer to/(from) accumulated funds previous year - Other transfers + 7.1.4 Other (specify) previous year + 7.2.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year + 7.2.2 Unrealised gains/(losses) on revaluation of investments previous year + 7.2.3 Realised (gains)/losses on derecognition of investments previous year + 7.2.4 Revaluation adjustment previous year + 7.2.5.2 Transfer (to)/from reserves previous year: Other (specify)previous year + 7.3.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year + 7.3.2 Unrealised gains/(losses) on revaluation of property, plant and equipment previous year + 7.3.3 Revaluation adjustment previous year + 7.3.4.2 Transfer (to)/from reserves previous year: Other (specify) previous year + 7.4.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year + 7.4.2.2 Transfer (to)/from reserves previous year: Other (specify) previous year + 7.5.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year +</p>	<p>6.1.24 - Other comprehensive income previous year must agree with the total of parts 7.1.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year, 7.1.3.2 Transfer to/(from) accumulated funds previous year - Due to re-measurement property, plant and equipment, 7.1.3.3 Transfer to/(from) accumulated funds previous year - Other transfers, 7.1.4 Other (specify) previous year, 7.2.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year, 7.2.2 Unrealised gains/(losses) on revaluation of investments previous year, 7.2.3 Realised (gains)/losses on derecognition of investments previous year, 7.2.4 Revaluation adjustment previous year, 7.2.5.2 Transfer (to)/from reserves: Other (specify)previous year, 7.3.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year, 7.3.2 Unrealised gains/(losses) on revaluation of property, plant and equipment previous year, 7.3.3 Revaluation adjustment previous year, 7.3.4.2 Transfer (to)/from reserves: Other (specify) previous year, 7.4.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year, 7.4.2.2 Transfer (to)/from reserves: Other (specify) previous year, 7.5.1.2 - Prior year adjustment (including the first time adoption of IFRS) previous year, 7.5.2.2 Transfer (to)/from reserves: Other (specify) previous year</p>
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	7.5.2.2 Transfer (to)/from reserves: Other (specify) previous year	
6.1	Part 6.1: Previous year figures were restated/reclassified.	Part 6.1: Please provide the reasons for any prior year restatements/reclassifications.
6.2	6.2.1 YTD Gross contribution income = 6.1.1 Gross contribution income (current year column)	Part 6.2.1 YTD Gross contribution income must agree with part 6.1.1 Gross contribution income (current year column)
6.2	6.2.2 YTD Less: Savings contribution income = 6.1.2 Less: Savings contribution income (current year column)	Part 6.2.2 YTD Less: Savings contribution income must agree with part 6.1.2 Less: Savings contribution income (current year column)
6.2	6.2.4.1 YTD Net claims incurred = 6.1.4.1 Net claims incurred (current year column)	Part 6.2.4.1 YTD Net claims incurred must agree with part 6.1.4.1 Net claims incurred (current year column)
6.2	6.2.4.2 YTD Net income/(expense) on risk transfer arrangements = 6.1.4.2 Net income/(expense) on risk transfer arrangements (current year column)	Part 6.2.4.2 YTD Net income/(expense) on risk transfer arrangements must agree with part 6.1.4.2 Net income/(expense) on risk transfer arrangements (current year column)
6.2	6.2.6 YTD Net income/(expense) on commercial reinsurance contracts = 6.1.6 Net income/(expense) on commercial reinsurance contracts (current year column)	Part 6.2.6 YTD Net income/(expense) on commercial reinsurance contracts must agree with part 6.1.6 Net income/(expense) on commercial reinsurance contracts (current year column)
6.2	6.2.7 YTD Less: Managed care: management services = 6.1.7 Less: Managed care: management services (current year column)	Part 6.2.7 YTD Less: Managed care: management services must agree with part 6.1.7 Less: Managed care: management services (current year column)
6.2	6.2.7.1 YTD Managed care: management services: paid to administrator and its related parties = 4.12.30 Total managed care: management services (Administrator/Self-administration column) * -1	Part 6.2.7.1 YTD Managed care: management services: paid to administrator and its related parties must agree with {part 4.12.30 Total managed care: management services (Administrator/Self-administration column) * -1}

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6.2	6.2.8.1 YTD Less: Broker service fees = 6.1.8.1 Less: Broker service fees (current year column)	Part 6.2.8.1 YTD Less: Broker service fees must agree with part 6.1.8.1 Less: Broker service fees (current year column)
6.2	6.2.8.2 YTD Less: Other distribution costs = 6.1.8.2 Less: Other distribution costs (current year column)	Part 6.2.8.2 YTD Less: Other distribution costs must agree with part 6.1.8.2 Less: Other distribution costs (current year column)
6.2	6.2.9 YTD Less: Administration expenses = 6.1.9 Less: Administration expenses (current year column)	Part 6.2.9 YTD Less: Administration expenses must agree with part 6.1.9 Less: Administration expenses (current year column)
6.2	6.2.10 YTD Net impairment losses: Trade and other receivables = 6.1.10 Net impairment losses: Trade and other receivables (current year column)	Part 6.2.10 YTD Net impairment losses: Trade and other receivables must agree with part 6.1.10 Net impairment losses: Trade and other receivables (current year column)
6.2	6.2.12 YTD Surplus/(Deficit) for the year after consolidation = 6.1.23 Surplus/(Deficit) for the year after consolidation (current year column)	Part 6.2.12 YTD Surplus/(Deficit) for the year after consolidation must agree with part 6.1.23 Surplus/(Deficit) for the year after consolidation (current year column)
7.1	Part 7.1: Previous year figures were restated/reclassified in line 7.1.1.2 (both current year and previous year columns).	Part 7.1: Please provide the reasons for any prior year restatements/reclassifications.
7.2	Part 7.2: Previous year figures were restated/reclassified in line 7.2.1.2 (both current year and previous year columns).	Part 7.2: Please provide the reasons for any prior year restatements/reclassifications.
7.3	Part 7.3: Previous year figures were restated/reclassified in line 7.3.1.2 (both current year and previous year columns).	Part 7.3: Please provide the reasons for any prior year restatements/reclassifications.
7.4	Part 7.4: Previous year figures were restated/reclassified in line 7.4.1.2 (both current year and previous year consolidated columns).	Part 7.4: Please provide the reasons for any prior year restatements/reclassifications.

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7.5	Part 7.5: Previous year figures were restated/reclassified in line 7.5.1.2 (both current year and previous year consolidated columns).	Part 7.5: Please provide the reasons for any prior year restatements/reclassifications.
8	8.8 - Cash and cash equivalents at the end of the year (current year column) = 4.4.7 - Total cash and cash equivalents per balance sheet - 4.8.5 - Bank overdraft.	Part 8.8 - Cash and cash equivalents at the end of the year (current year column) must agree with part 4.4.7 - Total cash and cash equivalents per balance sheet <u>less</u> part 4.8.5 - Bank overdraft.
8	8.8 - Cash and cash equivalents at the end of the year (previous year column) <= 5.1.2.4 - Cash and cash equivalents (previous year column).	Part 8.8 - Cash and cash equivalents at the end of the year (previous year column) must be equal to or smaller than part 5.1.2.4 - Cash and cash equivalents (previous year column).
8	Part 8: Previous year figures were restated/reclassified in line 8.5.2 (both current year and previous year columns).	Part 8: Please provide the reasons for any prior year restatements/reclassifications.
9(a)	9(a) Total fair value - Subtotal: Category 3(a) + subtotal: Category 3(b) >= 4.2.1 - Total Investment property + 4.1.3 - Net carrying amount at end of year (Land & Buildings column).	Part 9(a) Total fair value - Subtotal: Category 3(a) plus subtotal: Category 3(b) must be equal to or greater than part 4.2.1 - Total Investment property + part 4.1.3 - Net carrying amount at end of year (Land & Buildings column).
9(a)	9(a) Total fair value - Subtotal: Category 7(a)(i) = 5.1.2.1 - Inventories (current year column)	Part 9(a) Total fair value - Subtotal: Category 7(a)(i) must agree with part 5.1.2.1 - Inventories (current year column).
9(a)	9(a) Total fair value - Subtotal: category 7(a)(iii) >= 4.1.3 - Net carrying amount at end of year (Computer equipment column + Furniture & fittings column + Motor Vehicles column + Other column).	Part 9(a) Total fair value - Subtotal: category 7(a)(iii) must be equal to or greater than part 4.1.3 - Net carrying amount at end of year (Computer equipment column + Furniture & fittings column + Motor Vehicles column + Other column).

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9(a)	Part 9(a) Total Fair Value Category 4(a)(v) + Total Fair Value Category 6(a) and 6(b) = 9.9 Total net assets per Regulation 30: Policies of Insurance	Part 9(a) Total Fair Value Category 4(a)(v) and the Total Fair Value Category 6(a) and 6(b) should agree to the 9.9 Total net assets per Regulation 30: Policies of Insurance
9(a)	Part 9(a) Total Fair Value Category 4(a)(iv) = 9.9 Total net assets per Regulation 30: Equity Unit Trusts or Pooled Equity Managed Funds	Part 9(a) Total Fair Value Category 4(a)(iv) should agree to the 9.9 Total net assets per Regulation 30: Equity Unit Trusts or Pooled Equity Managed Funds
9(a)	9(a).14 Total fair value - Total assets = 5.1.3 - Total assets (current year column) + 4.4.8 - Outstanding cheques.	Part 9.14(a) Total fair value - Total assets must agree with part 5.1.3 - Total assets (current year column) plus 4.4.8 - Outstanding cheques.
9(b)	Total net assets per Regulation 30 in Part 9(a)- Part 9.9 = Total net assets per Regulation 30 in Part 9(b) - Part 9.2.2 Total column.	Total net assets per Regulation 30 in Part 9(a) - Part 9.9 must agree with Total net assets per Regulation 30 in Part 9(b) - Part 9.2.2 Total column.
10.1	10.1.2 does not equal 0.	Part 10.1: Please indicate the reasons for the prior year adjustment.
10.2	If the solvency ratio in part 10.2.11 < 25%, then the reason box should be completed.	The scheme had a solvency ratio less than 25% at 31 December; and the reason box in part 10.2 is not completed.
10.2	When was/will the business plan be submitted to the Council for Medical Schemes (in terms of section 35 (11) and Regulation 30(4))? (Solvency < 25% for more than 90 days)	Part 10.2: If the solvency was less than 25% for a period longer than 90 days, please indicate the date of submission of the business plan.



Pull throughs for the 2011 Annual Statutory Return

Field where link must be (to)	Field from where pull thru must occur (from)
Part 1.4.6(c) Details of risk transfer arrangements: Previous year column	Part 1.4.6(c) Details of risk transfer arrangements: Current year column (2010 Return)
Part 1.4.6(e) Administration contract	Part 1.1 Administrator and Co-administrator names
Part 2.1: Benefit Option names	Part 1.2 - Option names
Part 2.2.12 - December's Members	Part 2.1.2 - Consolidated total of Members
Part 2.2.12 - December's Adult Dependents	Part 2.1.2 - Consolidated total of Adult Dependents
Part 2.2.12 - December's Child Dependents	Part 2.1.2 - Consolidated total of Child Dependents
Part 2.3: Benefit Option names	Part 1.2 - Option names
Part 2.6.1.1 (Previous year column) Number of beneficiaries visiting GPs at least once a year	Part 2.6.1.1 (2010 Return: Current year column) Number of beneficiaries visiting GPs at least once a year
Part 2.6.1.2 (Previous year column) Total number of visits to GPs	Part 2.6.1.2 (2010 Return: Current year column) Total number of visits to GPs
Part 2.6.1.3 (Previous year column) Number of beneficiaries visiting dentists at least once a year	Part 2.6.1.3 (2010 Return: Current year column) Number of beneficiaries visiting dentists at least once a year
Part 2.6.1.4 (Previous year column) Total number of visits to dentists	Part 2.6.1.4 (2010 Return: Current year column) Total number of visits to dentists
Part 2.6.1.5 (Previous year column) Number of beneficiaries visiting private nurses at least once a year	Part 2.6.1.5 (2010 Return: Current year column) Number of beneficiaries visiting private nurses at least once a year
Part 2.6.1.6 (Previous year column) Total number of visits to private nurses	Part 2.6.1.6 (2010 Return: Current year column) Total number of visits to private nurses
Part 2.6.1.7 (Previous year column) Number of beneficiaries enrolled in primary care networks	Part 2.6.1.7 (2010 Return: Current year column) Number of beneficiaries enrolled in primary care networks
Part 2.6.2.1 (Previous year column) Number of beneficiaries admitted	Part 2.6.2.1 (2010 Return: Current year column) Number of beneficiaries admitted

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Part 2.6.2.2 (Previous year column) Number of hospital admissions	Part 2.6.2.2 (2010 Return: Current year column) Number of hospital admissions
Part 2.6.2.3 (Previous year column) Number of same-day admissions	Part 2.6.2.3 (2010 Return: Current year column) Number of same-day admissions
Part 2.6.2.5 (Previous year column) Number of beneficiaries admitted for Prescribed Minimum Benefits	Part 2.6.2.5 (2010 Return: Current year column) Number of beneficiaries admitted for Prescribed Minimum Benefits
Part 2.6.2.6 (Previous year column) Number of beneficiaries admitted at Day clinics/ unattached operating theatres (discipline 76 and 77)	Part 2.6.2.6 (2010 Return: Current year column) Number of beneficiaries admitted at Day clinics/ unattached operating theatres (discipline 76 and 77)
Part 2.6.2.7 (Previous year column) Number of beneficiaries receiving MRI scans	Part 2.6.2.7 (2010 Return: Current year column) Number of beneficiaries receiving MRI scans
Part 2.6.2.8 (Previous year column) Number of MRI scans administered	Part 2.6.2.8 (2010 Return: Current year column) Number of MRI scans administered
Part 2.6.2.9 (Previous year column) Number of beneficiaries receiving CT scans	Part 2.6.2.9 (2010 Return: Current year column) Number of beneficiaries receiving CT scans
Part 2.6.2.10 (Previous year column) Number of CT scans administered	Part 2.6.2.10 (2010 Return: Current year column) Number of CT scans administered
Part 2.6.2.11 (Previous year column) Number of pregnancies	Part 2.6.2.11 (2010 Return: Current year column) Number of pregnancies
Part 2.6.2.12 (Previous year column) Number of births	Part 2.6.2.12 (2010 Return: Current year column) Number of births
Part 2.6.2.13 (Previous year column) Number of live births	Part 2.6.2.13 (2010 Return: Current year column) Number of live births
Part 2.6.2.14 (Previous year column) Number of caesarean sections performed	Part 2.6.2.14 (2010 Return: Current year column) Number of caesarean sections performed
Part 2.6.2.15 (Previous year column) Number of births to women between 12 and 18 years	Part 2.6.2.15 (2010 Return: Current year column) Number of births to women between 12 and 18 years
Part 2.6.2.16 (Previous year column) Number of mammograms paid for	Part 2.6.2.16 (2010 Return: Current year column) Number of mammograms paid for

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Part 2.6.2.17 (Previous year column) Number of pap smears paid for	Part 2.6.2.17 (2010 Return: Current year column) Number of pap smears paid for
Part 2.6.2.18 (Previous year column) Number of deaths	Part 2.6.2.18 (2010 Return: Current year column) Number of deaths
Part 2.6.2.19 (Previous year column) Number of beneficiaries receiving PET scans	Part 2.6.2.19 (2010 Return: Current year column) Number of beneficiaries receiving PET scans
Part 2.6.2.20 (Previous year column) Number of PET scans administered	Part 2.6.2.20 (2010 Return: Current year column) Number of PET scans administered
Part 2.6.2.21 (Previous year column) Number of beneficiaries receiving angiograms	Part 2.6.2.21 (2010 Return: Current year column) Number of beneficiaries receiving angiograms
Part 2.6.2.22 (Previous year column) Number of angiograms administered	Part 2.6.2.22 (2010 Return: Current year column) Number of angiograms administered
Part 2.6.2.23 (Previous year column) Number of beneficiaries receiving bone density scans	Part 2.6.2.23 (2010 Return: Current year column) Number of beneficiaries receiving bone density scans
Part 2.6.2.24 (Previous year column) Number of bone density scans administered	Part 2.6.2.24 (2010 Return: Current year column) Number of bone density scans administered
Part 2.6.2.25 (Previous year column) Number of total days in hospital for beneficiaries	Part 2.6.2.25 (2010 Return: Current year column) Number of total days in hospital for beneficiaries
Part 2.6.2.26 (Previous year column) Number of admissions to ICU	Part 2.6.2.26 (2010 Return: Current year column) Number of admissions to ICU
Part 2.6.2.27 (Previous year column) Number of admissions to High Care	Part 2.6.2.27 (2010 Return: Current year column) Number of admissions to High Care
Part 2.6.2.28 (Previous year column) Number of admissions to General Ward	Part 2.6.2.28 (2010 Return: Current year column) Number of admissions to General Ward
Part 2.6.2.29 (Previous year column) Number of admissions to Emergency Unit	Part 2.6.2.29 (2010 Return: Current year column) Number of admissions to Emergency Unit
Part 2.6.2.30 (Previous year column) Number of admissions for Renal Dialysis	Part 2.6.2.30 (2010 Return: Current year column) Number of admissions for Renal Dialysis

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Part 2.6.2.31 (Previous year column) Number of beneficiaries enrolled in hospital networks	Part 2.6.2.31 (2010 Return: Current year column) Number of beneficiaries enrolled in hospital networks
Part 2.6.3.1 (Previous year column) Number of beneficiaries admitted	Part 2.6.3.1 (2010 Return: Current year column) Number of beneficiaries admitted
Part 2.6.3.2 (Previous year column) Number of hospital admissions	Part 2.6.3.2 (2010 Return: Current year column) Number of hospital admissions
Part 2.6.3.3 (Previous year column) Number of ame-day admissions	Part 2.6.3.3 (2010 Return: Current year column) Number of same-day admissions
Part 2.6.3.5 (Previous year column) Number of beneficiaries admitted for Prescribed Minimum Benefits	Part 2.6.3.5 (2010 Return: Current year column) Number of beneficiaries admitted for Prescribed Minimum Benefits
Part 2.6.3.6 (Previous year column) Number of beneficiaries receiving MRI scans	Part 2.6.3.6 (2010 Return: Current year column) Number of beneficiaries receiving MRI scans
Part 2.6.3.7 (Previous year column) Number of MRI scans administered	Part 2.6.3.7 (2010 Return: Current year column) Number of MRI scans administered
Part 2.6.3.8 (Previous year column) Number of beneficiaries receiving CT scans	Part 2.6.3.8 (2010 Return: Current year column) Number of beneficiaries receiving CT scans
Part 2.6.3.9 (Previous year column) Number of CT scans administered	Part 2.6.3.9 (2010 Return: Current year column) Number of CT scans administered
Part 2.6.3.10 (Previous year column) Number of pregnancies	Part 2.6.3.10 (2010 Return: Current year column) Number of pregnancies
Part 2.6.3.11 (Previous year column) Number of births	Part 2.6.3.11 (2010 Return: Current year column) Number of births
Part 2.6.3.12 (Previous year column) Number of live births	Part 2.6.3.12 (2010 Return: Current year column) Number of live births
Part 2.6.3.13 (Previous year column) Number of caesarean sections performed	Part 2.6.3.13 (2010 Return: Current year column) Number of caesarean sections performed
Part 2.6.3.14 (Previous year column) Number of births to women between 12 and 18 years	Part 2.6.3.14 (2010 Return: Current year column) Number of births to women between 12 and 18 years

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Part 2.6.3.15 (Previous year column) Number of mammograms paid for	Part 2.6.3.15 (2010 Return: Current year column) Number of mammograms paid for
Part 2.6.3.16 (Previous year column) Number of pap smears paid for	Part 2.6.3.16 (2010 Return: Current year column) Number of pap smears paid for
Part 2.6.3.17 (Previous year column) Number of deaths	Part 2.6.3.17 (2010 Return: Current year column) Number of deaths
Part 2.6.3.18 (Previous year column) Number of beneficiaries receiving PET scans	Part 2.6.3.18 (2010 Return: Current year column) Number of beneficiaries receiving PET scans
Part 2.6.3.19 (Previous year column) Number of PET scans administered	Part 2.6.3.19 (2010 Return: Current year column) Number of PET scans administered
Part 2.6.3.20 (Previous year column) Number of beneficiaries receiving angiograms	Part 2.6.3.20 (2010 Return: Current year column) Number of beneficiaries receiving angiograms
Part 2.6.3.21 (Previous year column) Number of angiograms administered	Part 2.6.3.21 (2010 Return: Current year column) Number of angiograms administered
Part 2.6.3.22 (Previous year column) Number of beneficiaries receiving bone density scans	Part 2.6.3.22 (2010 Return: Current year column) Number of beneficiaries receiving bone density scans
Part 2.6.3.23 (Previous year column) Number of bone density scans administered	Part 2.6.3.23 (2010 Return: Current year column) Number of bone density scans administered
Part 2.6.3.24 (Previous year column) Number of total days in hospital for beneficiaries	Part 2.6.3.24 (2010 Return: Current year column) Number of total days in hospital for beneficiaries
Part 2.6.3.25 (Previous year column) Number of admissions to ICU	Part 2.6.3.25 (2010 Return: Current year column) Number of admissions to ICU
Part 2.6.3.26 (Previous year column) Number of admissions to High Care	Part 2.6.3.26 (2010 Return: Current year column) Number of admissions to High Care
Part 2.6.3.27 (Previous year column) Number of admissions to General Ward	Part 2.6.3.27 (2010 Return: Current year column) Number of admissions to General Ward
Part 2.6.3.28 (Previous year column) Number of admissions to Emergency Unit	Part 2.6.3.28 (2010 Return: Current year column) Number of admissions to Emergency Unit

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Medical Scheme:
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Part 2.6.3.29 (Previous year column) Number of admissions for Renal Dialysis	Part 2.6.3.29 (2010 Return: Current year column) Number of admissions for Renal Dialysis
Part 2.7: Benefit Option names	Part 1.2 - Option names
Part 2.7.1 (Per benefit option) (Previous year column) Addison's Disease	Part 2.7.1 (Per benefit option) (2010 Return: Current year column) Addison's Disease
Part 2.7.2 (Per benefit option) (Previous year column) Asthma	Part 2.7.2 (Per benefit option) (2010 Return: Current year column) Asthma
Part 2.7.3 (Per benefit option) (Previous year column) Bipolar Mood Disorder	Part 2.7.3 (Per benefit option) (2010 Return: Current year column) Bipolar Mood Disorder
Part 2.7.4 (Per benefit option) (Previous year column) Bronchiectasis	Part 2.7.4 (Per benefit option) (2010 Return: Current year column) Bronchiectasis
Part 2.7.5 (Per benefit option) (Previous year column) Cardiac Failure	Part 2.7.5 (Per benefit option) (2010 Return: Current year column) Cardiac Failure
Part 2.7.6 (Per benefit option) (Previous year column) Cardiomyopathy Disease	Part 2.7.6 (Per benefit option) (2010 Return: Current year column) Cardiomyopathy Disease
Part 2.7.7 (Per benefit option) (Previous year column) Chronic Obstructive Pulmonary Disease	Part 2.7.7 (Per benefit option) (2010 Return: Current year column) Chronic Obstructive Pulmonary Disease
Part 2.7.8 (Per benefit option) (Previous year column) Chronic Renal Disease	Part 2.7.8 (Per benefit option) (2010 Return: Current year column) Chronic Renal Disease
Part 2.7.9 (Per benefit option) (Previous year column) Coronary Artery Disease	Part 2.7.9 (Per benefit option) (2010 Return: Current year column) Coronary Artery Disease
Part 2.7.10 (Per benefit option) (Previous year column) Crohn's Disease	Part 2.7.10 (Per benefit option) (2010 Return: Current year column) Crohn's Disease
Part 2.7.11 (Per benefit option) (Previous year column) Diabetes Insipidus	Part 2.7.11 (Per benefit option) (2010 Return: Current year column) Diabetes Insipidus
Part 2.7.12 (Per benefit option) (Previous year column) Diabetes Mellitus Type 1	Part 2.7.12 (Per benefit option) (2010 Return: Current year column) Diabetes Mellitus Type 1
Part 2.7.13 (Per benefit option) (Previous year column) Diabetes Mellitus Type 2	Part 2.7.13 (Per benefit option) (2010 Return: Current year column) Diabetes Mellitus Type 2

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Part 2.7.14 (Per benefit option) (Previous year column) Dysrhythmias	Part 2.7.14 (Per benefit option) (2010 Return: Current year column) Dysrhythmias
Part 2.7.15 (Per benefit option) (Previous year column) Epilepsy	Part 2.7.15 (Per benefit option) (2010 Return: Current year column) Epilepsy
Part 2.7.16 (Per benefit option) (Previous year column) Glaucoma	Part 2.7.16 (Per benefit option) (2010 Return: Current year column) Glaucoma
Part 2.7.17 (Per benefit option) (Previous year column) Haemophilia	Part 2.7.17 (Per benefit option) (2010 Return: Current year column) Haemophilia
Part 2.7.18 (Per benefit option) (Previous year column) HIV	Part 2.7.18 (Per benefit option) (2010 Return: Current year column) HIV
Part 2.7.19 (Per benefit option) (Previous year column) Hyperlipidaemia	Part 2.7.19 (Per benefit option) (2010 Return: Current year column) Hyperlipidaemia
Part 2.7.20 (Per benefit option) (Previous year column) Hypertension	Part 2.7.20 (Per benefit option) (2010 Return: Current year column) Hypertension
Part 2.7.21 (Per benefit option) (Previous year column) Hypothyroidism	Part 2.7.21 (Per benefit option) (2010 Return: Current year column) Hypothyroidism
Part 2.7.22 (Per benefit option) (Previous year column) Multiple Sclerosis	Part 2.7.22 (Per benefit option) (2010 Return: Current year column) Multiple Sclerosis
Part 2.7.23 (Per benefit option) (Previous year column) Parkinson's Disease	Part 2.7.23 (Per benefit option) (2010 Return: Current year column) Parkinson's Disease
Part 2.7.24 (Per benefit option) (Previous year column) Rheumatoid Arthritis	Part 2.7.24 (Per benefit option) (2010 Return: Current year column) Rheumatoid Arthritis
Part 2.7.25 (Per benefit option) (Previous year column) Schizophrenia	Part 2.7.25 (Per benefit option) (2010 Return: Current year column) Schizophrenia
Part 2.7.26 (Per benefit option) (Previous year column) Systemic Lupus Erythematosus	Part 2.7.26 (Per benefit option) (2010 Return: Current year column) Systemic Lupus Erythematosus
Part 2.7.27 (Per benefit option) (Previous year column) Ulcerative Colitis	Part 2.7.27 (Per benefit option) (2010 Return: Current year column) Ulcerative Colitis

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Part 3.1.2 - Medical Specialists (Amount charged by supplier column)	Part 3.2.29 - Total of Analysis of Medical Specialists (Amount charged by supplier column)
Part 3.1.2 - Medical Specialists (Risk amount paid by scheme column)	Part 3.2.29 - Total of Analysis of Medical Specialists (Risk amount paid by scheme column)
Part 3.1.2 - Medical Specialists (Savings amount paid by scheme on behalf of member column)	Part 3.2.29 - Total of Analysis of Medical Specialists (Savings amount paid by scheme on behalf of member column)
Part 3.1.2 - Medical Specialists (Amount paid by member column)	Part 3.2.29 - Total of Analysis of Medical Specialists (Amount paid by member column)
Part 3.1.4 - Dental Specialists (Amount charged by supplier column)	Part 3.2.37 - Total of Analysis of Dental Specialists (Amount charged by supplier column)
Part 3.1.4 - Dental Specialists (Risk amount paid by scheme column)	Part 3.2.37 - Total of Analysis of Dental Specialists (Risk amount paid by scheme column)
Part 3.1.4 - Dental Specialists (Savings amount paid by scheme on behalf of member column)	Part 3.2.37 - Total of Analysis of Dental Specialists (Savings amount paid by scheme on behalf of member column)
Part 3.1.4 - Dental Specialists (Amount paid by member column)	Part 3.2.37 - Total of Analysis of Dental Specialists (Amount paid by member column)
Part 3.1.5 - Supplementary and Allied Health Professionals (Amount charged by supplier column)	Part 3.3.26 - Total of analysis of Allied and Support Health Professionals (Amount charged by supplier column)
Part 3.1.5 - Supplementary and Allied Health Professionals (Risk amount paid by scheme column)	Part 3.3.26 - Total of Analysis of Allied and Support Health Professionals (Risk amount paid by scheme column)
Part 3.1.5 - Supplementary and Allied Health Professionals (Savings amount paid by scheme on behalf of member column)	Part 3.3.26 - Total of Analysis of Allied and Support Health Professionals (Savings amount paid by scheme on behalf of member column)
Part 3.1.5 - Supplementary and Allied Health Professionals (Amount paid by member column)	Part 3.3.26 - Total of Analysis of Allied and Support Health Professionals (Amount paid by member column)
Part 3.1.9 - Other benefit services (Amount charged by supplier column)	Part 3.4.17 - Total of Analysis of Other benefits (Amount charged by supplier column)
Part 3.1.9 - Other benefit services (Risk amount paid by scheme column)	Part 3.4.17 - Total of Analysis of Other benefits (Risk amount paid by scheme column)

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Part 3.1.9 - Other benefit services (Savings amount paid by scheme on behalf of member column)	Part 3.4.17 - Total of Analysis of Other benefits (Savings amount paid by scheme on behalf of member column)
Part 3.1.9 - Other benefit services (Amount paid by member column)	Part 3.4.17 - Total of Analysis of Other benefits (Amount paid by member column)
4.1.1.1.1 - Gross Carrying Amount: As previously reported (Land & Buildings)	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Land & Buildings)
4.1.1.1.1 - Gross Carrying Amount: As previously reported (Computer equipment and Software)	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Computer equipment and Software)
4.1.1.1.1 - Gross Carrying Amount: As previously reported (Furniture & Fittings)	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Furniture & Fittings)
4.1.1.1.1 - Gross Carrying Amount: As previously reported (Motor Vehicles)	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Motor Vehicles)
4.1.1.1.1 - Gross Carrying Amount: As previously reported (Other)	4.1.1.9 (2010 annual return) - Gross Carrying Amount: At end of year (Other)
4.1.2.1.1 - Accumulated Depreciation: As previously reported (Land & Buildings)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Land & Buildings)
4.1.2.1.1 - Accumulated Depreciation: As previously reported (Computer equipment and Software)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Computer Equipment and Software)
4.1.2.1.1 - Accumulated Depreciation: As previously reported (Furniture & Fittings)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Furniture & Fittings)
4.1.2.1.1 - Accumulated Depreciation: As previously reported (Motor Vehicles)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Motor Vehicles)
4.1.2.1.1 - Accumulated Depreciation: As previously reported (Other)	4.1.2.8 (2010 annual return) - Accumulated Depreciation: At end of year (Other)
4.5.1 - Balance on savings plan liability at the beginning of the year (credit balance)	4.5.16 (2010 annual return) - Savings plan liability credit balance at the end of the year
4.5.3-- Less: Advances on savings plan accounts	4.5.15 * -1 (2010 annual return) - Advances on savings plan accounts included in accounts receivable

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4.5.5.1— Savings plan contributions received or receivable for the current year	4.10.2 *-1 - Less: Savings plan account contribution income
4.5.8 - Interest paid on savings plan accounts	4.22.2 Interest paid on savings plan accounts
4.5.10 - Less: Claims paid on behalf of members	4.11.2 - Less: Savings plan claims paid (Total column)
4.5.11 - Less: Administration expenses	4.16.40 current year (fund column only) - Less: Administration expenses recoverable from savings plan accounts
4.8.7 - Current portion of non-current borrowings and other non-current liabilities	4.6.4 - Current column of interest bearing borrowings + 4.6.4 - Current column of non-interest bearing borrowings + (4.7.2 *-1) - Less: Current portion included in current liabilities
4.9.1.1 - Total column - Outstanding claims provision (as previously reported)	4.9.8 (2010 annual return) - Total outstanding claims provision at end of year
4.9.1.1 - Column B - Outstanding claims provision (as previously reported)	4.9.8 (2010 annual return) - Column B: Total outstanding claims provision at end of year
4.9.1.1 - Column C - Outstanding claims provision (as previously reported)	4.9.8 (2010 annual return) - Column C: Total outstanding claims provision at end of year
4.9.1.1 - Column D - Outstanding claims provision (as previously reported)	4.9.8 (2010 annual return) - Column D: Total outstanding claims provision at end of year
4.11.2 - Less: Savings plan claims paid (Column B)	3.1.11 - Total Benefits (Savings amount paid by scheme on behalf of member column) *-1
4.11.3 - Discount received on claims (Column B)	3.1.11 - Total Benefits (Discount received column) *-1
4.11.6 - Provision for outstanding claims at the end of the year (Column A)	4.9.6 - Total outstanding claims provision at end of year (Column A)
4.11.6 - Provision for outstanding claims at the end of the year (Column B)	4.9.6 - Total outstanding claims provision at end of year (Column B) + 4.9.6 (Column C)
4.11.6 - Provision for outstanding claims at the end of the year (Column C)	4.9.6 - Total outstanding claims provision at end of year (Column D)
4.11.7 - Less: Provision for outstanding claims at the end of the previous year (column A)	4.9.1 - Total outstanding claims provision at beginning of year *-1 (column A)

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4.11.7 - Less: Provision for outstanding claims at the end of the previous year (column B)	4.9.1 - Total outstanding claims provision at beginning of year * -1 (column B + column C)
4.11.7 - Less: Provision for outstanding claims at the end of the previous year (column C)	4.9.1 - Total outstanding claims provision at beginning of year * -1 (column D)
4.11.9 - Net (income)/expense on risk transfer arrangements (Column C)	4.13.4 (Consolidated total) net (income)/expense from other risk transfer arrangements
Part 4.12: Other third party names	Part 1.4 question 6 a (ii)
Part 4.13: Contract names	Part 1.4 question 6 c
Part 4.13.1 Per Contract name (Previous year column): Premiums/fees paid (capitation fee)	Part 4.13.1 Per Contract name (Current year column 2010 Return): Premiums/fees paid (capitation fee)
Part 4.13.2 Per Contract name (Previous year column): Less: Claims recoveries in respect of related risk transfer arrangements	Part 4.13.2 Per Contract name (Current year column 2010 Return): Less: Claims recoveries in respect of related risk transfer arrangements
Part 4.13.3 Per Contract name (Previous year column): Other (specify)	Part 4.13.3 Per Contract name (Current year column 2010 Return): Other (specify)
Part 4.14: Contract names	Part 1.4 question 6 d
4.16.37 (current year fund column) - Trustee remuneration and considerations	4.17.2 (Total column) - Total trustee remuneration and considerations
4.16.1 to 4.16.41 (Previous year: Fund column)	4.16.1 to 4.16.41 (2010 annual return) (Fund column)
4.16.1 to 4.16.41 (Previous year: Own Facilities column)	4.16.1 to 4.16.41 (2010 annual return) (Own Facilities column)
Part 4.17: Trustee names	Part 1.3 - Names of Trustees
4.21.2.3 - Less: Administration expenditure	4.16.41 Current year (Own facility column) - Total administration expenses * -1
4.21.2.5 - Add: Costs relating to members included in claims	4.11.1.7 - Services provided to members in own facilities (Total column)
Part 4.23: Benefit Option names	Part 1.2 - Option names
4.23.38 - Number of members at the end of the year (per option)	2.1.1 Number of members per option.
4.23.39 - Number of beneficiaries at the end of the year (per option)	2.1.1 Number of beneficiaries per option.
4.26.1.1 - Trustee remuneration	4.17.2 - Total trustee remuneration expense: Total

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4.26.1.2 - Trustees: Fees received in respect of services rendered to related parties	4.17.2 - Total trustee remuneration expense: Fees received in respect of services rendered to related parties
4.26.1.3 - Principle officer remuneration	4.16.27 - Principal Officer fees and remuneration (current year: fund + own facilities) + 4.16.28 - Principal Officer travel and other expenses (current year: fund + own facilities)
4.26.1.4 - Consolidated parties	Part 1.4 question 7: if selected "yes" pull-through names and relationships of parties consolidated
4.26.2.1 - Consolidated parties	Part 1.4 question 7: if selected "yes" pull-through names and relationships of parties consolidated
5.1.1.1 - Property, plant and equipment (current year column)	4.1.3 - Total net carrying amount at end of year (Total column)
5.1.1.1 - Property, plant and equipment (previous year column)	4.1.1.1 Total Gross carrying amount at beginning of year + 4.1.2.1 - Total accumulated depreciation at beginning of year
5.1.1.2 - Investments (current year column)	4.2.8 - Non-current column: Total investments
5.1.1.2 - Investments: previous year column	5.1.1.2 - Investments: current year column 2010 return
5.1.1.3 - Other non-current assets: previous year	5.1.1.3 - Other non-current assets: current year column 2010 return
5.1.2.1 - Inventories: previous year column	5.1.2.1 - Inventories: current year column 2010 return
5.1.2.2 - Trade and other receivables (current year column)	4.3.17 - Total trade and other receivables
5.1.2.2 - Trade and other receivables: previous year	5.1.2.2 - Trade and other receivables: current year column 2010 return
5.1.2.3 - Investments (current year column)	4.2.8 - Current column: Total investments
5.1.2.3 - Investments (previous year column)	5.1.2.3 - Investments: current year column 2010 return
5.1.2.4 - Cash and cash equivalents (current year column)	4.4.7 - Total cash and cash equivalents per balance sheet
5.1.2.4 - Cash and cash equivalents (previous year column)	5.1.2.4 - Cash and cash equivalents: current year column 2010 return
5.1.2.5 Other current assets (specify) (previous year column)	5.1.2.5 Other current assets (specify) (current year column 2010 return)
5.2.1.1 - Accumulated funds (current year column)	7.1.5 - Accumulated funds: Balance at the end of the year (current year column)

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5.2.1.1 - Accumulated funds (previous year column)	7.1.5 - Accumulated funds: Balance at the end of the year (previous year column)
5.2.1.2 - Revaluation Reserve - Investments (current year column)	7.2.7 - Revaluation Reserve - Investments: Balance at the end of the year (current year column)
5.2.1.2 - Revaluation Reserve - Investments (previous year column)	7.2.7 - Revaluation Reserve - Investments: Balance at the end of the year (previous year column)
5.2.1.3 - Revaluation Reserve - Property, plant and equipment (current year column)	7.3.6 - Revaluation Reserve - Property, plant and equipment: Balance at the end of the year (current year column)
5.2.1.3 - Revaluation Reserve - Property, plant and equipment (previous year column)	7.3.6 - Revaluation Reserve - Property, plant and equipment: Balance at the end of the year (previous year column)
5.2.1.4 - Reserves set aside for specific purposes (current year column)	7.4.4 - Reserves set aside for specific purposes: Consolidated balance at the end of the year (current year column)
5.2.1.4 - Reserves set aside for specific purposes (previous year column)	7.4.4 - Reserves set aside for specific purposes: Consolidated balance at the end of the year (previous year column)
5.2.1.5 - Other reserves (current year column)	7.5.4 - Other reserves: Consolidated balance at the end of the year (current year column)
5.2.1.5 - Other reserves (previous year column)	7.5.4 - Other reserves: Consolidated balance at the end of the year (previous year column)
5.2.1.6 - Minority interest (previous year column)	5.2.1.6 - Minority interest: current year column 2010 return
5.2.2.1 - Borrowings (current year column)	4.6.4 - Total non-current borrowings: interest bearing borrowings + 4.6.4 - Total non-current borrowings: non-interest bearing borrowings
5.2.2.1 - Borrowings (previous year column)	5.2.2.1 - Borrowings: current year column 2010 return
5.2.2.2 - Other non-current liabilities (current year column)	4.7.5 - Total other non-current liabilities
5.2.2.2 - Other non-current liabilities (previous year column)	5.2.2.2 - Other non-current liabilities: current year column 2010 return
5.2.3.1 - Savings plan liability (current year column)	4.5.16 - Balance of savings plan liability at the end of the year (credit balance)

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5.2.3.1 - Savings plan liability (previous year column)	4.5.1 - Savings plan liability (balance at the beginning of the year) + 4.5.2 - Prior year adjustment
5.2.3.2 - Trade and other payables (current year column)	4.8.14 - Total trade and other payables
5.2.3.2 - Trade and other payables (previous year column)	5.2.3.2 - Trade and other payables: current year column 2010 return
5.2.3.3 - Outstanding claims provision (current year column)	4.9.8 - Total column: Total outstanding claims provision at end of year
5.2.3.3 - Outstanding claims provision (previous year column)	4.9.1.1 Total column - As previously reported + 4.9.1.2 Total column - Prior year adjustment
5.2.3.4 - Other current liabilities (previous year column)	5.2.3.4 - Other current liabilities: current year column 2010 return
6.1.4.2 Net income/(expense) on risk transfer arrangements (previous year column)	4.13.4 Net (income)/expense from other risk transfer arrangements consolidated total previous year column * -1
6.1.9 Less: Administration expenses (previous year column)	4.16.41 Previous Year Fund Total administration expenses *-1
Part 6 Previous year column	Part 6 Current year column 2010 return
6.1.1 Gross contribution income (current year column)	4.23.1 - Consolidated gross contribution income
6.1.2 Less: Savings contribution income (current year column)	4.23.2 - Consolidated savings contribution income
6.1.4.1 Net claims incurred (current year column)	[4.23.11 Net claims incurred in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts) + 4.23.16 Net claims incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance)]* -1
6.1.4.2 Net income/(expense) on risk transfer arrangements (current year column)	4.23.17 Net (income)/expense on risk transfer arrangements * -1
6.1.6 Net income/(expense) on commercial reinsurance contracts (current year column)	4.23.20 Consolidated Net income/(expense) on commercial reinsurance contracts
6.1.7 Less: Managed care: management services (current year column)	4.23.21 - Consolidated Less: Managed care: management services

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6.1.8.1 Less: Broker service fees (current year column)	4.23.22.1 - Consolidated Less: Broker service fees
6.1.8.2 Less: Other distribution costs (current year column)	4.23.22.2 - Consolidated Less: Other distribution costs
6.1.9 Less: Administration expenses (current year column)	4.23.23 Consolidated Less: Administration expenses
6.1.10 Net impairment losses: Trade and other receivables (current year column)	4.23.24 Consolidated Net impairment losses: Trade and other receivables
6.1.12 Net impairment losses: Other (specify) (current year column)	4.23.26 Consolidated Net impairment losses: Other (specify)
6.1.13 Other investment income (current year column)	4.23.27 Consolidated other investment income
6.1.14 Less: Investment management fees (current year column)	4.23.28 Consolidated Less: Investment management fees
6.1.15 Less: Operating expenses on rental of investment property (current year column)	4.23.29 Consolidated Less: Operating expenses on rental of investment property
6.1.16 Other realised and unrealised gains/(losses) (current year column)	4.23.30 Consolidated Other realised and unrealised gains/(losses)
6.1.17 Other income (specify) (current year column)	4.23.31 Consolidated Other operating income (specify)
6.1.18 Own facility surplus/(deficit) (current year column)	4.23.32 Consolidated Own facility surplus/(deficit)
6.1.19 Less: Other expenses (specify) (current year column)	4.23.33 Consolidated Less: Other operating expenses (specify)
6.1.20 Less: Finance costs (current year column)	4.23.34 Consolidated Less: Finance costs
6.1.22 Consolidation results (current year column)	4.23.36 Consolidated Consolidation results
7.1.1.1 - Accumulated funds: Balance at the beginning of the year: As previously reported (previous year column)	7.1.1 (2010 annual return) - Accumulated funds balance at the beginning of the year (current year column)
7.1.1.1 - Accumulated funds: Balance at the beginning of the year: As previously reported (current year column)	7.1.5 - Accumulated funds: Balance at the end of the year (previous year column)
7.1.2 - Surplus/(deficit) for the year (previous year column)	6.1.23 - Surplus/(deficit) for the year (previous year column)
7.1.2 - Surplus/(deficit) for the year (current year column)	6.1.23 - Surplus/(deficit) for the year (current year column)
7.2.1.1 - Revaluation reserve (investments): Balance at the beginning of the year: As previously reported (previous year)	7.2.1 (2010 annual return) - Revaluation reserves (investments): Balance at the beginning of the year (current year column)
7.2.1.1 - Revaluation reserve (investments): Balance at the beginning of the year: As previously reported (current year column)	7.2.7 - Revaluation reserve (investments): Balance at the end of the year (previous year column)

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7.2.2 - Revaluation reserve (investments): Unrealised gains/(losses) on revaluation of investments (current year column)	6.1.25 - Fair value adjustment on available-for-sale investments Current year
7.2.2 - Revaluation reserve (investments): Unrealised gains/(losses) on revaluation of investments (previous year column)	6.1.25 - Fair value adjustment on available-for-sale investments Previous year
7.2.3 - Revaluation reserve (investments): Realised (gains)/losses on derecognition of investments (current year column)	6.1.26 - Reclassification adjustment current year
7.2.3 - Revaluation reserve (investments): Realised (gains)/losses on derecognition of investments (previous year column)	6.1.26 - Reclassification adjustment Previous year
7.3.1.1 - Revaluation reserve (property, plant and equipment): Balance at the beginning of the year: As previously reported (previous year column)	7.3.1 - (2010 annual return) Revaluation reserve (property, plant and equipment): Balance at the beginning of the year (current year column)
7.3.1.1 - Revaluation reserve (property, plant and equipment): Balance at the beginning of the year: As previously reported (current year column)	7.3.6 - Revaluation reserve (property, plant and equipment): Balance at the end of the year (previous year column)
7.3.2 - Revaluation reserve (property, plant and equipment): Unrealised gains/(losses) on revaluation of property, plant and equipment (current year)	6.1.27 - Land and buildings revaluation Current year
7.3.2 - Revaluation reserve (property, plant and equipment): Unrealised gains/(losses) on revaluation of property, plant and equipment (previous year)	6.1.27 - Land and buildings revaluation Previous year
7.4.1.1 - Per reserve: Reserves set aside for specific purposes: Balance at the beginning of the year: As previously reported (previous year column)	7.4.1 (2010 annual return) Per reserve: Reserves set aside for specific purposes: Balance at the beginning of the year (current year column)
7.4.1.1 - Per reserve: Reserves set aside for specific purposes: Balance at the beginning of the year: As previously reported (current year)	7.4.4 - Per Reserve: Reserves set aside for specific purposes: Balance at the end of the year (previous year)
7.5.1.1 - Per reserve: Other reserves: Balance at the beginning of the year: As previously reported (previous year column)	7.5.1 - (2010 annual return): Per reserve: Other reserves: Balance at the beginning of the year (current year column)

Pull throughs for the 2011 Annual Statutory Return

Medical Scheme:

Ref No.:

Financial Year End:



7.5.1.1 - Per reserve: Other reserves: Balance at the beginning of the year: As previously reported (current year column)	7.5.4 - Per reserve: Other reserves: Balance at the end of the year (previous year column)
8.5.1 - Cash and cash equivalents at the beginning of the year: As previously reported (previous year column)	8.5 (2010 annual return) - Cash and cash equivalents at beginning of period (current year column)
8.5.1 - Cash and cash equivalents at the beginning of the year: As previously reported (current year column)	8.8 - Cash and cash equivalents at the end of the year (previous year column)
9(a): 7(a)(iii)- Direct investment: PROPERTY, PLANT AND EQUIPMENT: Computer equipment and Software	4.1.3 - Net Carrying amount at end of year (Computer Equipment and Software)
9(a): 7(a)(iii) - Direct investment: PROPERTY, PLANT AND EQUIPMENT: Furniture and Fittings	4.1.3 - Net Carrying amount at end of year (Furniture and Fittings)
9(a): 7(a)(iii) - Direct investment: PROPERTY, PLANT AND EQUIPMENT: Motor Vehicles	4.1.3 - Net Carrying amount at end of year (Motor Vehicles)
9(a): 7(a)(iii) - Direct investment: PROPERTY, PLANT AND EQUIPMENT: Other	4.1.3 - Net Carrying amount at end of year (Other)
9(a): 9.8 - Direct investment: Less: Assets Encumbered	4.25.2 - (Total encumbered assets + Total suretyships) *-1
9(a): 9.10 - Direct investment: Less: Assets Encumbered	9(a): 9.8 - Direct investment: Less: Assets Encumbered *-1
9(a): 9.12 - Direct investment: Trade and other receivables	5.1.2.2 - Trade and other receivables (current year column)
10.1.1 - Balance at beginning of period	10.1.7 (2010 annual return) - Cumulative net gain on re-measurement to fair value of properties and investments included in accumulated funds
10.1.3 - Unrealised gains/(losses) on revaluation of investments and property, plant and equipment included in the income statement	4.20.4 - Unrealised gain/(loss) on revaluation of investment property + 4.20.5 - Unrealised gain/(loss) on revaluation of investments carried at fair value through the income statement + 7.1.3.2 - Due to re-measurement of investments and property, plant and equipment (current year column)
10.1.5 - Consolidation results	6.1.22 - Total Consolidation results
10.2.1 - Total members' funds per balance sheet	5.2.1 (current year column) - Members' funds

Pull throughs for the 2011 Annual Statutory Return

Medical Scheme:
Ref No.:
Financial Year End:



10.2.2 - Less: Unrealised non-distributable reserve.	{5.2.1.2 (current year column) - Revaluation reserve (investments) + 5.2.1.3 (current year column) - Revaluation reserve (property, plant & equipment)} >0 *-1
10.2.3 - Less: Funds set aside for specific purposes	5.2.1.4 (current year column) - Reserves set aside for specific purposes *-1
10.2.4 - Less: Cumulative net gains on revaluation of investments and property, plant and equipment included in the income statement	10.1.9 - Cumulative net gain on revaluation of investments and Property, plant and equipment included in the income statement > 0 *-1; however if 10.2.2 < 0 AND 10.1.9 < 0 then 10.2.4 = 10.1.9 *-1, limited to 10.2.2 *-1
10.2.5 - Less: Specific Assets Encumbered for third party liabilities	4.25.2 - Total encumbered assets + Total suretyships *-1
10.2.6 - Less: Minority Interest	5.2.1.6 - Minority interest *-1
10.2.9 - Total net assets	10.2.8 - Total net assets
10.2.10 - Annualised gross contributions	6.1.1 - Total gross contribution income (current year)



HELP FILE WITH REGARDS TO THE 2011 ANNUAL STATUTORY RETURN



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SUMMARY OF CHANGES FOR THE 2011 YEAR:

The following constitutes a summary of the main changes to the 2011 annual statutory return:

- Part 1.4: Report of the Board of Trustees
The Board of Trustees needs to report on the composition of the audit committee
- Part 2.8: Utilisation of services by medical and dental specialists
Additional line in respect of specialist family medicine
- Part 2.9: Utilisation of services by supplementary and allied health professionals
Additional lines in respect of community dentistry, nurses institute, orthotist and prosthetist, psychometry, registered councillor, and dispensing optometrists
- Part 2.10: Utilisation of other benefit services
Additional lines in respect of private rehabilitation hospital (acute) and prosthetic supplier
- Parts 4 – 8: The scheme would need to supply the reasons for any prior year adjustments and reclassifications in the financial data
- Part 4.13: Net (income)/expenses from other risk transfer arrangements (excluding commercial reinsurance contracts):
The previous year's data pulls through from the 2010 return
- Part 4.15(a) Broker service fees
In the past there were several misallocations on this part. It is hopefully now a bit more user-friendly
- Part 4.16: Administration expenses
Schemes would need to provide detail on co-administration fees paid where no such co-administrator exists in part 1.1
- Part 6.1: Statement of comprehensive income
The current year data now pulls through from part 4.23 (Net surplus/(deficit) per benefit option). The scheme would now only need to complete the data relating to other comprehensive income
- Part 6.2: Monthly statement of net healthcare result
This is a new part to the return.
The scheme is required to provide a monthly breakdown of the various items out of which the net healthcare result exist, as well as a monthly breakdown of the net surplus/(deficit) incurred
- Parts 7.2 – 7.5
The line items relating to the transfers between reserves now make specific provision for transfers upon amalgamation. These line items are excluded from the validation rule in which the total movement in the reserves is compared to the other comprehensive income accounted for in part 6.1 (Statement of comprehensive income)
- Part 8: Cash flow statement
The cash flow statement now requires the disclosure of the cash flows from operating activities as per the direct method whereby major classes of gross cash receipts and gross cash payments are disclosed
- Part 9(a): Assets held in the Republic in terms of Regulation 30 in conjunction with Annexure B to the Regulations
This part has been adjusted so that schemes that amalgamated during the year can disclose the breakdown of the underlying assets as at the last date of business, removing them in line 9.13 to reflect a zero balance as at 31 December 2011
- Part 10.1: Cumulative net gains on re-measurement of properties and investments through the income statement
This part now also makes provision for the realisation of assets upon amalgamation during the year
- Part 11: Assurance report in accordance with Sections 35(6) and 36(8) of the Medical Schemes Act 131 of 1998



The footnotes to this report have been elaborated to provide more guidance on not only the format of the report, but also required audit procedures

SAVINGS PLAN MONIES

With reference to Circular 38 of 2011 and the clarifying circular issued in February 2012 schemes should note that the relevant changes to the annual statutory return will only be made in respect of the 2012 annual statutory return; this is due to the fact that schemes would not have been able to make the necessary system changes and disinvestment of assets by 31 December 2011.

The savings plan assets and liabilities will therefore still be included as part of the scheme assets and liabilities in the 2011 return; similarly compliance to Annexure B will be tested on the total scheme assets which includes the savings plan assets.

In the event that the scheme has been able to invest their savings plan monies separately from scheme assets by 31 December 2011, it is recommended that a letter to this effect is submitted together with the return (part 9A) to explain such deviation from the limitations imposed by Annexure B.

Help File: 2011 Annual Statutory Return



LOGIN ONTO ANNUAL STATUTORY RETURN



Not yet a user on the system:

Click on the words 'Register Here'.

Help File: 2011 Annual Statutory Return



The following screen will appear when the user clicked on the 'Register Here' button:

The screenshot shows a web browser window titled 'Register - Windows Internet Explorer' with the address bar displaying 'http://cmsuat01/returns/register.aspx'. The page features the CMS logo and navigation links for 'Home' and 'Contact Us'. A dropdown menu is present with the instruction 'Click on the "..." button to select one or many Schemes'. Below this is a large empty rectangular box. The registration form includes the following fields: First Name, Last Name, Email, Confirm Email, Telephone, Cellphone, Fax, Street, City, Postal Code, UserName, Secret Question and Answer (for lost password validation), and Mothers Maiden Name (with a dropdown arrow). A 'Register' button is located at the bottom of the form. The browser's status bar at the bottom shows 'Local intranet | Protected Mode: Off' and the time '10:12 AM 2011/02/18'.

The user should ensure that he or she selects all the schemes, for which he or she would want to register, when clicking on the selection-button.

When the user submits his or her request to be registered, an e-mail will be sent to the 'administrator' of that scheme, to approve the registration of the user. Please note that our system has one administrator for each scheme, which is the very first person to register as a user for that specific scheme.

As soon as we receive the approval from the 'administrator' of the scheme, the Office will e-mail the new user his or her username and password to access the online statutory return.

Help File: 2011 Annual Statutory Return



Registered as an user on the system

The user should then capture his or her user name and password on the login screen and press submit.

Login to the Statutory Returns Portal - Windows Internet Explorer

http://cmsuat01/returns/

Home - Council for Medical Schemes

Login to the Statutory ... Council for Medical Schemes

CMS COUNCIL FOR MEDICAL SCHEMES

Home Contact Us

Welcome to the Statutory Returns Portal

Please Log In

Username: Julindi

Password:

submit reset

Not a member yet? [Register here](#)

Forgot your password? [Click here](#)

• [Legal information](#) | [Privacy Policy Statement](#)

© Council for Medical Schemes

Done

Local intranet | Protected Mode: Off

10:15 AM 2011/02/18

Help File: 2011 Annual Statutory Return



Forgot your password?

Should a user forget his or her password, the user should use the button provided on the login screen stating "Forgot your Password? Click Here"

The following screen will appear, and the user will be required to complete the required information and press OK. If the secret answer corresponds with the answer captured during the registration process of the user, the user will receive an e-mail from the Office with his password.

A screenshot of a web browser window titled 'Forgot - Windows Internet Explorer'. The address bar shows 'http://cmsuat01/returns/forgot.aspx'. The page has a blue header with the CMS logo and 'COUNCIL FOR MEDICAL SCHEMES'. Below the header, there are links for 'Home' and 'Contact Us'. The main content area is white and contains the text: 'Complete the form below, if you have forgotten your password. The password will be e-mailed to you.' Below this text is a form with three labels: 'UserName', 'Secret Question', and 'Secret Answer'. The 'Secret Question' dropdown menu is open, showing 'Mothers Maiden Name' as the selected option. There is an 'Ok' button below the form. The browser's status bar at the bottom shows 'Local intranet | Protected Mode: Off' and the system clock indicates '10:15 AM 2011/02/18'.

Help File: 2011 Annual Statutory Return



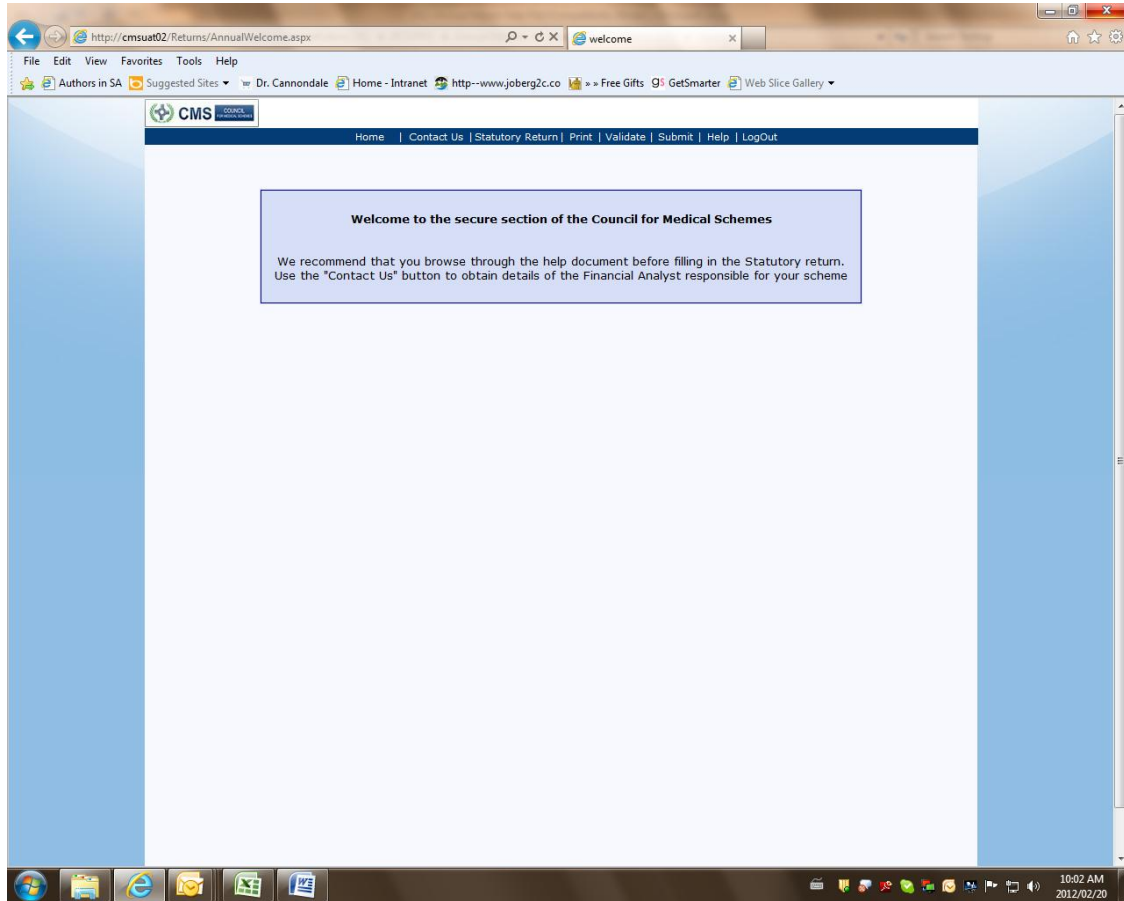
As soon as the user has logged in, the following screen will appear:

The user should choose the specific scheme he or she wants to access. The user will also have the option to choose whether he or she wants to access the current year's return or the previous years' returns (in a read-only format).

Help File: 2011 Annual Statutory Return



After selecting the scheme, the following screen will appear:



Help File: 2011 Annual Statutory Return



CONTACT US

Should a user experience any problems with the online statutory return, he or she can contact the Office at any point in time by just clicking on the 'Contact us' option on the task bar. The following screen will appear:

The screenshot shows a web browser window titled 'Annual Contact - Windows Internet Explorer'. The address bar displays 'http://cmsuat01/returns/annualcontact.aspx'. The browser's Favorites bar includes 'Annual Contact' and 'Council for Medical Schemes...'. The main content area features the CMS logo and a navigation bar with links: 'Home', 'Contact Us', 'Statutory Return', 'Print', 'Validate', 'Submit', 'Help', and 'LogOut'. Below the navigation bar, a form is displayed with the following text: 'Complete this form for any assistance. Your enquiry will immediately be send to your Financial Analyst'. It then states 'The financial analyst for this scheme is: Kabelo Mahobye'. There is a text input field for 'Subject of Enquiry' and a larger text area for 'Type your enquiry below and press send:'. At the bottom of the form are 'Send' and 'Clear' buttons. The browser's status bar at the bottom shows 'Waiting for http://cmsuat01/returns/annualcontact.aspx...', 'Local intranet | Protected Mode: Off', and the system clock '10:16 AM 2011/02/18'.

The name of the financial analyst responsible for the specific scheme will appear on the screen. The user should only complete the details of his or her enquiry and press 'send'. An e-mail will be send to the specific financial analyst responsible for the scheme. It is then the financial analyst's responsibility to contact the scheme and resolve the enquiry.



STATUTORY RETURN

To access the individual parts of the online statutory return, the user should click on the 'statutory return' button on the task bar. Part 1.1 will automatically open.

General comments on the completion of the return

The system does not recognise apostrophes (') and &-signs.

The user will not be able to input any figures with decimals; only whole figures will be accepted.

To ensure that the return is viewed optimally, the user should ensure that the computer screen size is set at 1 280 x 1024.

PART 1 MEDICAL SCHEME DETAILS

Part 1.1 Details of Medical Scheme and Certification of Return

Help File: 2011 Annual Statutory Return



The details of the scheme and its officials are maintained by the Office. Part 1 will therefore always be in a read-only format. In order to affect changes in this part, refer to the pop-up for the contact details of the relevant person to address the updates to.

Please ensure that the latest details of the Principal Officer, Chairperson, Trustee signatory, Scheme, Administrator, Co-Administrator, Fund manager, User, Auditor(s) and Liquidator or Curator (where applicable) are updated every period in part 1.1 of the return. Kindly also refer to Circular 9 of 2009 in this respect. Please note that the word document will be automatically e-mailed to the various persons indicated in Part 1 of the return.

Kindly note that the Principal Officer and Board of Trustees (or Curator where applicable) as at 31 December will be responsible for the signing of the return. (Also refer to "*Certification of the return*" for further requirements in respect of the signing of the return.)



Reference number

When the scheme was originally uploaded onto the system, a reference number was automatically registered on our system.

Please note that the reference number will stay the same even if the scheme changed its name.

Amalgamations

A final set of audited accounts (as at the date of the amalgamation), including the statutory return (as at 31 December) for the year in which a scheme has amalgamated have to be prepared and submitted to the Registrar.

Please take note that all the sections must be completed with the data for the period in which the scheme that amalgamated was still in operation. This is done to ensure that the full 12 months' figures are obtained for all sections, especially parts 3 and 4 in respect of the service providers and the statement of comprehensive income (the reason being that the new scheme will not report on that data in their return as only opening balances are taking into account in their return).

Help File: 2011 Annual Statutory Return



Every line item of the statement of financial position should be completed in detail. The closing statement of financial position figures will become zero in the return through the use of the last line item "Less: Transfer of assets / liability due to amalgamation during the year". These lines are applicable for amalgamations that occurred during the year, as the annual financial statements would have been prepared as at the date of amalgamation, whilst the return is as at 31 December. For example:

	Non-Current R	Current R	Total R
4.2.1 Investment property	7,000,000	0	7,000,000
4.2.2 Available for sale investments	4,000,000	0	4,000,000
4.2.3 Held-to-maturity investments	400	600	1,000
4.2.4 Investments held at fair value through profit or loss	643,996,432	3,468,459,576	4,112,456,008
4.2.5 Other (specify):	600	400	1,000
4.2.6 Group investments on consolidation	0	3,000,000	3,000,000
4.2.7 Less: Transfer of assets due to amalgamation during the year	0	0	0
4.2.8 Total investments	654,997,432	3,471,460,576	4,126,458,008

Please ensure that the closing balances of the scheme that amalgamated agree with the opening balance that has been taken forward to the new scheme for incorporation into their accounts.

Help File: 2011 Annual Statutory Return



Consolidations

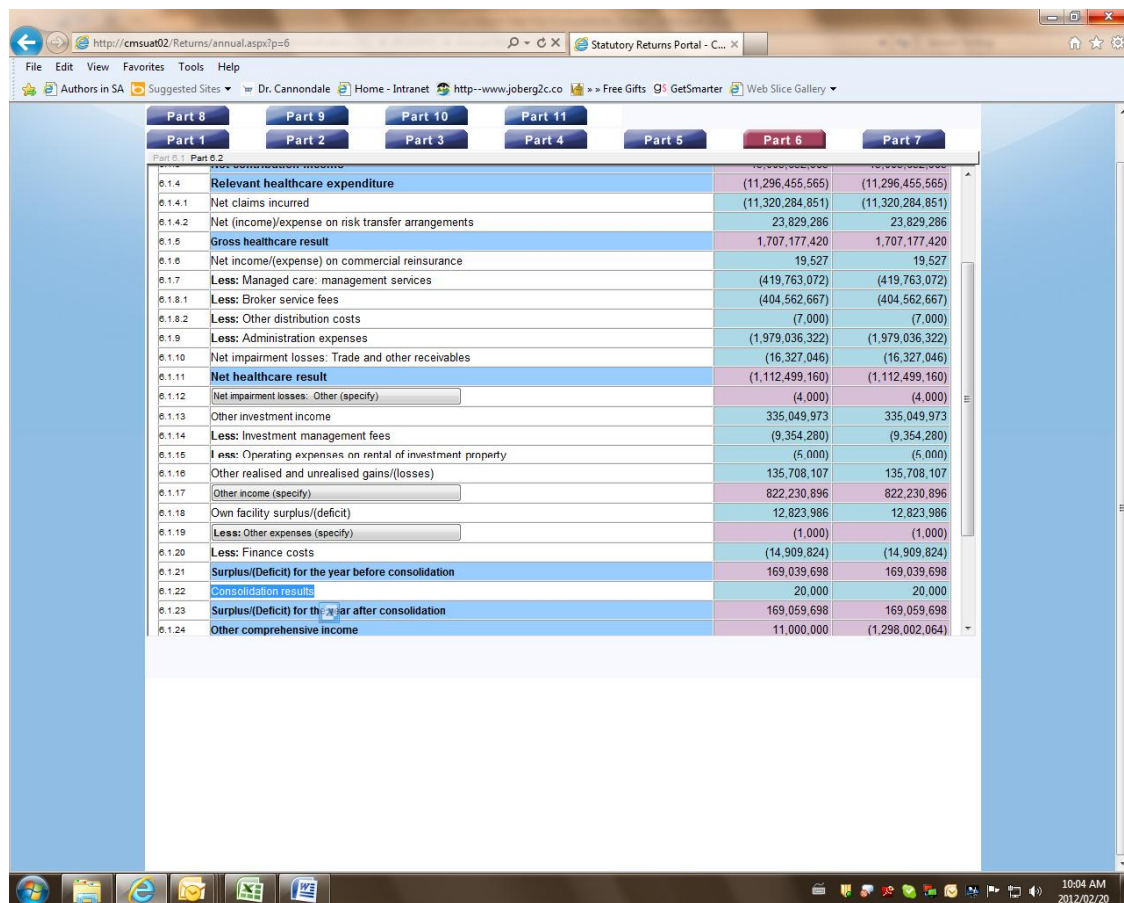
Where a scheme completes the annual return on a consolidated basis, group transactions that relates to other parties in the group (not the scheme) should be aggregated and included in the specific line provided for on the statement of financial position items.

	Non-Current R	Current R	Total R
4.2.1 Investment property	7,000,000	0	7,000,000
4.2.2 Available for sale investments	4,000,000	0	4,000,000
4.2.3 Held-to-maturity investments	400	600	1,000
4.2.4 Investments held at fair value through profit or loss	643,996,432	3,468,459,576	4,112,456,008
4.2.5 Other (specify)	600	400	1,000
4.2.6 Group investments on consolidation	0	3,000,000	3,000,000
4.2.7 Less: Transfer of assets due to amalgamation during the year	0	0	0
4.2.8 Total investments	654,997,432	3,471,460,576	4,126,458,008

Help File: 2011 Annual Statutory Return



All income statement transactions for the group companies should be included in part 4.23 line 4.23.36 and part 6.1 line 6.1.22:



Line Item	Value	Value
6.1.4 Relevant healthcare expenditure	(11,296,455,565)	(11,296,455,565)
6.1.4.1 Net claims incurred	(11,320,284,851)	(11,320,284,851)
6.1.4.2 Net (income)/expense on risk transfer arrangements	23,829,286	23,829,286
6.1.5 Gross healthcare result	1,707,177,420	1,707,177,420
6.1.6 Net income/(expense) on commercial reinsurance	19,527	19,527
6.1.7 Less: Managed care: management services	(419,763,072)	(419,763,072)
6.1.8.1 Less: Broker service fees	(404,562,667)	(404,562,667)
6.1.8.2 Less: Other distribution costs	(7,000)	(7,000)
6.1.9 Less: Administration expenses	(1,979,036,322)	(1,979,036,322)
6.1.10 Net impairment losses: Trade and other receivables	(16,327,046)	(16,327,046)
6.1.11 Net healthcare result	(1,112,499,160)	(1,112,499,160)
6.1.12 Net impairment losses: Other (specify)	(4,000)	(4,000)
6.1.13 Other investment income	335,049,973	335,049,973
6.1.14 Less: Investment management fees	(9,354,280)	(9,354,280)
6.1.15 Less: Operating expenses on rental of investment property	(5,000)	(5,000)
6.1.16 Other realised and unrealised gains/(losses)	135,708,107	135,708,107
6.1.17 Other income (specify)	822,230,896	822,230,896
6.1.18 Own facility surplus/(deficit)	12,823,966	12,823,966
6.1.19 Less: Other expenses (specify)	(1,000)	(1,000)
6.1.20 Less: Finance costs	(14,909,824)	(14,909,824)
6.1.21 Surplus/(Deficit) for the year before consolidation	169,039,698	169,039,698
6.1.22 Consolidation results	20,000	20,000
6.1.23 Surplus/(Deficit) for the year after consolidation	169,059,698	169,059,698
6.1.24 Other comprehensive income	11,000,000	(1,298,002,064)

Liquidations

A final set of accounts, including the statutory return, should be prepared until the effective date of liquidation. As with amalgamations, the submitted financial statements would be prepared as at the date of the liquidation, whilst the statutory return should be prepared as at 31 December.

Again the scheme would need to complete all the line items of the statement of financial position in detail. The closing statement of financial position figures will become zero in the return through the use of the last line item.

Auditor(s)

The details of the auditor(s), as approved by the Registrar in terms of section 36 of the Act for the applicable financial year, will be reflected in part 1.9.

Certification of the return

In terms of section 39(1) of the Act a medical scheme shall be deemed not to have complied with any provision of this Act which imposes upon such a medical scheme the obligation to furnish to the Registrar a



document prepared by the medical scheme, unless such document is signed by either the Principal Officer and one other person authorised in accordance with the rules of the medical scheme to sign documents or the Curator.

In addition section 39(2)(a) of the Act requires that the following persons shall sign any document within terms of any provision of the Act must be furnished by a medical scheme to the Registrar:

- (a) In the case of a board of trustees, the chairperson of the board of trustees, and by one other member of such board; and
- (b) In any other case, persons designated by the Registrar who exercise control over the business of the medical scheme concerned.

It is important to note that the signing authority of a Principal Officer and/or Chairperson can only be delegated to a suitable person appointed by the board of trustees; the appointment of the acting Principal Officer should be in line with the provisions of section 57(4) (a) and 57(7) of the Medical Schemes Act, and the appointment of the acting Chairperson in line with the rules of the scheme.

Where applicable, a copy of the signed board of trustee resolution, where another person was appointed, should accompany the annual statutory return.

The auditor must initial parts 4 to 10 of the return for identification purposes, and the Principal Officer should initial all parts of the return for identification purposes.

Help File: 2011 Annual Statutory Return



Part 1.2 Benefit Options

The Council keeps record of the registered benefit options of the scheme and as such part 1.2 will be in a read-only format. Part 1.2 reflects all registered options for the financial year concerned; even if some of the options were discontinued during the course of the year.

A scheme should NOT request the registration of an option in part 1.2 if that option was not in operation during the year concerned. Provision has been made for financial transactions in the 'other' column in part 4.23 of the return, should the scheme have incurred some financial transactions in the year concerned for options been deregistered but are in process of being winded down.

The benefit options captured in part 1.2 will automatically pull through to parts 2.1, 2.3, 2.7 and 4.23.

Help File: 2011 Annual Statutory Return



Part 1.3 Board of Trustees

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

http://cmsuat01/returns/annual.aspx?p=8&d=3

Home | Contact Us | Statutory Return | Print | Validate | Submit | Help | LogOut

Part 8 | Part 9 | Part 10 | Part 11 | Part 1 | Part 2 | Part 3 | Part 4 | Part 5 | Part 6 | Part 7

Part 1.1 | Part 1.2 | **Part 1.3** | Part 1.4

PART 1.3: BOARD OF TRUSTEES

Trustee Name
LERATO SEHULARO
PAUL BOSCH
GLENDA MOSLEY
MOLEBOENG MOLAHE
JULINDI SCHEEPERS (RESIGNED 31 OCTOBER 2010)
ELIZABETH FIGUEIREDO (APPOINTED 31 JULY 2010)
KABELO MAHOBYE

Scheme : (MMED) Financial Year : (2010)

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As the Office keeps record of the details of the scheme and its officials, this part is in a read-only format. The names of all the board of trustees that were in office during the financial year (at any point in time) are listed in this part. It should be noted that the names captured in part 1.3 automatically pulls through to part 4.17, where the scheme completes the remuneration and considerations paid to the board of trustee members during the financial year concerned.

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Part 1.4 Report of the Management Board/Committee

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Part 1.1 Part 1.2 Part 1.3 Part 1.4

PART 1.4: REPORT OF THE BOARD OF TRUSTEES

Questions	Answer
GENERAL	YES NO
1. Has there been a change in accounting policies? Please provide full details. Investment properties are now accounted for at historic cost.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
2. Has there been a change in accounting estimates? Please provide full details. The outstanding claims provision was affected.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. Has any company/institution/person to your knowledge received or dealt with the contributions of the scheme otherwise than in terms of Section 26(6) and 26(7)? Please provide full details. Rogue broker.	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
4. Are transfers to and from reserves fully disclosed in the attached financial statements? Please provide full details.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

Scheme: (MMED) Financial Year: (2010)

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This part requires the board of trustees to complete a number of questions. The format of the questions requires a "yes" or "no" answer. More details might be required in some questions depending on the answer. Please note that the user's answer will not be accepted if the boxes that require more detail are not completed.

The names of the contracts entered in question 6(c) in the previous year's return will automatically pull through to the current year. Similarly the contract names in question 6(e) will be generated from the information displayed in part 1.1 of the return. Any additional contracts should be entered manually by the scheme.

The names of third party providers in question 6(a)(ii) pulls through to part 4.12. Similarly names detailed in the answers to questions 6(c), 6(d) and 7 pulls through to parts 4.13, 4.14 and 4.26 respectively.

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PART 2 NON FINANCIAL DATA

Please note that when certain specifications are met, the user will be required to complete a reason box. The user will not be able to submit the return without completing the relevant reason boxes.

Part 2.1 Membership at the End of the Financial Year

	Benefit Options	Members	Adult Dependants	Child Dependants	Beneficiaries	Dependant Ratio
2.1.1.1	OPTION A	180,762	126,155	139,943	446,860	1.47
2.1.1.2	OPTION B	45,845	28,246	24,274	98,365	1.15
2.1.1.3	OPTION C	49,566	31,799	37,067	118,432	1.39
2.1.1.4	OPTION D	16,992	10,702	10,746	38,440	1.26
2.1.1.5	OPTION E	2,180	1,210	1,415	4,805	1.20
2.1.1.6	OPTION F	62,523	39,955	37,276	139,754	1.24
2.1.2	Consolidated Total	837,709	490,406	586,671	1,914,786	1.29

Please provide the reasons, should the members and/or adult and/or child dependants be zero for any option: [Click here](#)

Please provide the reasons, and actions to be taken, should the principal members be less than 6 000 members: [Click here](#)

The membership figures for each of the benefit options should be provided in this part. The dependants should also be split between adult and child dependants as defined in the rules of the scheme. Beneficiaries are the sum of members and dependants.

Dependant ratio

The dependant ratio is calculated as the total dependants (adult plus child) divided by the number of members. This calculation is done automatically.

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Reason boxes

The following reason boxes must be completed when specifications are met:

- Please provide the reasons, should the members and/or adult and/or child dependants be zero for any option; and
- Please provide the reasons, and action to be taken, should the principle members be less than 6 000 members.

Part 2.2 Number of Registered Members and Dependants at the End of Each Month

	Benefit Options	Members	Adult Dependants	Child Dependants	Beneficiaries	Dependant Ratio
2.2.1	January	799,806	493,527	561,297	1,854,630	1.32
2.2.2	February	803,742	494,177	562,035	1,859,954	1.31
2.2.3	March	808,611	495,419	563,448	1,867,478	1.31
2.2.4	April	808,522	481,176	575,720	1,865,418	1.31
2.2.5	May	812,761	482,882	577,761	1,873,404	1.30
2.2.6	June	819,586	485,648	581,070	1,886,304	1.30
2.2.13	Average	819,958	491,005	575,485	1,886,448	1.30

Please provide the reasons if the members and/or adult dependants and/or child dependants are zero in any month: [Click here](#)

The scheme should capture the number of members, adult dependants and child dependants (as defined in the scheme's rules) per month in this section. Beneficiaries are the sum of members and dependants.

The December figures automatically pulls from part 2.1.

Average members and dependants

The total number of members and dependants for the year divided by the number of months in which the medical scheme had members. For example, if a scheme had members from October to December for the financial year, the total will be divided by three. This calculation is done automatically.

Dependant ratio

The dependant ratio is calculated as the total number of dependants (adult plus child) divided by the number of members. This calculation is done automatically.



Reason boxes

The following reason box must be completed when specifications are met:

- Please provide the reasons, should the members and/or adult and/or child dependants be zero for any option.

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Part 2.3 Age Analysis of Beneficiaries as at the End of the Financial Year

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http://cmsuat01/returns/annual.aspx?p=2&d=3

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

Part 2.3: AGE ANALYSIS OF BENEFICIARIES AS AT END OF THE FINANCIAL YEAR

	Consolidated Total		Per Benefit Option OPTION A	
	Male	Female	Male	Female
2.3.1 Less than one year	33,707	32,101	6,573	6,239
2.3.2 1-4 years	63,372	60,676	13,590	12,852
2.3.3 5-9 years	70,151	67,701	16,755	15,921
2.3.4 10-14 years	66,034	63,806	17,149	16,460
2.3.5 15-19 years	64,598	63,011	17,365	16,813
2.3.6 20-24 years	64,273	73,873	9,108	10,255
2.3.20 Total	937,954	976,832	215,940	230,920
Cumulative Total	1,914,786		446,860	
65 Years + Ratio	5.28 %		7.35 %	
Average Age per Beneficiary	31.26		34.20	

Please provide the reasons, should the total males or females be zero for any option: [Click here](#)

The scheme should capture the number of beneficiaries as at 31 December per age band in this section. It is important to note that the age of the beneficiary should be calculated as at 1 January of the financial year concerned. This information should be provided on an option level, and should be split between male and female beneficiaries.

The consolidated number of beneficiaries as well as the number of beneficiaries per option should validate to the number of beneficiaries captured in part 2.1.

65 years + ratio

The system automatically calculates the number of beneficiaries older than 65 years as a percentage of the total beneficiaries. This is done on a consolidated as well as option level.

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Average age per beneficiary

The system automatically calculates the average age per beneficiary for the scheme as well as the individual options.

Reason boxes

The following reason box must be completed when specifications are met:

- Please provide the reasons, should the total males or females be zero for any option.

Part 2.4.1 Member Movement

The screenshot shows the 'Statutory Returns Portal - CMS Annual Section' in a Windows Internet Explorer browser. The page displays the CMS logo and navigation links. The main content area is titled 'PART 2.4.1: MEMBER MOVEMENT' and contains a table with the following data:

	Number of New Members Joining the Scheme			Number of New Dependants Joining the Scheme	Number of Members Leaving the Scheme	Number of Dependants Leaving the Scheme
	Number of Members Transferring from Other Schemes	Number of Members Not Transferring from Other Schemes	Total			
2.4.1.1 January	0	0	0	0	60,156	0
2.4.1.2 February	6,130	5,711	11,841	13,311	7,905	11,923
2.4.1.3 March	6,807	6,297	13,104	14,994	8,235	12,339
2.4.1.4 April	3,473	3,491	6,964	8,035	7,053	10,006
2.4.1.5 May	5,764	5,691	11,455	14,014	7,216	10,267
2.4.1.6 June	6,772	7,527	14,299	16,739	7,474	10,664
2.4.1.13 Total	61,504	64,966	126,470	152,318	148,723	130,065

The bottom of the screen shows the taskbar with the Windows logo, several application icons, and the system clock displaying '10:22 AM 2011/02/18'.

The scheme should complete the number of members transferring from other schemes as well as the number of members not transferring from other schemes (new entries into the medical scheme environment), per month in this part. The number of dependants joining the scheme should also be completed per month.



The number of members and dependants leaving the scheme should also be completed per month.

It should be noted that the net monthly movement in the beneficiaries in this part should agree with the movement in beneficiaries per month, as completed in part 2.2 of the return.

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Part 2.4.2 Age Analysis of Member Movement as at the End of the Financial Year

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http://cmsuat01/returns/annual.aspx?p=2&d=5

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PART 2.4.2: AGE ANALYSIS OF MEMBER MOVEMENT FOR THE FINANCIAL YEAR

		Number of New Members Joining the Scheme	Number of New Dependants Joining the Scheme	Number of Members Leaving the Scheme	Number of Dependants Leaving the Scheme
2.4.2.1	Less than one year	7	23,294	4	7,931
2.4.2.2	1-4 years	5	17,216	4	15,571
2.4.2.3	5-9 years	13	17,183	6	16,097
2.4.2.4	10-14 years	30	15,006	15	14,213
2.4.2.5	15-19 years	1,916	13,009	578	13,549
2.4.2.6	20-24 years	23,879	19,887	10,710	3,831
2.4.2.20	Total	126,470	152,318	148,723	130,065

Please provide the reasons for inclusion of members in the category: Less than one year [Click here](#)

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The scheme should complete the number of new members and dependants joining the scheme as well as the number of members and dependants leaving the scheme per age band.

Important to note that the age of the beneficiary should be calculated as at 1 January of the financial year concerned.

The total number of members and dependants joining the scheme should agree with the number of members and dependants joining the scheme as captured in part 2.4.1. The same applies for the number of members and dependants leaving the scheme.



The scheme should note the reasons in the event that there were members for the age groups less than one year who joined or left the scheme as they are usually considered to be dependants on a scheme.

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Part 2.5 Waiting Periods

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PART 2.5: WAITING PERIODS

	Number of New Beneficiaries to whom General Waiting Periods were Imposed		Number of New Beneficiaries to whom Pre-existing Condition Exclusions were Imposed		Number of New Beneficiaries to whom Late Joiner Penalties were Imposed	
	New Beneficiaries	Transferred Beneficiaries	New Beneficiaries	Transferred Beneficiaries	New Beneficiaries	Transferred Beneficiaries
2.5.1 Less than one year	35	3	27	6	0	0
2.5.2 1-4 years	133	25	87	5	0	0
2.5.3 5-9 years	264	32	91	3	0	0
2.5.4 10-14 years	269	26	93	1	0	0
2.5.5 15-19 years	324	42	91	1	0	0
2.5.20 Total	4,589	660	3,971	160	2,550	159

Please provide reasons why no general waiting periods were imposed:

Scheme: (MMED) Financial Year: (2010)

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The scheme should complete the number of beneficiaries, per age band (new beneficiaries that entered the medical schemes environment as well as new beneficiaries transferred from other medical schemes) to whom the following were imposed:

- General waiting periods
- Pre-existing condition exclusions
- Late joiner penalties

Important to note that the age of the beneficiary should be calculated as at 1 January of the financial year concerned.

Reason boxes

The following reason boxes must be completed when specification are met:

- Please provide reasons why no general waiting periods were imposed;

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- Please provide reasons why no pre-existing condition exclusions were imposed; and
- Please provide reasons why no late joiner penalties were imposed.

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Part 2.6 Utilisation

		Current year	Previous year (LOCKED)
2.6.1 Primary and emergency care services:			
2.6.1.1	Number of beneficiaries visiting GP's at least once a year	1,874,562	1,348,930
2.6.1.2	Total number of visits to GP's	2,345,678	4,874,068
2.6.1.3	Number of beneficiaries visiting dentists at least once a year	894,561	556,297
2.6.1.4	Total number of visits to dentists	924,562	1,212,740
2.6.1.5	Number of beneficiaries visiting private nurses at least once a year	24,561	23,091
2.6.1.6	Total number of visits to private nurses	52,456	73,187
2.6.1.7	Number of beneficiaries enrolled in primary care networks	256,789	143,481
2.6.2 Private Hospitals: Beneficiaries			
2.6.2.1	Number of beneficiaries admitted	453,254	330,841
2.6.2.2	Number of hospital admissions	789,456	46,789
2.6.2.3	Number of same-day admissions	1,245,678	445,778
2.6.2.4	Number of total admissions	2,035,134	492,567
2.6.2.5	Number of beneficiaries admitted for Prescribed Minimum Benefits	423,789	184,354
2.6.2.6	Number of beneficiaries admitted at Day clinics/ unattached operating theatres (disciplines 76 and 77)	23,789	21,765
2.6.2.7	Number of beneficiaries receiving MRI scans	8,756	6,227
2.6.2.8	Number of MRI scans administered	10,123	6,407
2.6.2.9	Number of beneficiaries receiving CT scans	500	1,620

The previous year's figures are automatically pulled through from the previous year's return. The "Unlock previous year figures" button allows the scheme to make adjustments to these figures if needs be. In the event that the scheme had to make any adjustments to the previous year's figures, the details and/or reasons for the changes needs to be provided in the reason box.

It is important to note that the scheme is required to provide data on the number of admissions to ICU, High Care, General Ward, Emergency Unit and Renal Dialysis, and not the number of beneficiaries admitted to ICU, High Care, General Ward and Renal Dialysis.

2.6.1.1 Refers to the number of beneficiaries visiting GP's at least once a year e.g. should the scheme have 6 000 beneficiaries and only 4 000 beneficiaries visited the GP at least once during the year, then 4 000 should be included in part 2.6.1.1.



However, taken from the above example, should those 4 000 beneficiaries visited the GP 3 times each during the year, then 12 000 visits should be recorded in part 2.6.1.2.

On part 2.6.1 the number of beneficiaries visiting at least once a year should be smaller than or equal to the (total number of beneficiaries registered as at 31 December OR average numbers of beneficiaries as at 31 December). The number of beneficiaries visiting at least once a year should be smaller than or equal to the total number of visits.

On both parts 2.6.2 and 2.6.3 the number of beneficiaries receiving administrations should be smaller than or equal to the (total number of beneficiaries registered as at 31 December OR average numbers of beneficiaries as at 31 December). The number of beneficiaries receiving administrations should be smaller than or equal to the number of administrations.

Please note that part 2.6.2 refers to utilisation both in-hospital and out-of-hospital.

Number of beneficiaries admitted refers to the total number of people who were admitted / hospitalised. Thus, number of beneficiaries admitted would refer to the number of individuals belonging to a medical scheme who were admitted at a private or state hospital. Number of admissions refers to the total number of times that a specific individual was admitted/ hospitalised. Hospital admissions = admission with overnight stay (lasting 24 hours or more). Same-day admissions = (e.g. same-day procedures, lasting less than 24 hours). Total number of admissions = same-day admissions + admissions.

Please note, both the number of beneficiaries admitted and the number of admissions are also used to “estimate” the admissions per beneficiary. For example, 12 beneficiaries admitted and 24 admissions would translate to 2 admissions per beneficiary per year

The number of births as per parts 2.6.2.12 and 2.6.3.11 includes both live – and still births.

On both parts 2.6.2 and 2.6.3, the following should hold:

- Number of pregnancies should be smaller or equal the number of female beneficiaries belonging to a medical scheme;
- If number of births is > 0 then number of pregnancies should not be equal to zero; and
- Number of births to women between 12 and 18 years should be smaller than number of births

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Please note, both the number of pregnancies and the number of births are also used to "estimate" the number of births per female beneficiary per year.

The number of deaths (2.6.2.18 and 2.6.3.17) only relates to deaths of people under treatment.

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Part 2.7 Number of Beneficiaries Suffering From the Following Chronic Diseases

Please note that the Office regards the information provided in this part as confidential, and will not distribute it to the public.

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PART 2.7: NUMBER OF BENEFICIARIES WITH THE FOLLOWING CHRONIC DISEASES

Unlock	Name of disease	Consolidated Previous Year	Consolidated Current Year	Per Benefit Option OPTION A	
				Previous Year	Current Year
2.7.1	Addison's Disease	240	0	110	0
2.7.2	Asthma	55,533	0	20,443	0
2.7.3	Bipolar Mood Disorder	7,055	0	3,649	0
2.7.4	Bronchiectasis	218	0	108	0
2.7.5	Cardiac Failure	9,057	0	3,329	0
2.7.6	Cardiomyopathy Disease	2,186	0	831	0
2.7.7	Chronic Obstructive Pulmonary Disease	6,108	0	2,734	0

Please provide the reasons for any changes made to the prior year data: [Click here](#)

The previous year's figures are automatically pulled through from the previous year's return. The "Unlock previous year figures" button allows the scheme to make adjustments to these figures if needs be. In the event that the scheme had to make any adjustments to the previous year's figures, the details and/or reasons for the changes needs to be provided in the reason box.

The prevalence of persons with the listed chronic conditions is required. Every beneficiary who has any of the listed chronic conditions in the financial year (January - December) must be counted.

For beneficiaries with multiple conditions - each condition must be counted separately.



REF entry and verification criteria must not be used for the Annual Statutory Return data submission as these two datasets are collected for fundamentally different purposes. DO NOT supply REF count data as this will be verified and subsequently rejected. The objective of Part 2.7 is to measure the burden of the disease whereas the REF data would reflect the highest cost of chronic disease.

ICD-10 codes should be used to identify the prevalence of these conditions. (NAPPI and other codes should never be used). Valid ICD-10 codes to be used are shown in Table 1.

The number of beneficiaries with a chronic condition should be less than or equal to the total number of beneficiaries in a scheme as at 31 December OR Average number of beneficiaries as at 31 December.

Please note that blanks or missing numbers will not be accepted.

Table 1: ICD-10 codes for the identification of persons with chronic conditions

Disease	ICD-10 code
Addison's Disease	E27.1
Asthma	J45.0 J45.1 J45.8 J45.9 J46
Bipolar mood disorder	F31.0 F31.1 F31.2 F31.3 F31.4 F31.5 F31.6



Disease	ICD-10 code
	F31.7 F31.8 F31.9
Bronchiectasis	J47 Q33.4
Cardiac failure	I50.0 I50.1 I50.9 I11.0 I13.0 I13.2
Cardiomyopathy	I42.0 - I42.9 I25.5
Chronic Renal Disease	N03.0 - N03.9 N11.0 N11.1 N11.8 N11.9 N18.0 N18.8 N18.9 I12.0 I13.1 I13.2



Disease	ICD-10 code
	O10.2 O10.3
Chronic Obstructive Pulmonary Disease	J43.0 J43.1 J43.2 J43.8 J43.9 J44.0 J44.1 J44.8 J44.9
Coronary Artery Disease	I20.0 I20.1 I20.8 I20.9 I25.0 I25.1 I25.2 I25.3 I25.4 I25.5 I25.6 I25.8 I25.9
Crohn's Disease	K50.0



Disease	ICD-10 code
	K50.1 K50.8 K50.9
Diabetes Insipidus	E23.2
Diabetes Mellitus Type 1	E10.0 E10.1 E10.2†N08.3* E10.3†H28.0* E10.3†H36.0* E10.4†G73.0* E10.4†G99.0* E10.4†G59.0* E10.4†G63.2* E10.5 E10.5†I79.2* E10.6 E10.6†M14.2* E10.6†M14.6* E10.7 E10.8 E10.9 E12.0 E12.1 E12.2†N08.3*



Disease	ICD-10 code
	E12.3†H28.0* E12.3†H36.0* E12.4†G73.0* E12.4†G99.0* E12.4†G59.0* E12.4†G63.2* E12.5 E12.5†I79.2* E12.6 E12.6†M14.2* E12.6†M14.6* E12.7 E12.8 E12.9 O24.0 O24.2 O24.3
Diabetes Mellitus Type 2	E11.0 E11.1 E11.2†N08.3* E11.3†H28.0* E11.3†H36.0* E11.4†G73.0* E11.4†G99.0* E11.4†G59.0*



Disease	ICD-10 code
	E11.4†G63.2*
	E11.5
	E11.5†I79.2*
	E11.6
	E11.6†M14.2*
	E11.6†M14.6*
	E11.7
	E11.8
	E11.9
	E12.0
	E12.1
	E12.2†N08.3*
	E12.3†H28.0*
	E12.3†H36.0*
	E12.4†G73.0*
	E12.4†G99.0*
	E12.4†G59.0*
	E12.4†G63.2*
	E12.5
	E12.5†I79.2*
	E12.6
	E12.6†M14.2*
	E12.6†M14.6*
	E12.7
	E12.8



Disease	ICD-10 code
	E12.9 O24.1 O24.2 O24.3
Dysrhythmias	I47.2 I48
Epilepsy	G40.0 - G40.9 G41.0 G41.1 G41.2 G41.8 G41.9
Glaucoma	H40.0 H40.1 H40.2 H40.3 H40.4 H40.5 H40.6 H40.8 H40.9 Q15.0
Haemophilia	D66 D67
Hyperlipidaemia	E78.0



Disease	ICD-10 code
	E78.1 - E78.5
Hypertension	I10 I11.0 I11.9 I12.0 I12.9 I13.0 I13.1 I13.2 I13.9 I15.0 I15.1 I15.2 I15.8 I15.9 O10.0 O10.1 O10.2 O10.3 O10.4 O10.9 O11
Hypothyroidism	E01.8 E02 E03.0



Disease	ICD-10 code	
	E03.1	
	E03.2	
	E03.3	
	E03.4	
	E03.5	
	E03.8	
	E03.9	
	E89.0	
Multiple Sclerosis	G35	
Parkinson's disease	G20	
	G21.0	
	G21.1	
	G21.2	
	G21.3	
	G21.8	
	G21.9	
Rheumatoid Arthritis	M05.00	M05.38†I52.8*
	M05.01	M05.38†I39.0*
	M05.02	M05.38†I39.1*
	M05.03	M05.38†I39.2*
	M05.04	M05.38†I39.3*
	M05.05	M05.38†I39.4*
	M05.06	M05.38†I39.8*
	M05.07	M05.38†I41.8*
	M05.08	M05.38†G73.7*



Disease	ICD-10 code	
	M05.09	M05.38†I32.8*
	M05.10†J99.0*	M05.38†G63.6*
	M05.11†J99.0*	M05.39†I52.8*
	M05.12†J99.0*	M05.39†I39.0*
	M05.13†J99.0*	M05.39†I39.1*
	M05.14†J99.0*	M05.39†I39.2*
	M05.15†J99.0*	M05.39†I39.3*
	M05.16†J99.0*	M05.39†I39.4*
	M05.17†J99.0*	M05.39†I39.8*
	M05.18†J99.0*	M05.39†I41.8*
	M05.19†J99.0*	M05.39†G73.7*
	M05.20	M05.39†I32.8*
	M05.21	M05.39†G63.6*
	M05.22	M05.80
	M05.23	M05.81
	M05.24	M05.82
	M05.25	M05.83
	M05.26	M05.84
	M05.27	M05.85
	M05.28	M05.86
	M05.29	M05.87
	M05.30†I52.8*	M05.88
	M05.30†I39.0*	M05.89
	M05.30†I39.1*	M05.90
	M05.30†I39.2*	M05.91



Disease	ICD-10 code	
	M05.30†I39.3*	M05.92
	M05.30†I39.4*	M05.93
	M05.30†I39.8*	M05.94
	M05.30†I41.8*	M05.95
	M05.30†G73.7*	M05.96
	M05.30†I32.8*	M05.97
	M05.30†G63.6*	M05.98
	M05.31†I52.8*	M05.99
	M05.31†I39.0*	M06.00
	M05.31†I39.1*	M06.01
	M05.31†I39.2*	M06.02
	M05.31†I39.3*	M06.03
	M05.31†I39.4*	M06.04
	M05.31†I39.8*	M06.05
	M05.31†I41.8*	M06.06
	M05.31†G73.7*	M06.07
	M05.31†I32.8*	M06.08
	M05.31†G63.6*	M06.09
	M05.32†I52.8*	M06.10
	M05.32†I39.0*	M06.11
	M05.32†I39.1*	M06.12
	M05.32†I39.2*	M06.13
	M05.32†I39.3*	M06.14
	M05.32†I39.4*	M06.15
	M05.32†I39.8*	M06.16



Disease	ICD-10 code
	M05.32†I41.8* M06.17
	M05.32†G73.7* M06.18
	M05.32†I32.8* M06.19
	M05.32†G63.6* M06.20
	M05.33† I52.8* M06.21
	M05.33†I39.0* M06.22
	M05.33†I39.1* M06.23
	M05.33†I39.2* M06.24
	M05.33†I39.3* M06.25
	M05.33†I39.4* M06.26
	M05.33†I39.8* M06.27
	M05.33†I41.8* M06.28
	M05.33†G73.7* M06.29
	M05.33†I32.8* M06.30
	M05.33†G63.6* M06.31
	M05.34†I52.8* M06.32
	M05.34†I39.0* M06.33
	M05.34†I39.1* M06.34
	M05.34†I39.2* M06.35
	M05.34†I39.3* M06.36
	M05.34†I39.4* M06.37
	M05.34†I39.8* M06.38
	M05.34†I41.8* M06.39
	M05.34†G73.7* M06.40
	M05.34†I32.8* M06.41



Disease	ICD-10 code	
	M05.34†G63.6*	M06.42
	M05.35†I52.8*	M06.43
	M05.35†I39.0*	M06.44
	M05.35†I39.1*	M06.45
	M05.35†I39.2*	M06.46
	M05.35†I39.3*	M06.47
	M05.35†I39.4*	M06.48
	M05.35†I39.8*	M06.49
	M05.35†I41.8*	M06.80
	M05.35†G73.7*	M06.81
	M05.35†I32.8*	M06.82
	M05.35†G63.6*	M06.83
	M05.36† I52.8*	M06.84
	M05.36†I39.0*	M06.85
	M05.36†I39.1*	M06.86
	M05.36†39.2*	M06.87
	M05.36†I39.3*	M06.88
	M05.36†I39.4*	M06.89
	M05.36†I39.8*	M06.90
	M05.36†I41.8*	M06.91
	M05.36†G73.7*	M06.92
	M05.36†I32.8*	M06.93
	M05.36†G63.6*	M06.94
	M05.37†I52.8*	M06.95
	M05.37†I39.0*	M06.96



Disease	ICD-10 code
	M05.37†I39.1* M06.97
	M05.37†I39.2* M06.98
	M05.37†I39.3* M06.99
	M05.37†I39.4* M08.00
	M05.37†I39.8* M08.01
	M05.37†I41.8* M08.02
	M05.37†G73.7* M08.03
	M05.37†I32.8* M08.04
	M05.37†G63.6* M08.05
	M08.06
	M08.07
	M08.08
	M08.09
Schizophrenia	F20.0
	F20.1
	F20.2
	F20.3
	F20.4
	F20.5
	F20.6
	F20.8
	F20.9
Systemic Lupus Erythematosus	M32.0
	M32.1†I32.8*
	M32.1†I39.0*



Disease	ICD-10 code
	M32.1†I39.1* M32.1†I39.2* M32.1†I39.3* M32.1†I39.4* M32.1†I39.8* M32.1†N08.5* M32.1†N16.4* M32.1†J99.1* M32.8 M32.9 L93.0 L93.1 L93.2
Ulcerative colitis	K51.0 K51.1 - K51.5 K51.8 K51.9

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Part 2.8 Analysis of Utilisation of Services by Specialists

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PART 2.8: UTILISATION OF SERVICES BY MEDICAL AND DENTAL SPECIALISTS

Health Professional (BHF PCNS Discipline code)	Total Number of Visits to Specialists	Number of Beneficiaries Visiting at Least Once Per Year
Medical Specialists:		
2.8.1 Dermatologists (12)	125,843	83,668
2.8.2 Obstetricians & Gynaecologists (16)	470,862	198,246
2.8.3 Pulmonologists (17)	44,895	12,904
2.8.4 Specialist Physicians (18)	4,524,810	111,466
2.8.5 Gastroenterologists (19)	36,095	15,122
2.8.6 Neurologists (20)	68,232	27,184
2.8.7 Cardiologists (21)	107,171	45,111
2.8.8 Psychiatrists (22)	161,188	40,025
2.8.9 Medical Oncologists (23)	24,502	4,273
2.8.10 Neurosurgeons (24)	59,620	22,573

Scheme: (MMED) Financial Year: (2010)

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Both the number of visits to specialists as well as the number of beneficiaries who visited a specialist at least once in the financial year concerned should be completed in this part.

Should any specialist not be included in the list provided, the scheme should complete the required information in the 'other' box provided in part 2.8.28, and specify the specific specialist. The scheme must please ensure that only specialists not referred to elsewhere in this applicable part are listed in part 2.8.28.

The variable "Other Medical or Clinical Support Specialists" should never be used when a pre-defined category exists. In cases where "Other Medical or Clinical Support Specialists" is used as a "dumping ground", the Annual Statutory Return will be rejected and returned to the Principal Officer for correction and re-submission

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The number of beneficiaries visiting at least once per year should be smaller than or equal to (the total number of beneficiaries in scheme as at 31 December OR average numbers of beneficiaries as at 31st December).

The number of beneficiaries visiting at least once per year should be smaller than or equal to the total number of visits to specialists.

The number of beneficiaries visiting at least once per year and the total number of visits to specialists should not be equal to zero (i.e. zeros and blanks will not be accepted).

Part 2.9 Analysis of Utilisation of Services by Allied and Support Health Professionals

Health Professional (BHF PCNS Discipline code)	Total Number of Visits to Supplementary and Allied Health Professionals	Number of Beneficiaries Visiting at Least Once Per Year
2.9.1 Art Therapists (67)	11,290	120
2.9.2 Audiologists (82)	149,477	28,162
2.9.3 Biokineticists (75-009)	132,944	16,141
2.9.4 Clinical / Medical / Laboratory Technologists (75)	92,832	27,675
2.9.5 Dieticians (84)	70,699	24,722
2.9.6 Hearing Aid Acousticians (83)	2,087	1,714
2.9.7 Medical Scientists (69)	158	113
2.9.8 Occupational Therapists (66)	176,322	17,124
2.9.9 Optometrists (70)	472,341	346,971
2.9.10 Orthodontists (78)	686	380

The number of visits to Supplementary and Allied Health Professionals as well as the number of beneficiaries who visited Supplementary and Allied Health Professionals at least once in the financial year concerned should be completed in this part.



The number of beneficiaries visiting at least once per year should be smaller than or equal to the (total number of beneficiaries in scheme as at 31 December OR average numbers of beneficiaries as at 31st December). The number of beneficiaries visiting at least once per year should also be smaller than or equal to the total number of visits to Supplementary and Allied Health Professionals, but not equal to zero (i.e. zeros and blanks will not be accepted). The total number of visits to Supplementary and Allied Health Professionals should also not equal zero (i.e. zeros and blanks will not be accepted).

Should any Supplementary and Allied Health Professionals not be included in the list provided, the scheme should complete the required information in the 'other' box provided in part 2.9.25, and specify the specific Supplementary and Allied Health Professionals. The scheme must please ensure that only Supplementary and Allied Health Professionals not referred to elsewhere in this applicable part are listed in part 2.9.25.

The variable Other Supplementary and Allied Health Professionals should never be used when a pre-defined category exists. In cases where Other Supplementary and Allied Health Professionals is used as a "dumping ground", the Annual Statutory Return will be rejected and returned to the Principal Officer for correction and re-submission.

Part 2.10 Analysis of Utilisation of Other Benefit Services

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PART 2.10: UTILISATION OF OTHER BENEFIT SERVICES

Benefit Service (BHF PCNS Discipline Code)	Total Number of Claims from Beneficiaries	Number of Beneficiaries who Submitted at Least One Claim
2.10.1 Ambulance Services - Basic Life Support (13)	204	183
2.10.2 Ambulance Services - Intermediate Life Support (11)	1,096	984
2.10.3 Ambulance Services - Advanced Life Support (09)	28,111	23,059
2.10.4 Blood and Blood Product Couriers (03)	529	282
2.10.5 Blood Transfusion Services (78)	30,068	14,571
2.10.6 Clinical Services - Oxygen Supplier (90-001)	12,559	2,875
2.10.7 Clinical Services - Appliance Supplier (90-002/007/013/014)	2,757	1,396
2.10.8 Clinical Services - Prosthetic Supplier (90-003/004/005/006)	778	608
2.10.9 Clinical Services - Other (90-008/009/010/011/012)	62,128	36,753
2.10.10 Community Health Services (97)	61	31
2.10.11 Drug and Alcohol Rehabilitation (47)	2,384	1,213
2.10.12 Group Practice (50)	88,459	26,030
2.10.13 Hospice (79)	3,816	942
2.10.14 Mental Health Institutions (55)	8,560	3,402
2.10.15 Sub Acute Facilities/Step Down Facilities (49)	3,128	2,234
2.10.16 Private Rehabilitation Hospital (Acute) (059)	856	1,950,000
2.10.17 Prosthetic Supplier (58, 57, 77)	1,234	1,950,000

The number of claims from beneficiaries for the other benefit services listed as well as the number of beneficiaries who submitted at least one claim during the financial year concerned should be completed in this part.

The number of beneficiaries who submitted at least one claim should be smaller than or equal to the (total number of beneficiaries in scheme as at 31 December OR average numbers of beneficiaries as at 31st December). The number of beneficiaries who submitted at least one claim should be smaller than or equal to the total number of claims from beneficiaries, but not equal to zero (i.e. zeros and blanks will not be accepted). The total number of claims from beneficiaries should not be equal to zero (i.e. zeros and blanks will not be accepted).

Should any specific benefit not be included in the list provided, the scheme should complete the required information in the 'other' box provided in part 2.10.16, and specify the specific benefit service. The scheme must please ensure that only benefit services not referred to elsewhere in this applicable part are listed in part 2.10.16.

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The variable Other Benefit Services should never be used when a pre-defined category exists. In cases where Other Benefit Services is used as a “dumping ground”, the Annual Statutory Return will be rejected and returned to the Principle Officer for correction and re-submission.

Part 2.11 Analysis of Utilisation of Medicines

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PART 2.11: UTILISATION OF MEDICINES

	Total Number of Scripts Filled	Total Number of Items Dispensed
2.11.1 In Hospital:		
2.11.1.1 Medicines dispensed by Pharmacists	0	0
2.11.1.2 Medicines dispensed by General Practitioners	0	0
2.11.1.3 Medicines dispensed by Medical Specialists	0	0
2.11.1.4 Medicines dispensed by Supplementary and Allied Health Professionals	0	0
2.11.1.5 Medicines dispensed by Other Health Professionals	0	0
2.11.2 Out of Hospital:		
2.11.2.1 Medicines dispensed by Pharmacists	11,911,745	224,719,869
2.11.2.2 Medicines dispensed by General Practitioners	937,481	2,526,973
2.11.2.3 Medicines dispensed by Medical Specialists	21,566	33,151
2.11.2.4 Medicines dispensed by Supplementary and Allied Health Professionals	33,843	59,383
2.11.2.5 Medicines dispensed by Other Health Professionals	12,049	14,473

Scheme: (MMED) Financial Year: (2010)

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Part 2.11 requires the total number of scripts filled and the total number of items dispensed in-hospital and out-of-hospital by various categories of health professionals.

The total number of scripts filled and the total number of items dispensed should not be equal to zero OR left blank (i.e. blanks and zeros will not be accepted).

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Part 2.12 Distribution of Membership at End of Financial Year

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http://cmsuat01/returns/annual.aspx?p=2&d=13

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PART 2.12: DISTRIBUTION OF MEMBERSHIP AT THE END OF THE FINANCIAL YEAR

	Province	Members	Adult Dependants	Child Dependants	Beneficiaries
2.12.1	Gauteng	406,063	223,676	281,732	911,471
2.12.2	Limpopo	11,963	7,824	9,762	29,539
2.12.3	Mpumalanga	32,347	20,807	25,491	78,645
2.12.4	North West	28,146	17,680	22,697	68,523
2.12.5	Free State	25,630	15,505	17,465	58,600
2.12.6	Kwa-Zulu Natal	115,777	71,125	85,557	272,459
2.12.11	Total	837,707	490,406	586,671	1,914,784

Please indicate how the scheme is collecting the data for this part:

	Members	Adult Dependants	Child Dependants
Private Postal Address			

Scheme: (MMED) Financial Year: (2010)

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The number of members, adult dependants and child dependants per province should be completed in this part. Beneficiaries are the sum of members and dependants.

The total number of members and dependants in this part should agree with the consolidated total number of members and dependants in part 2.1.

This information is normally collected from the following sources:

- Private Postal Address
- Business Postal Address
- Employer (Pay Point)



In the event that the information is collected from other sources than the above-mentioned sources, the scheme would be required to provide more detail.

The Office would prefer this part to illustrate the distribution of members based on where services are delivered to the beneficiaries.

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Part 2.13 Utilisation of Private Hospitals by Age Group and Gender

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
2.13.1	Female			
2.13.1.1	Less than one year	6,239	7,000	7,100
2.13.1.2	1-4 years	12,852	13,900	14,000
2.13.1.3	5-9 years	15,921	17,212	18,000
2.13.1.4	10-14 years	16,460	16,951	21,000
2.13.1.5	15-19 years	16,813	21,543	25,000
2.13.1.6	20-24 years	10,255	16,542	16,999
2.13.1.7	25-29 years	12,283	16,542	16,999
2.13.1.8	30-34 years	20,574	30,245	30,999
2.13.1.9	35-39 years	22,130	27,564	28,600
2.13.1.10	40-44 years	19,841	26,542	26,542

The number of beneficiaries admitted to private hospitals, the number of admissions to private hospitals as well as the number of days admitted during the financial year concerned should be completed in this part.

The number of beneficiaries admitted to private hospitals should be smaller than or equal to the (total number of beneficiaries in scheme as at 31 December OR average numbers of beneficiaries as at 31st December). The number of beneficiaries admitted to private hospitals should be smaller than or equal to the total number of admissions to private hospitals but not equal to zero (i.e. zeros and blanks will not be accepted).

The number of admissions to private hospitals should be smaller than or equal to the number of days admitted. Both the number of admissions and the number of days admitted should not be equal to zero (i.e. zeros and blanks will not be accepted)

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Part 2.14 Utilisation of Public Hospitals by Age Group and Gender

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PART 2.14: UTILISATION OF PUBLIC HOSPITALS BY AGE GROUP AND GENDER

	Age group	Number of beneficiaries admitted	Number of admissions	Number of days
2.14.1	Female			
2.14.1.1	Less than one year	6,239	7,000	7,100
2.14.1.2	1-4 years	12,852	13,900	14,000
2.14.1.3	5-9 years	15,921	17,212	18,000
2.14.1.4	10-14 years	16,460	16,951	21,000
2.14.1.5	15-19 years	16,813	21,543	25,000
2.14.1.6	20-24 years	10,255	16,453	17,000
2.14.1.7	25-29 years	12,283	16,542	16,999
2.14.1.8	30-34 years	20,574	30,245	30,999
2.14.1.9	35-39 years	22,130	27,564	28,600
2.14.1.10	40-44 years	19,841	26,542	26,542

Scheme: (MMED) Financial Year: (2010)

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The number of beneficiaries admitted to public hospitals, the number of admissions to public hospitals as well as the number of days admitted during the financial year concerned should be completed in this part.

The number of beneficiaries admitted to public hospitals should be smaller than or equal to the (total number of beneficiaries in scheme as at 31 December OR average numbers of beneficiaries as at 31st December). The number of beneficiaries admitted to public hospitals should be smaller than or equal to the total number of admissions to public hospitals, but not equal to zero (i.e. zeros and blanks will not be accepted).

The number of admissions to public hospitals should be smaller than or equal to the number of days admitted. Both the number of admissions and the number of days admitted should not be equal to zero (i.e. zeros and blanks will not be accepted)



Part 2.15 Utilisation of Hospitals in respect of Selected Principal Diagnosis Types per ICD10 Codes

	ICD10 codes	Principal diagnosis	Number of beneficiaries admitted	Number of admissions	Number of days
2.15.1	A00–E99	Certain infectious and parasitic diseases	456	1,000	1,000
2.15.2	C00–D48	Neoplasms	780,321	879,412	900,000
2.15.3	D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	12,340	65,469	70,000
2.15.4	E00–E90	Endocrine, nutritional and metabolic diseases	123,545	657,891	700,000
2.15.5	F00–F99	Mental and behavioural disorders	123,456	234,561	300,000
2.15.6	G00–G99	Diseases of the nervous system	45,641	50,000	60,000
2.15.7	H00–H59	Diseases of the eye and adnexa	1,234	2,000	3,000
2.15.8	H60–H95	Diseases of the ear and mastoid process	4,189	5,000	5,000

The number of beneficiaries admitted to in respect of the selected principal diagnosis types per ICD10 codes, the number of admissions in respect of these selected principal diagnosis types per ICD10 codes, as well as the relevant number of days admitted during the financial year concerned should be completed in this part.

The number of beneficiaries admitted in respect of the selected principal diagnosis types per ICD10 codes should be smaller than or equal to the (total number of beneficiaries in scheme as at 31 December OR average numbers of beneficiaries as at 31st December). The number of beneficiaries admitted should be smaller than or equal to the total relevant number of admissions, but not equal to zero (i.e. zeros and blanks will not be accepted).

The number of admissions in respect of the selected principal diagnosis types per ICD10 codes should be smaller than or equal to the number of days admitted. Both the number of admissions and the number of days admitted should not be equal to zero (i.e. zeros and blanks will not be accepted).

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PART 3 BENEFIT INFORMATION

Part 3.1 Analysis of Benefits Actually Paid During the Financial Year

The screenshot shows a web browser window with the URL <http://cmsuat01/returns/annual.aspx?p=3>. The page displays the CMS Council for Medical Schemes logo and navigation links. The main content area shows the 'Part 3.1: ANALYSIS OF BENEFITS ACTUALLY PAID DURING THE FINANCIAL YEAR' table. The table has six columns: 'Total amount charged by supplier', 'Risk amount paid by scheme', 'Savings amount paid by scheme on behalf of member', 'Amount paid by member', and 'Discount received'. Each column has a sub-column for 'R' (Rands). The table lists various medical professionals and hospitals, with their respective financial data for the financial year.

		Total amount charged by supplier R	Risk amount paid by scheme R	Savings amount paid by scheme on behalf of member R	Amount paid by member R	Discount received R
3.1.1	General Practitioners	1,187,653,240	483,894,239	404,399,748	299,359,253	0
3.1.2	Medical Specialists	4,672,665,663	2,756,690,003	784,878,098	1,131,097,558	0
3.1.3	Dentists	968,641,168	195,671,312	428,501,392	344,468,464	0
3.1.4	Dental Specialists	304,966,957	83,220,190	85,341,872	136,404,895	0
3.1.5	Supplementary and Allied Health Professionals	1,777,165,769	656,324,675	654,727,206	466,113,885	0
3.1.6	Hospitals					
3.1.6.1	Unattached Operating Theatres/ Day Clinics					
3.1.6.1.1	Ward Fees	12,888,658	9,171,760	2,185,235	1,531,663	0

Amounts charged by supplier must always be bigger or equal to the aggregate risk amounts paid by the scheme, amounts paid from the savings accounts as well as amounts paid by the member.

The risk amount paid by the scheme must reflect the net benefit after deduction of trade-, volume- and cash discount received.

It should be noted that part 3.1.11 (risk amount paid by the scheme column) should agree with the total benefits in part 4.11.5 (actual net claims paid and reported) (Column B) plus 4.13.1(consolidated total current year column).

The amount paid by the member are all the out of pocket expenses incurred by the member which are known to the administrator.

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The scheme should capture any in-hospital managed care arrangements which are not provided for in the return in part 3.1.6.2.2.5, and any out-of-hospital managed care arrangements not provided for in the return in part 3.1.10.3.

Any other benefits not provided for in part 3.1 of the return should be completed in part 3.4, which pulls through to part 3.1.9, and the scheme should specify the specific benefit. The scheme must please ensure that only benefits not referred to elsewhere in this part are listed in part 3.4.16.

The scheme should provide the exact nature of any amounts included in parts 3.1.6.1.7, 3.1.6.2.1.7, and 3.1.6.3.7 relating to other expenditure incurred in respect of unattached operating theatres/day clinics, private hospitals and state/provincial hospitals. The scheme should only complete these parts if the return does not cater specifically for that kind of transaction elsewhere in part 3.1.

Part 3.2.29 automatically pulls through to the total benefits for medical specialists (3.1.2) and part 3.2.37 automatically pulls through to the total benefits for dental specialists pull automatically (3.1.4). Part 3.3.26 automatically pulls through to total benefits to Supplementary and Allied Health Professionals (part 3.1.5).

Part 3.2 Analysis of Medical and Dental Specialists

The screenshot shows the CMS Annual Section interface in a Windows Internet Explorer browser. The page title is "Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer". The address bar shows the URL "http://cmsuat01/returns/annual.aspx?p=3&d=2". The page features a navigation menu with links for Home, Contact Us, Statutory Return, Print, Validate, Submit, Help, and LogOut. Below the navigation menu, there are buttons for Part 8, Part 9, Part 10, Part 11, Part 1, Part 2, Part 3, Part 4, Part 5, Part 6, and Part 7. The main content area displays the "PART 3.2: ANALYSIS OF MEDICAL AND DENTAL SPECIALISTS" table. The table has five columns: Medical Professional (BHF PCNS Discipline code), Total amount charged by supplier, Risk amount paid by scheme, Savings amount paid by scheme on behalf of member, and Amount paid by member. The table lists various medical specialists and their corresponding amounts. The total for dental professionals is also shown at the bottom of the table.

Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
	R	R	R	R
Medical Specialists:				
3.2.1 Dermatologists (12)	55,513,007	12,036,978	25,211,123	18,264,905
3.2.2 Obstetricians & Gynaecologists (16)	399,759,973	166,883,081	98,108,929	134,767,962
3.2.3 Pulmonologists (17)	31,342,702	19,700,338	5,736,408	5,905,956
3.2.4 Specialists Physicians (18)	216,522,039	133,257,107	31,622,791	51,642,141
3.2.5 Gastroenterologists (19)	26,684,073	14,451,917	3,463,304	8,768,852
3.2.6 Neurologists (20)	48,357,895	27,364,502	8,547,119	12,446,274
3.2.7 Cardiologists (21)	134,404,251	80,807,051	26,274,344	27,322,856
3.2.37 Total Dental Professionals	304,966,957	83,220,190	85,341,872	136,404,895

Help File: 2011 Annual Statutory Return



Amounts charged by supplier must always be bigger or equal to the aggregate risk amounts paid by the scheme, amounts paid from the savings accounts as well as amounts paid by the member. The amounts charged by supplier should include all cost (including medicine cost).

The risk amount paid by the scheme must reflect the net benefit after deduction of trade-, volume- and cash discount received.

The amount paid by the member are all the out of pocket expenses incurred by the member which are known to the administrator.

The scheme should capture any medical specialists that are not provided for in the return in part 3.2.28, and the scheme should specify the specific medical specialist. The scheme must please ensure that only medical specialists not referred to elsewhere in this part are listed in part 3.2.28.

Part 3.3 Analysis of Allied and Support Health Professionals

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

http://cmsuat01/returns/annual.aspx?p=3&d=3

Home | Contact Us | Statutory Return | Print | Validate | Submit | Help | LogOut

Part 8 | Part 9 | Part 10 | Part 11

Part 1 | Part 2 | Part 3 | Part 4 | Part 5 | Part 6 | Part 7

Part 3.1 | Part 3.2 | Part 3.3 | Part 3.4 | Part 3.5

PART 3.3: ANALYSIS OF SUPPLEMENTARY AND ALLIED HEALTH PROFESSIONALS

Medical Professional (BHF PCNS Discipline code)	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
	R	R	R	R
3.3.1 Art Therapists (67)	352,278	106,490	66,102	179,686
3.3.2 Audiologists (82)	67,377,045	25,009,324	16,921,678	25,446,043
3.3.3 Finkineticians (75-009)	25,577,489	11,578,471	6,985,084	7,008,934
3.3.4 Clinical / Medical / Laboratory Technologists (75)	131,726,556	120,999,387	2,372,930	8,354,239
3.3.5 Dieticians (84)	15,246,421	5,675,071	4,897,379	4,673,971
3.3.6 Hearing Aid Acousticians (83)	15,640,538	5,951,418	3,868,036	5,821,084
3.3.7 Medical Scientists (69)	202,466	51,801	35,516	115,149
3.3.28 Total	1,777,165.7	656,324.675	654,727.206	466,113.885

Scheme: (MMED) Financial Year: (2010)

Local intranet | Protected Mode: Off

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Amounts charged by supplier must always be bigger or equal to the aggregate risk amounts paid by the scheme, amounts paid from the savings accounts as well as amounts paid by the member.

The risk amount paid by the scheme must reflect the net benefit after deduction of trade-, volume- and cash discount received.

The amount paid by the member are all the out of pocket expenses incurred by the member which are known to the administrator.

The scheme should capture any Supplementary and Allied Health Professionals that are not provided for in the return in part 3.3.25, and the scheme should specify the specific Supplementary and Allied Health Professional. The scheme must please ensure that only Supplementary and Allied Health Professional not referred to elsewhere in this part are listed in part 3.3.25.

Part 3.4 Analysis of Other Benefits

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

http://cmsuat01/returns/annual.aspx?g=3&d=4

Home | Contact Us | Statutory Return | Print | Validate | Submit | Help | LogOut

Part 8 | Part 9 | Part 10 | Part 11 | Part 1 | Part 2 | Part 3 | Part 4 | Part 5 | Part 6 | Part 7

Part 3.1 | Part 3.2 | Part 3.3 | Part 3.4 | Part 3.5

PART 3.4: ANALYSIS OF OTHER BENEFITS

Other Benefit Services (BHF PCNS Discipline code)		Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member
		R	R	R	R
3.4.1	Ambulance Services - Basic Life Support (13)	293,028	214,727	0	78,301
3.4.2	Ambulance Services - Intermediate Life Support (11)	1,749,813	1,396,690	421	352,702
3.4.3	Ambulance Services - Advanced Life Support (09)	89,074,213	83,560,767	1,247	5,512,199
3.4.4	Blood and Blood Product Courier (03)	249,450	219,625	806	29,019
3.4.5	Blood Transfusion Services (78)	97,929,446	88,834,343	108,165	8,986,938
3.4.6	Clinical Services - Oxygen Supplier (90-001)	9,469,285	4,040,837	1,730,408	3,698,039
3.4.7	Clinical Services - Appliance Supplier (90-002/007/013/014)	17,847,469	12,938,776	1,235,665	3,673,028
3.4.17	Total	482,485,343	336,691,500	25,031,385	120,762,455

Scheme: (MMED) Financial Year: (2010)

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Amounts charged by supplier must always be bigger than or equal to the aggregate risk amounts paid by the scheme, amounts paid from the savings accounts as well as amounts paid by the member.



The risk amount paid by the scheme must reflect the net benefit after deduction of trade-, volume- and cash discount received.

The amount paid by the member are all the out of pocket expenses incurred by the member which are known to the administrator.

The scheme should capture any other benefits that are not provided for in the return in part 3.4.16, and the scheme should specify the specific benefit. The scheme must please ensure that only benefits not referred to elsewhere in this part are listed in part 3.4.16.

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Part 3.5 Analysis of Total Benefits Paid in respect of Selected Principal Diagnosis Types per ICD10 Codes

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

http://cmsuat01/returns/annual.aspx?pe=3&d=5

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Part 3.1 Part 3.2 Part 3.3 Part 3.4 Part 3.5

PART 3.5: ANALYSIS OF TOTAL BENEFITS PAID IN RESPECT OF SELECTED PRINCIPAL DIAGNOSIS TYPES PER ICD10 CODES

ICD10 codes	Principal Diagnosis	Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by Member
		R	R	R	R
3.5.1 A00-B99	Certain infectious and parasitic diseases	293,028	214,727	0	78,301
3.5.2 C00-D48	Neoplasms	1,749,813	1,396,690	421	352,702
3.5.3 D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	89,074,213	83,560,767	1,247	5,512,199
3.5.22 -	Total	1,103,734,346	720,905,473	85,813,005	296,990,863

Scheme: (MMED) Financial Year: (2010)

Local intranet | Protected Mode: Off

10:29 AM 2011/02/18

Amounts charged by supplier must always be bigger than or equal to the aggregate risk amounts paid by the scheme, amounts paid from the savings accounts as well as amounts paid by the member.

The risk amount paid by the scheme must reflect the net benefit after deduction of trade-, volume- and cash discount received.

The amount paid by the member are all the out of pocket expenses incurred by the member which are known to the administrator.

The total amount charged by the supplier in respect of the selected principal diagnosis types per ICD10 codes should not be equal to zero (i.e. zeros and blanks will not be accepted).

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PART 4 NOTES TO THE FINANCIAL STATEMENTS

Please note that when certain specifications are met, the user will be required to complete a reason box. The user will not be able to submit the return without completing the relevant reason boxes.

Part 4.1 Property, Plant and Equipment

	Total	Land and Buildings	Computer Equipment and Software	Furniture and Fittings	Motor Vehicles
	R	R	R	R	R
4.1.1 Gross Carrying Amount					
4.1.1.1 At beginning of year	9,540,000	7,990,000	500,000	20,000	1,000,000
4.1.1.1.1 - As previously reported	13,289,218	12,935,772	80,326	142,029	0
4.1.1.1.2 - Prior year adjustment	(3,749,218)	(4,945,772)	419,674	(122,029)	1,000,000
4.1.1.2 Additions	1,121,091	800,000	120,000	100,000	0
4.1.1.3 Disposals	(1,270,000)	(200,000)	(60,000)	(10,000)	(1,000,000)
4.1.1.4 Impairment write down	(102,000)	(100,000)	0	(2,000)	0
4.1.1.5 Revaluation surplus	1,000,000	1,000,000	0	0	0
4.1.1.6 Other movements (specify)	(999,873)	(554,228)	(479,674)	34,029	0
4.1.1.7 Other group balances on consolidation	4,000,000	4,000,000	0	0	0
Transfer of assets due to					

The opening balances in lines 4.1.1.1.1 and 4.1.2.1.1 pulls through from lines 4.1.1.9 and 4.1.2.8 of the previous year's annual return respectively.

A minus must be placed in front of all credit entries (i.e. disposals / impairment write down / accumulated depreciation).

The total depreciation charges in part 4.1.2.2 must agree with the depreciation in part 4.16.14.

Investment property should not be included in this part. Land & buildings in this part only relates to owner-occupied assets. Investment properties should be included in part 4.2.

All assets not specifically provided for in the column headings of part 4.1 (e.g. office equipment) should be aggregated and included in the 'other' column provided.

Help File: 2011 Annual Statutory Return



The scheme should provide the exact nature of any amounts included in parts 4.1.1.6 and 4.1.2.5. The scheme should only complete this part if the return does not cater specifically for that kind of transaction elsewhere in part 4.1.

The following reason box should be completed (if the specifications are met):

Specification	Reason box wording
Previous year figures were restated / reclassified in line 4.1.1.1.2 or line 4.1.2.1.2.	Please provide the reasons for any prior year restatements/reclassifications.

Part 4.2 Investments

The screenshot shows the CMS Statutory Returns Portal interface. The browser address bar displays the URL: <http://cmsuat02>Returns/annual.aspx?p=4&cd=2>. The page title is "Statutory Returns Portal - C...". The navigation menu includes links for Home, Contact Us, Statutory Return, Print, Validate, Submit, Help, and LogOut. Below the navigation menu, there are tabs for Parts 1 through 11, with Part 4 selected. The main content area displays "PART 4.2: INVESTMENTS" with a table of investment details.

	Non-Current R	Current R	Total R
4.2.1 Investment property	7,000,000	0	7,000,000
4.2.2 Available for sale investments	4,000,000	0	4,000,000
4.2.3 Held-to-maturity investments	400	600	1,000
4.2.4 Investments held at fair value through profit or loss	643,996,432	3,468,459,576	4,112,456,008
4.2.5 Other (specify)	600	400	1,000
4.2.6 Group investments on consolidation	0	3,000,000	3,000,000
4.2.7 Less: Transfer of assets due to amalgamation during the year	0	0	0
4.2.8 Total investments	654,997,432	3,471,460,576	4,126,458,008

With reference to Circular 38 of 2011 and its clarifying circular issued in February 2012 schemes should note that the relevant changes to the annual statutory return will only be made in respect of the 2012 annual statutory return; this is due to the fact that schemes would not have been able to make the necessary system changes and disinvestment of assets by 31 December 2011. The savings plan assets and liabilities will therefore still be included as part of the scheme assets and liabilities in the 2011 return.

Help File: 2011 Annual Statutory Return



The investments should be split between non-current (long-term) investments and (current) short-term investments, as per the audited financial statements of the scheme. Investments are considered to be current when it satisfies any of the following criteria:

- It is expected to be realised in, or is intended for sale in, the scheme's normal operation cycle;
- It is held primarily for the purpose of being traded; or
- It is expected to be realised within 12 months after statement of financial position date.

Every class of investments should be aggregated and disclosed in the line item provided for that specific class of investments. The scheme should provide the full details of any investments included in the 'other' button in 4.2.5.

Part 4.3 Trade and Other Receivables

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

Part 4.3 (a)

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

http://cmsuat01/returns/annual.aspx?p=4&d=3

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Part 8 | Part 9 | Part 10 | Part 11

Part 1 | Part 2 | Part 3 | Part 4 | Part 5 | Part 6 | Part 7

Part 4.1 | Part 4.2 | Part 4.3(a) | Part 4.3(b) | Part 4.4 | Part 4.5 | Part 4.6 | Part 4.7 | Part 4.8 | Part 4.9 | Part 4.10 | Part 4.11 | Part 4.12 | Part 4.13 | Part 4.14 | Part 4.15(a) | Part 4.15(b) | Part 4.16 | Part 4.17 | Part 4.18 | Part 4.19 | Part 4.20 | Part 4.21 | Part 4.22 | Part 4.23 | Part 4.24 | Part 4.25 | Part 4.26

PART 4.3 (a): TRADE AND OTHER RECEIVABLES

	Total
	R
4.3.1 Contributions outstanding:	624,576,760
4.3.1.1 - Current	614,994,466
4.3.1.2 - 30 days	5,697,022
4.3.1.3 - 60 days	(358,416)
4.3.1.4 - 90 days	(806,723)
4.3.1.5 - 120 days +	5,050,411
4.3.2 Recoveries from members for co-payments paid and payable (except for contributions, loans and savings plan account advances)	10,030
4.3.2.1 - Current	2,000
4.3.2.2 - 30 days	10
4.3.2.3 - 60 days	10
4.3.2.4 - 90 days	10
4.3.2.5 - 120 days +	8,000

Scheme: (MMED) Financial Year: (2010)

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The scheme should provide a proper ageing of debtor balances, where required in the return. The scheme should not disclose the full debtor balance under one age category.



Any advances on savings plan accounts should be shown separately as part of trade and other receivables (part 4.3.3); these balances should also be aged.

The total advances on the savings plan accounts should agree with the savings plan advances disclosed in part 4.5.15(a).

Risk transfer arrangements (4.3.4) are the sum of commercial reinsurance contracts (4.3.4.1) and other risk transfer arrangements (4.3.4.2).

Commercial reinsurance contracts will constitute insurance contracts entered into with a long-term insurer registered in terms of section 9 of the Long-term Insurance Act, 1998 (Act No. 52 of 1998), or a short-term insurer registered in terms of section 9 of the Short-term Insurance Act, 1998 (Act No. 53 of 1998).

The share of outstanding claims provision covered by commercial reinsurance contracts (4.3.4.1.1) plus the share of claims reported not yet paid covered by commercial reinsurance contracts (4.3.4.1.2) must agree with the provision for reinsurance claims recovered in part 4.14.3. 4.3.4.1.1 also has to agree to the closing balance of the "outstanding claims provision-covered by commercial reinsurance contracts" (4.9.8 Column C).

Commercial reinsurance claims paid by the scheme but not yet recovered from the reinsurer should be included in part 4.3.4.1.2.

A risk transfer asset is considered to be impaired when there is objective evidence, as a result of an event that occurred after initial recognition of the asset, that the scheme may not recover its full exposure in kind in terms of the contract, and that the event has a reliably measurable impact on the amounts that the scheme will now have to pay to the member. The provision for impaired losses in respect of commercial reinsurance contracts must be included in 4.3.4.1.3.

Other risk transfer arrangements will constitute all "other" reinsurance contracts that fall within the definition of IFRS 4, for example a capitation agreement entered into with a managed healthcare provider. Please note that not all capitation agreements will fall within the definition of IFRS 4 by default. Each contract will have to be evaluated in terms of IFRS 4. (Also refer to the relevant Appendix of the SAICA Medical Schemes Accounting Guide (SAICA Guide))

Depending on the tail of the specified benefits provided and the timing and accuracy of the information received from the managed healthcare provider regarding the specified benefits delivered before year end, the scheme should recognise an outstanding claims provision and an "other risk transfer" asset. This represents the scheme's best estimate of costs incurred and "costs" recovered in kind before year end, but not yet reported at the time.

The share of outstanding claims provision covered by other risk transfer arrangements (4.3.4.2.1) should therefore agree with the closing balance of the "outstanding claims provision-covered by other risk transfer arrangements" (4.9.8 Column D). A risk transfer asset, under for example a capitation agreement, is considered to be impaired when there is objective evidence, as a result of an event that occurred after initial recognition of the asset, that the scheme may not recover its full exposure in kind in terms of the contract, and that the event has a reliably measurable impact on the amounts that the scheme will now have to pay to the member. The provision for impaired losses in respect of other risk transfer arrangements must be included in 4.3.4.2.3.

The corresponding entries in respect of the share of claims reported not yet paid (both commercial reinsurance contracts (4.3.4.1.2) and other risk transfer arrangements (4.3.4.2.2) needs to be included in 4.8.1 (reported claims not yet paid).



The scheme should provide the exact nature of any prepaid expenditure included in line 4.3.7.

Accrued interest (part 4.3.9) should include all accrued interest, including those specified on the schemes' investment portfolios.

AI amounts owing by providers (i.e. overpayments made to providers), should be included in the provider balances line in part 4.3.11 of the return.

The scheme should include any related party debit balances at year-end in 4.3.12.5 (unless the return provides for that related party in another specific line). These balances should correspond with the scheme's related party disclosure note in terms of IAS 24 in its audited financial statements. The nature of the related party relationship should also be indicated.

The scheme should ensure that they disclose every debtor in the specific line provided for in part 4.3. Sundry debtors (4.3.13) should only be used if the return did not make provision for that specific debtor.

The scheme should furthermore NOT aggregate all its sundry debtor balances together in one line item in sundry debtors (4.3.13). Any balance greater than 10% of the total trade and other receivables should be disclosed separately in part 4.3.13.

Users are referred to the guidance provided in the SAICA Guide in respect of the recognition of Road Accident Fund (RAF) debtors.

The following reason boxes might warrant completion (if the specifications are met):

<i>Specification</i>	<i>Reason box wording</i>
Contributions outstanding for more than 30 days	Please indicate whether the scheme has any agreements in place with employers / members to pay their contributions after 3 days of it becoming due.
Contributions outstanding for more than 30 days	Please indicate the remedial actions taken by the scheme where contributions were received after three days of it becoming due
4.3.12.1 > R0	What is the nature of/reasons for the amount owed by the administrator?
4.3.12.2 > R0	What is the nature of/reasons for the amount owed by reinsurers (other than claims recoveries)?
4.3.12.3 > R0	What is the nature of/reasons for the amount owed by managed care organisations (other than claims recoveries)?
4.3.12.4 > R0	What is the nature of/reasons for the amount owed by brokers?
4.3.12.5 > R0	What is the nature of/reasons for the amount owed by other related parties?

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Part 4.3(b)

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

http://cmsuat01/returns/annual.aspx?p=4&d=4

Statutory Returns Portal - CMS Annual Section - Council for Medical Schemes

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Part 8 | Part 9 | Part 10 | Part 11 | Part 1 | Part 2 | Part 3 | **Part 4** | Part 5 | Part 6 | Part 7

Part 4.1 | Part 4.2 | Part 4.3(a) | **Part 4.3(b)** | Part 4.4 | Part 4.5 | Part 4.6 | Part 4.7 | Part 4.8 | Part 4.9 | Part 4.10 | Part 4.11 | Part 4.12 | Part 4.13 | Part 4.14 | Part 4.15(a) | Part 4.15(b) | Part 4.16 | Part 4.17 | Part 4.18 | Part 4.19 | Part 4.20 | Part 4.21 | Part 4.22 | Part 4.23 | Part 4.24 | Part 4.25 | Part 4.26

PART 4.3(b): ANALYSIS OF MOVEMENTS IN RESPECT OF RISK TRANSFER ARRANGEMENTS ASSETS

	Total R
4.3.1 Commercial reinsurance contracts	290,000
4.3.1.1 Balance at beginning of year	290,000
4.3.1.2 Less: Payments in respect of prior year	(50,000)
4.3.1.3 (Over)/under provision in respect of prior year	(240,000)
4.3.1.4 Adjustment for current year	290,000
4.3.2 Other risk transfer arrangements	2,846,680
4.3.2.1 Balance at beginning of year	2,846,680
4.3.2.2 Less: Payments in respect of prior year	(2,846,680)
4.3.2.3 (Over)/under provision in respect of prior year	0
4.3.2.4 Adjustment for current year	2,846,680
4.3.3 Total risk transfer arrangements assets	3,136,680

Scheme: (MMED) Financial Year: (2010)

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In part 4.3(b) the scheme has to split out the movements in respect of risk transfer arrangements. These balances should correspond with the balances entered in part 4.3(a), and the movements in these balances between periods with the scheme's risk transfer arrangements (trade and other receivables) disclosure note in terms of IFRS 4 par.37(e) in its audited financial statements.



Part 4.4 Cash and Cash Equivalents

Any bank overdraft balances should not be netted off against positive bank balances in this part; bank overdrafts should be disclosed in part 4.8 (trade and other payables).

Outstanding cheques are only disclosed in part 4.4.8 if it has not already been written back to trade and other payables (4.8). If the outstanding cheques are included in cash and cash equivalents, it should be noted that 4.4.8 is only a disclosure item, to enable the Office to test the scheme's compliance with Regulation 30, read together with Annexure B. Line 4.4.7 should still agree with the scheme's audited cash and cash equivalents.

The screenshot shows the 'PART 4.4: CASH AND CASH EQUIVALENTS' section of the CMS Statutory Returns Portal. The interface includes a navigation bar with links to various parts of the return, a table for entering data, and a summary table at the bottom.

PART 4.4: CASH AND CASH EQUIVALENTS		Total
		R
4.4.1	Call accounts	281,410,625
4.4.2	Current accounts	242,693,813
4.4.3	Fixed deposits	20,000
4.4.4	Money market instruments	28,626,355
4.4.5	Cash and cash equivalents of group companies on consolidation	80,000
4.4.6	Less: Transfer of assets due to amalgamation during the year	0
4.4.7	Total cash and cash equivalents per balance sheet	552,830,793
4.4.8	Outstanding cheques	7,000
4.4.9	Total cash and cash equivalents per part 9 of the return	552,837,793

Help File: 2011 Annual Statutory Return



Part 4.5 Savings Plan Liability

Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer

http://cmsuat01/returns/annual.aspx?p=4&d=6

Home - Council for Medical Schemes

Statutory Returns Portal - Council for Medical Schemes

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Part 8 | Part 9 | Part 10 | Part 11 | Part 1 | Part 2 | Part 3 | Part 4 | Part 5 | Part 6 | Part 7

Part 4.1 | Part 4.2 | Part 4.3(a) | Part 4.3(b) | Part 4.4 | Part 4.5 | Part 4.6 | Part 4.7 | Part 4.8 | Part 4.9 | Part 4.10 | Part 4.11 | Part 4.12 | Part 4.13 | Part 4.14 | Part 4.15(a) | Part 4.15(b) | Part 4.16 | Part 4.17 | Part 4.18 | Part 4.19 | Part 4.20 | Part 4.21 | Part 4.22 | Part 4.23 | Part 4.24 | Part 4.25 | Part 4.26

PART 4.5: SAVINGS PLAN LIABILITY

	Total
	R
4.5.1 Balance on savings plan liability at the beginning of the year (credit balance)	1,222,301,612
4.5.2 Prior year adjustment	69,147,313
4.5.3 Less: Advances on savings plan accounts	(50,000)
4.5.4 Balance on savings plan liability at the beginning of the year (net balance)	1,291,398,925
4.5.5 Savings plan account contributions received or receivable	3,615,606,466
4.5.5.1 - For the current year	3,615,556,366
4.5.5.2 - Received in advance	50,000
4.5.5.3 - Allocated to settle prior year advances	100
4.5.6 Transfers from other schemes	32,095,446
4.5.7 Savings plan liabilities transferred to/from the scheme upon amalgamation	500,000
4.5.8 Interest paid on savings plan accounts	14,850,504
4.5.9 Less: Transfers to other schemes	(50,100)

Scheme: (MMED) Financial Year: (2010)

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With reference to Circular 38 of 2011 and its clarifying circular issued in February 2012 schemes should note that the relevant changes to the annual statutory return will only be made in respect of the 2012 annual statutory return; this is due to the fact that schemes would not have been able to make the necessary system changes and disinvestment of assets by 31 December 2011. The savings plan assets and liabilities will therefore still be included as part of the scheme assets and liabilities in the 2011 return.

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

The savings plan liability at the beginning of the year 4.5.1 as well as the opening advances on the savings plan account 4.5.3 is pulled through from the previous year's closing savings plan liability (4.5.16 in the previous year's annual return) and advances on the savings plan account (4.5.15 in the previous year's annual return).

The savings contributions for the current year in part 4.5.5.1 pulls automatically through from part 4.10.2.

The interest paid on savings plan accounts in part 4.5.8 pulls automatically through from part 4.22.2 (finance costs – interest paid on savings accounts).

The claims paid on behalf of members in part 4.5.10 pulls automatically through from part 4.11.2 (savings claims paid).



Administration expenses in part 4.5.11 pulls automatically through from part 4.16.40 (administration expenses recoverable from savings plan accounts).

The scheme should provide the exact nature of any amounts included in line 4.5.13. The scheme should only complete this part if the return does not cater specifically for that kind of transaction elsewhere in part 4.5.

It is very important to split the debit balances included in the savings plan liability from the credit balances. These debit balances at year-end should be disclosed in part 4.5.15.

The scheme is required to split the credit savings balance at year-end between current members and resigned members. The scheme should further perform an ageing of the credit savings balances of resigned members between the balances younger than 6 months and the balances older than 6 months.

Resigned members in the ageing should include members resigned from the scheme as well as members resigned from an option with savings to an option without savings within the scheme.

Savings plan contributions are credited on the accrual basis and withdrawals on the cash basis, i.e. no provision is made for outstanding claims at the end of the accounting period.

When certain specifications are met, the reason boxes need to be completed:

<i>Specification</i>	<i>Reason box wording</i>
Line 4.5.17.2.2 > R0	What procedures are in place to follow-up on members that need to be refunded?
Previous year figures were restated / reclassified in line 4.5.2.	Please provide the reasons for any prior year restatements/reclassifications.

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Part 4.6 Borrowings

Part 4.6: BORROWINGS

	Description (specify)	Interest bearing borrowings		Non-interest bearing borrowings		Total
		Current	Non-Current	Current	Non-Current	
		R	R	R	R	R
4.6.1		10,000	2,000	3,000	7,000	22,000
4.6.2	Borrowings of group companies on consolidation	9,118,124	900,000	247,000	243,000	10,508,124
4.6.3	Less: Transfer of liabilities due to amalgamation during the year	0	0	0	0	0
4.6.4	Total borrowings	9,128,124	902,000	250,000	250,000	10,530,124

Were the borrowings approved by Council? [Click here](#)

The scheme should split its borrowings between interest bearing borrowings and non-interest bearing borrowings. The borrowings should further be split between current borrowings and non-current borrowings.

A liability shall be classified as current when it satisfies any of the following criteria:

- It is expected to be settled in the scheme's normal operating cycle;
- It is due to be settled within 12 months after the statement of financial position date; or
- The scheme does not have an unconditional right to defer settlement of the liability for at least 12 months after the statement of financial position date.

Details of every borrowing should be provided in the description line provided (4.6.1); it should be noted that all the scheme's borrowings should not be aggregated and disclosed as a single line in part 4.6.1.

In this regard it is important to note that section 35(6) (c) states that a medical scheme shall not directly or indirectly borrow money without the prior approval of the Council or subject to such directives as the Council may issue, this being the reason why further detail in respect of approval of the borrowings is requested in the reason box.

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Part 4.7 Other Non-Current Liabilities

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

Details of every non-current liability should be provided in the description line provided (4.7.1); it should be noted that all the scheme's non-current liabilities should not be aggregated and disclosed as a single line in part 4.7.1.

The screenshot shows the CMS Statutory Returns Portal interface. The browser address bar displays the URL: <http://cmsuat02>Returns/annual.aspx?p=4&d=8>. The page title is "Statutory Returns Portal - C...". The CMS logo is visible in the top left corner. The navigation bar includes links for Home, Contact Us, Statutory Return, Print, Validate, Submit, Help, and LogOut. Below the navigation bar, there are tabs for Part 8, Part 9, Part 10, and Part 11. A secondary row of tabs shows Part 1, Part 2, Part 3, Part 4 (highlighted), Part 5, Part 6, and Part 7. A detailed list of sub-parts is visible below these tabs, including Part 4.1 through Part 4.26. The main content area is titled "PART 4.7: OTHER NON-CURRENT LIABILITIES". It contains a table with the following data:

	Total R
4.7.1 Other non-current liabilities (specify)	1,454,490
4.7.2 Less: Current portion included in current liabilities	(356,069)
4.7.3 Balances of group companies on consolidation	80,200
4.7.4 Less: Transfer of liability due to amalgamation during the year	0
4.7.5 Total other non-current liabilities	1,178,621

The Windows taskbar at the bottom shows the system clock as 10:15 AM on 2012/02/20.

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Part 4.8 Trade and Other Payables

PART 4.8: TRADE AND OTHER PAYABLES		Total
		R
4.8.1	Reported claims not yet paid	201,522,856
4.8.1.1	Reported claims not yet paid - due to members (including outstanding cheques)	66,823,046
4.8.1.2	Reported claims not yet paid - due to providers (including outstanding cheques)	134,699,810
4.8.2.1	Stale cheques for claims expenses	20,000
4.8.2.2	Stale cheques for expenses other than claims	20,000
4.8.3	Net contributions received in advance	4,106,738
4.8.4	Payments received in advance under risk transfer arrangements	280,473
4.8.4.1	Payments received in advance under commercial reinsurance contracts	280,473
4.8.4.2	Payments received in advance under other risk transfer arrangements	0
4.8.5	Bank overdraft (current account)	0
4.8.6	Amounts owing to:	224,310,301
4.8.6.1	- Administrator	188,529,398

4.8.1 (Reported claims not yet paid) should include all the scheme's claims creditors (including outstanding cheques relating to reported claims not yet paid that were written back to trade and other payables). It should be noted that the reported claims not yet paid must be equal to part 4.11.1.3 (Direct benefits reported not yet paid) (Total column) and part 4.11.1.6 (Managed care: healthcare benefits reported not yet paid (no transfer of risk)) (Total column).

All outstanding cheques relating to expenses other than claims that have been written back to trade and other payables should be included in other payables and accrued expenses (4.8.11). The nature of these expenses must also be included.

Stale cheques are those long outstanding cheques that have not yet been cashed, but have also not yet prescribed.

The scheme should include all related party credit balances at year-end in 4.8.6.5 (unless the return provides for that related party in another specific line). These balances should correspond with the scheme's related party disclosure note in terms of IAS 24 in its audited financial statements. The nature of the related party relationship should also be indicated.

The current portion of non-current borrowings and other non-current liabilities (4.8.7) pulls automatically through from parts 4.6.4 (Total of current borrowings) and 4.7.2 (Current portion included in current liabilities).



It should be noted that all unallocated deposits should be disclosed separately in part 4.8.9 and should not be netted off against outstanding contributions in part 4.3.1 of the return.

The scheme should ensure that they disclose every creditor in the specific line provided for. Other payables and accrued expenses (4.8.11) should only be used if the return did not make provision for that specific creditor.

The scheme should furthermore NOT aggregate all its sundry creditor balances together in one line item in other payables and accrued expenses (4.8.11). Any balance greater than 10% of the total trade and other payables should be disclosed separately in part 4.8.11.

It is important to note that the provision for outstanding claims is not included in this section, but disclosed in part 4.9.

When certain specifications are met, the following reason boxes need to be completed:

<i>Specification</i>	<i>Reason box wording</i>
Line 4.8.6.1 > (Line 4.16.2 current year both columns / 12)	What is the nature of/the reasons for the amount owed to the administrator? The amount owed is larger than the average fee per month.
Line 4.8.6.3 > (- Line 6.8.1 total column / 12)	What is the nature of/the reasons for the amount owed to brokers? The amount owed is larger than the average fee per month.
If line 4.8.6.4 > ((- Line 6.7 total column + line 4.13.1) consolidated total / 12)	What is the nature of/the reasons for the amount owed to managed care organisations? The amount owed is larger than the average fee per month.
If 4.8.8 > (4.8.14 x 10%)	Part 4.8: What is the nature of/the reasons for the amount owed to members in line 4.8.8?
Line 4.8.9 > (Line 6.1 total column / 12)	What is the nature of/the reasons for the unallocated deposits? The amount owed is larger than the average gross contributions per month.
Third party administered scheme and line 4.8.10 > R0	In respect of which employees are the post retirement benefits due?
If lines 4.8.5 + 4.8.7 > R0	Please indicate whether the scheme obtained approval from Council to directly or indirectly borrow money, as is required by section 35(6)(c) of the Medical Schemes Act.

Please note that the queries raised in this part are linked to other parts in the return. After completing the return in full it will be necessary to return to this part, and address the queries.

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Part 4.9 Outstanding Claims Provision

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PART 4.9: OUTSTANDING CLAIMS PROVISION

	A	B	C	D
	Total	Outstanding claims provision - not covered by risk transfer arrangements	Outstanding claims provision - covered by commercial reinsurance contracts	Outstanding claims provision - covered by other risk transfer arrangements
	R	R	R	R
4.9.1 Balance at beginning of year	481,911,127	479,064,447	0	2,846,680
4.9.1.1 - As previously reported:	544,995,606	542,098,926	50,000	2,846,680
4.9.1.2 - Prior year adjustment	(63,084,479)	(63,034,479)	(50,000)	0
4.9.1.3 - Transfer of liability due to amalgamation (IN)	0	0	0	0

Scheme: (MMED) Financial Year: (2010)

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Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

The outstanding claims provision (total) (column A) consists out of the following categories:

- Outstanding claims provision (not covered by risk transfer arrangements) (column B)
- Outstanding claims provision (covered by commercial reinsurance contracts) (column C)
- Outstanding claims provision (covered by other risk transfer arrangements) (column D)

Please refer to explanation provided in 4.3(a) in respect of other risk transfer arrangements. Also refer to the SAICA Guide for further details.

The balance at the beginning of the year as previously reported (4.9.1.1) (columns A - D) pulls automatically through from the closing balance per the previous year's return in part 4.9.8.

Any prior year adjustments should be reflected in part 4.9.1.2 (prior year adjustment). A reason box will need to be completed to explain any such adjustments.



The outstanding claims provision at the end of the year (covered by commercial reinsurance contracts) (column C) must agree with part 4.3.4.1.1 (a) (commercial reinsurance contracts: share of outstanding claims provision).

The outstanding claims provision at the end of the year (covered by other risk transfer arrangements) (column D) must agree with part 4.3.4.2.1 (a) (other risk transfer arrangements: share of outstanding claims provision).

The scheme should at all times be able to explain any over or under provision of the prior year's outstanding claims provision. The reason box will require further details in respect of over/under provisions greater than 10% of the previous year's provision.

The liability adequacy test (LAT) provision adjustment in line 4.9.5 should be made in terms of IFRS 4. (Please refer to guidance provided in the SAICA Guide.)

The provision is net of estimated recoveries from members for co-payments and savings plan accounts. Thus, the provision is only calculated on the claims that the scheme has a liability to pay for. It should further be noted that the totals per line 4.9.8.5 should agree with the totals in line 4.9.8.

Part 4.10 Gross Contributions

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PART 4.10: GROSS CONTRIBUTIONS

	Total R
4.10.1 Gross contribution income	16,619,189,351
4.10.2 Less: Savings plan account contribution income	(3,615,556,366)
4.10.3 Risk contribution income	13,003,632,985

Please indicate reasons here if gross contributions are zero. [Click here](#)

Scheme: (IMMED) Financial Year: (2010)

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Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

Gross contributions are the amounts incurred by members, in terms of the registered rules of the scheme, for the purchase of healthcare benefits. Gross contributions include savings plan contributions. Therefore, any subsidies received from an employer, over and above the contributions per the registered rules of the scheme should not form part of gross contribution income. These subsidies should be disclosed in other income in parts 6.17 and 4.23.31 of the return.

Also, important to note that any prescribed unallocated deposits should also not form part of gross contribution income; as these amounts are not in line with the scheme's current year's registered contribution table. Any prescribed unallocated deposits should be disclosed in other income in parts 6.17 and 4.23.31 of the return.

Any contributions written off, which is not recoverable, should not be deducted from gross contributions; any write-offs of contribution income should form part of impairment losses: Trade and other receivables in parts 6.9.10 and 4.23.24 of the return.

Contributions are recognised in the accounting period to which the related risks refer. For this reason, any unpaid contributions at the end of the accounting period are reflected as current assets, and any contributions received in advance are reflected as current liabilities. These amounts are disclosed separately in trade and other receivables (part 4.3) or trade and other payables (part 4.8).

Services contracted to manage claim costs are neither deducted from gross contributions, nor included in claims costs, but are included in managed care: management services expenses (part 4.12).

In accordance with sections 26(1)(c) and 26(4) of the Act, a scheme is not allowed to collect fees payable by a member to a third party, e.g. a funeral fund/wellness programmes on behalf of that third party. Therefore, gross contributions should not include any such fees. Should any fees of this nature exist, it should be disclosed as a liability in part 4.8 of the return.

Schemes will be required to provide more details if no gross contributions were accrued during the year.

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Part 4.11 Relevant Healthcare Expenditure

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PART 4.11: RELEVANT HEALTHCARE EXPENDITURE

	A	B	C
	Total	In respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)	In respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)
	R	R	R
4.11.1 Gross claims paid and reported	14,835,949,939	14,652,240,722	183,709,217
4.11.1.1 - Direct benefits for the period	11,250,530,480	11,069,667,943	180,862,537
4.11.1.2 - Direct benefits for the previous period	1,253,131,634	1,250,284,954	2,846,680
4.11.1.3 - Direct benefits reported not yet paid	201,522,856	201,522,856	0
4.11.1.4 - Managed care: healthcare benefits for the period (no transfer of risk)	2,117,940,983	2,117,940,983	0
4.11.1.5 - Managed care: healthcare benefits for the previous period (no transfer of risk)	0	0	0
Managed care: healthcare benefits			

Scheme: (MMED) Financial Year: (2010)

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Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

Total (Column A)

4.11.1.4 - (Total column) Managed care: healthcare benefits for the period (no risk transfer) + 4.11.1.5 - Managed care: healthcare benefits for the previous period (no risk transfer) + 4.11.1.6 - Managed care: healthcare benefits reported not yet paid (no transfer of risk) + 4.13.1 - Premiums/fees paid (Capitation fees) (consolidated total current year) should be greater than or equal to 3.1.6.2.2.6 (risk amount paid by scheme column + savings amount paid by scheme on behalf of member + discount received columns) - Sub total of managed care arrangements (in hospital benefits) + 3.1.10.4 (risk amount paid by scheme column + savings amount paid by scheme on behalf of member + discount received columns) - Total managed care arrangements (out of hospital benefits).



Net relevant healthcare expenditure incurred in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts) (Column B)

Gross claims paid and reported

Total costs of settling all claims (before deducting claims paid from savings accounts) arising from healthcare events that have occurred in the period and those that have occurred previously (gross claims reported), and for which no provision was made, including costs for managed care: healthcare services (no transfer of risk).

The direct benefits reported not yet paid in line 4.11.1.3 should be greater or equal to the share of claims reported not yet paid in line 4.3.4.1.2.

Managed Care: Healthcare Benefits (no transfer of risk)

The cost of healthcare services under payment systems, such as capitation fees (healthcare services purchased), emergency services and disease management (where healthcare service benefits are included in the contract). However, amounts should only be included in 4.11.1.4, 4.11.1.5 and 4.11.1.6 if there was no transfer of risk from the scheme to the managed healthcare provider in terms of IFRS 4.

Claims incurred exclude payments made to third parties contracted to provide cost containment processes, such as specialist and hospital referrals, case management, peer reviews, claims audits, statistical analysis, and disease management (where healthcare service benefits are not included in the contract), as it constitutes managed care: management service expenses. These costs are disclosed in part 4.12 of the return.

The completion of line 4.11.1.5 is tested against the answer obtained in part 1.4 question 6b.

Services provided to members in own facilities

Line 4.11.1.7 should be greater than zero when there is a value in line 4.21.3.

Net claims incurred

Claims assessed, accrued and paid for services rendered during the accounting period and for services rendered during the previous accounting period not included in the previous period's outstanding claims provision, net of recoveries from members for co-payments and savings plan accounts and discounts received.

The savings claims paid in part 4.11.2 automatically pulls through from the total benefits in part 3.1.11 (total savings amount paid by scheme on behalf of member column).

Trade -, volume-, cash discounts and rebates received on claims pulls through from part 3.1.11 (Total Benefits (Discount Received)).

Provision for outstanding claims

The provision for outstanding claims at the end of the financial year in part 4.11.6 (column B) automatically pulls through from part 4.9.8 ((column B) (outstanding claims provision not covered by risk transfer



arrangements) + (column C) (outstanding claims provision covered by commercial reinsurance contracts at end of year)).

The provision for outstanding claims at the end of the previous financial year in part 4.11.7 (column B) automatically pulls through from 4.9.1 ((column B) outstanding claims provision not covered by risk transfer arrangements + (column C) (outstanding claims provision covered by commercial reinsurance contracts at end of year)).

It should be noted that the value in 4.11.5 (actual net claims paid and reported) (Column B) plus 4.13.1 (premiums/fees paid) (consolidated total current year column) should agree to the total benefits in part 3.1.11 (risk amount paid by the scheme column).

Net relevant healthcare expenditure incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts) (Column C)

Please note that this part must only be completed if the risk transfer arrangement (capitation agreement) meets the definition of a reinsurance contract in terms of IFRS 4. IFRS 4 requires the scheme to assess each contract separately to determine whether there is a significant transfer of insurance risk.

In the event that a capitation agreement meets the definition of a reinsurance agreement, IFRS 4 states that an insurer shall not offset risk transfer assets against the related insurance liabilities or income or expense from risk transfer arrangements against the expense or income from the related insurance contracts.

The cost that the scheme would have incurred (had it not entered into the capitation agreement) to deliver the specified benefits represents the scheme's exposure to its member (as the capitation agreement cannot absolve a medical scheme from its responsibility towards its members). These "costs" have to be disclosed in 4.11.1.1 and/or 4.11.1.2 and/or 4.11.1.3 as claims incurred from insurance contracts. The claims included in these parts should also include claims that have been incurred but not yet reported. (Please refer to the relevant SAICA Guide Appendix .) There is a validation rule testing that when the scheme had an outstanding claims provision in line 4.11.7, line 4.11.1.2 should have a value greater than zero.

The cost that the scheme would have incurred (had it not entered into the capitation agreement) to deliver the specified benefits represents the scheme's recovery in kind from the managed healthcare provider. This recovery in kind of cost incurred has to be disclosed as recoveries from risk transfer arrangements (4.13.2). The recovery included in part 4.13.2 must also include the recovery in respect of the risk transfer asset raised at year end.

Please take note that the above estimate claims incurred and estimated claims recoveries may not be offset.

The direct benefits reported not yet paid in line 4.11.1.3 should be equal to the share of claims reported not yet paid in line 4.3.4.12.2.



As amounts should only be included in 4.11.1.4, 4.11.1.5 and 4.11.1.6 if there was no transfer of risk from the scheme to the managed healthcare provider in terms of IFRS 4, these fields are fixed as zeros in column C.

Similarly are lines 4.11.2 (savings plan claims paid) and 4.11.3 (discount received on claims) also fixed as zeros.

The provision for outstanding claims at the end of the financial year in part 4.11.6 (column C) automatically pulls through from part 4.9.8 (column D) (outstanding claims provision covered by other risk transfer arrangements).

The provision for outstanding claims at the end of the previous financial year in part 4.11.7 (column C) automatically pulls through from 4.9.1 (column D) (outstanding claims provision covered by other risk transfer arrangements).

Part 4.11.9 (net (income)/expense from other risk transfer arrangements) column C (net claims incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts) automatically pulls through from part 4.13.4 (net (income)/expense from other risk transfer arrangements- consolidated total current year column). Part 4.11.9 column B is a fixed zero field.

Part 4.12 Managed Care: Management Services

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PART 4.12: MANAGED CARE: MANAGEMENT SERVICES

	Administrator / Self-administration	Per third party A Test (Pty) Ltd	Total
	R	R	R
4.12.1 Asthma programme	7,000	0	10,000
4.12.2 Case management	7,000	0	10,000
4.12.3 Chronic medicine management	7,000	0	10,000
4.12.4 Clinical review/auditing	7,000	0	10,000
4.12.5 Dental benefit management	7,000	0	10,000
4.12.6 Disease management	7,000	0	10,000
4.12.7 Disease/prescribed minimum benefit management	7,000	0	10,000
4.12.8 Drug utilisation review	7,000	0	10,000
4.12.9 Female Wellness programme	7,000	0	10,000
4.12.10 Fraud hotline	7,000	0	10,000
4.12.11 Health advice line	7,000	0	10,000

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Managed health care means clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programs.

Managed care: management services is therefore the cost of managing healthcare expenditure, such as bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis. It does not include the cost of any relevant healthcare services.

Managed care: management services expenses are disclosed, showing separately internal expenditure (incurred by the administrator) and outsourcing costs (services delivered by third parties). The expenses should be allocated per party. The names of the third party contracts will be pulled through from the detail supplied in part 1.4, question 6(a).

The scheme should ensure that they disclose every managed care: management service in the specific line provided for. The other line (4.12.29) should only be used if the return did not make provision for a specific managed care: management service.

The scheme should not aggregate all its managed care: management services together in one line item in the other box provided in part 4.12.29; a detailed split of all services received should be provided. Further detail will be required by way of a reason box if an aggregate amount is entered in this line.

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Users are also referred to circular 49 of 2007 "Financial reporting by accredited managed care arrangements" in which managed care organisations are instructed to supply schemes with a breakdown of the fee over the various services performed.

Part 4.13 *Net (income)/expenses from other risk transfer arrangements (excluding commercial reinsurance contracts)*

This part should be completed per contract ("other" risk transfer arrangement-`capitation agreement). The names of the various contracts for both the current and previous financial years will be pulled through from the detail completed in part 1.4, question 6(c).

The previous year's amounts are automatically pulled through from the previous year's return. The "Unlock previous year amounts" button allows the scheme to make adjustments to these figures if needs be. The scheme would then need to provide the reasons for any prior year adjustments.

Part 4.13: NET (INCOME)/EXPENSES FROM OTHER RISK TRANSFER ARRANGEMENTS (EXCLUDING COMMERCIAL REINSURANCE CONTRACTS)

		Consolidated total		Per contract Test A (LOCKED)	
		Current year	Previous year	Current year	Previous year
4.13.1	Premiums/fees paid (capitation fee)	40,521,324	157,033,251	40,521,324	20,957,891
4.13.2	Less: Claims recoveries in respect of related risk transfer arrangements	(51,846,241)	(183,709,217)	(51,846,241)	(12,719,405)
4.13.3	Other (specify)	0	2,846,680	0	2,846,680
4.13.4	Net (income)/expense from other risk transfer arrangements	(11,324,917)	(23,029,206)	(11,324,917)	11,005,166

Please provide the basis for the calculation of the estimated claims recoveries in respect of related risk transfer arrangements: [Click here](#)

Please provide the reasons for any prior year restatements: [Click here](#)

Important to note that this part should only be completed if the capitation agreement meets the definition of a reinsurance contract in terms of IFRS 4. IFRS 4 requires the scheme to assess each contract separately to determine whether there is a significant transfer of insurance risk. For additional guidance on risk transfer arrangements, please refer the SAICA Guide.



The premiums/fees paid (capitation fees) should be captured in part 4.13.1. The estimated claim recovery (as explained in part 4.11 under net claims in respect of related risk transfer arrangements) should be captured in part 4.13.2. Please note that this figure should be a negative figure, as claims recoveries is a credit balance.

Any other transactions not provided for in part 4.13.1 and part 4.13.2 should be captured in part 4.13.3 (other). The details of these transactions should be provided.

It should also be noted that where a risk transfer arrangement includes a portion of administration fees (i.e. a call centre or nurse line), the capitation fees should be split between the administration portion and the risk transfer portion. The administration portion should be included in either part 4.12 or part 4.16 of the return, where ever it is the most applicable.

It should further be noted that Part 4.13.2 (Less: Claims recoveries in respect of related risk transfer arrangements consolidated total current year column) should agree with:

- the sum of Part 4.11.1.1 to 4.11.1.3 (Column C: direct benefits in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)); and
- plus the difference movement in the provision for outstanding claims in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts) in lines 4.11.6 and 4.11.7 (Column C).

When certain specifications are met, the following reason boxes need to be completed:

<i>Specification</i>	<i>Reason box wording</i>
(Consolidated total current year lines 4.13.1 + 4.13.2)/Consolidated total current year line 4.13.1 > 50% or if < 50%	Please provide the basis for the calculation of the estimated claims recoveries in respect of related risk transfer arrangements,
Previous year figures were restated.	Please provide the reasons for any prior year restatements.

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Part 4.14 Net income/ (expenses) from risk transfer arrangements: commercial reinsurance contracts

This part should be completed per reinsurance contract. The names of the various contracts will be pulled through from the detail completed in part 1.4, question 6(d).

The screenshot shows the CMS Annual Section interface in a Windows Internet Explorer browser. The URL is <http://cmsuat01/returns/annual.aspx?p=4&d=15>. The page displays the CMS Council for Medical Schemes logo and navigation links. The main content area shows the 'PART 4.14: NET INCOME/(EXPENSE) FROM RISK TRANSFER ARRANGEMENTS: COMMERCIAL REINSURANCE CONTRACTS' section. A table is displayed with columns for 'Consolidated total' and 'Per reinsurance contract ABC Insurers'. The table includes rows for re-insurance premiums paid, re-insurance claims recovered, provision for reinsurance claims recovered, profit/(loss) on re-insurance arrangements, commissions on reinsurance agreements, discounts received, and net income/(expense) from commercial reinsurance arrangements.

	Consolidated total	Per reinsurance contract ABC Insurers
4.14.1 Re-insurance premiums paid	(222,696)	(222,696)
4.14.2 Re-insurance claims recovered	0	0
4.14.3 Provision for reinsurance claims recovered	300,000	300,000
4.14.4 Profit/(Loss) on re-insurance arrangements	(57,777)	(57,777)
4.14.5 Commissions on reinsurance agreements	0	0
4.14.6 Discounts received	0	0
4.14.7 Net income/(expense) from commercial reinsurance arrangements	19,527	19,527

A *reinsurance contract* is defined by IFRS 4 as an insurance contract issued by one insurer (the reinsurer) to compensate another insurer (the cedant) for losses on one or more contracts issued by the cedant. Contracts which meet the definition of reinsurance contracts in IFRS 4 are referred to as risk transfer arrangements in the SAICA Guide. Income and expenses relating to risk transfer arrangements are disclosed separately in the statement of comprehensive income.

A medical scheme may also enter into *commercial reinsurance contracts*, in terms of which it transfers some or all of its risk to a legally registered reinsurer. In this instance the reinsurer will compensate the medical scheme in cash for losses incurred.

It should be noted that all reinsurance contracts should be submitted to the Registrar in terms of section 20(3) of the Act.

Prepaid re-insurance premiums are included in current assets in part 4.3 of the return.

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Profit/ (loss) on a commercial reinsurance arrangements (4.14.4) should be recognised either as a debtor or creditor over the period of risk covered by the policy that covers a period for more than one year. Please note that this is not the difference between the claims recovered and the premiums paid, but the profit/ (loss) share in terms of the commercial reinsurance contract.

The commissions on commercial reinsurance arrangements (4.14.5) and discounts received (4.14.6) are as specified in the actual commercial reinsurance contract.

Please note that all expenses in respect of commercial reinsurance contracts must be captured as a negative amount and all income in respect of commercial reinsurance contracts as a positive amount.

Part 4.15(a)

Broker service fees

PART 4.15(a): BROKER SERVICE FEES	
	Broker service fees
	R
4.15.1	Paid to brokers
	400,562,667
4.15.2	Paid to related party brokers (specify)
	4,000,000
4.15.3	Total broker service fees
	404,562,667

Why does the broker fees per average member per month exceed the statutory limit of R74.84? [Click here](#)

Why does the broker fees exceed the statutory limit of 3.42% of gross contributions? [Click here](#)

A scheme may compensate a person, in accordance with its rules and the provisions of the Act and the regulations, for services provided to the scheme's members. Broker service fees usually accrue and are paid on a monthly basis as contributions are received. Amounts paid and payable for broker services comprise fees paid to brokers for new contracts initiated by the brokers "ongoing fees" in respect of current contracts. Acquisition costs are the costs that an insurer incurs to sell, underwrite and initiate a new insurance contract. Consideration should be given to related party relationships in transactions relating to brokers.



When certain specifications are met, the following reason boxes need to be completed:

Specification	Reason box wording
4.15.3/12/2.2.13 (Members)) > R74.84	Why does the broker fee per average member per month exceed the statutory limit of R74.84?
4.15.3 > (4.10.1 x 3.42%)	Why do the broker fees exceed the statutory limit of 3.42% of gross contributions?

Part 4.15(b)

Other distribution costs

PART 4.15(b): OTHER DISTRIBUTION COSTS		Other distribution costs
		R
4.15.1	Paid to related parties (specify)	700
4.15.2	Other (specify)	6,300
4.15.3	Total distribution costs	7,000

Distribution costs that are incurred under co-administration or other arrangements are included under administration expenses in the statement of comprehensive income and are separately disclosed in the notes, unless those fees are paid to brokers. Where those distribution fees are paid to brokers, they are included as part of brokers' service fees.

The scheme should ensure that an accurate split between broker fees and distribution costs are made between part 4.15(a) and part 4.15. (b). The scheme should furthermore ensure no distribution costs are included in part 4.16 (administration expenses).

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Distribution costs do not include marketing and advertising expenses unless those expenses are paid to brokers. Marketing and advertising costs are included in part 4.16.22 and part 4.16.3 respectively.

Consideration should be given to related party relationships and transactions relating to brokers fees and distribution costs. These transactions should correspond with the scheme's related party disclosure note in terms of IAS 24 in its audited financial statements.

The scheme should specify the distribution costs in part 4.15.2 per individual party; all distribution costs should not be aggregated and disclosed as one line item in part 4.15.2.

Part 4.16 Administration Expenses

	Current year		Previous year (LOCKED)	
	Fund R	Own Facilities R	Fund R	Own Facilities R
4.16.1 Actuarial fees	0	0	0	0
4.16.2 Administration fees:				
4.16.2.1 - Fees paid to the administrator	1,764,004,641	0	1,764,004,641	0
4.16.2.2 Indirect fees paid to the administrator	0	0	0	0
4.16.3 Advertising	0	0	0	0
4.16.4 Annual general meeting costs	0	0	0	0
4.16.5 Association fees	4,682,796	0	4,682,796	0
4.16.6 Audit expense:				
4.16.6.1 - Audit services	2,242,739	0	2,242,739	0
4.16.6.2 - Audit expenses	0	0	300,000	0
4.16.6.3 - Audit committees	186,751	0	186,751	0

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

The previous year's amounts are automatically pulled through from the previous year's return. The "Unlock previous year amounts" button allows the scheme to make adjustments to these figures if needs be. The scheme would then need to provide the reasons for any prior year restatements/reclassifications.

The scheme should ensure that they disclose every expense in the specific line provided for in part 4.16 of the return. Other administration expenses (4.16.39) should only be used if the return did not make provision for that specific expense.



Association fees (4.16.5) relate to fees paid to non-professional organisations, e.g. BHF membership etc.

The audit committee fees (4.16.6.3) should include all audit committee fees (i.e. fees paid to non-executive audit committee members); this line does not only refer to specific audit expenses incurred by the auditor.

In the event that a scheme entered an amount in line 4.16.9 (co-administration fees paid for ongoing services provided by third parties), but no such contracts exists in part 1.1, the scheme would be required to provide more information on the nature of the services, including the name of the provider.

Consultancy fees (4.16.11) are those fees paid where the board of trustees obtained expert advice on legal, accounting and/or any other business matter of which the members of the board of trustees may lack sufficient expertise.

Council for Medical Schemes expenses (4.16.12) are any other fees paid to the Council for Medical Schemes such as rule registration fees etc. It also includes membership levies paid to the Council for Medical Schemes. Penalties incurred should however not be included in this line, but in line 4.16.26.

The depreciation included in part 4.16.14 should agree with the total depreciation charges included in part 4.1.2.2.

In the event that the scheme has not incurred any expenses in respect of fidelity guarantee insurance fees (4.16.17) or professional indemnity insurance premiums (4.16.32), the scheme will be required to complete a reason box, indicating the reasons for not incurring the said expenditure (non-compliance with the requirements imposed by section 57(4)(f)).

Investigation fees (4.16.20) will include any special investigations initiated by the scheme (including fraud investigations).

Please note that marketing (4.16.22) and advertising (4.16.3) expenses exclude fees paid to brokers as well as any distribution costs, which are disclosed under part 4.15 of the return.

Principal Officer fees and remuneration (4.16.28) should include all fees and remuneration paid to the Principal Officer, which is regarded as remuneration for his own benefit.

Principal Officer travel and other expenses incurred (4.16.29) should include all fees paid to the Principal Officer in terms of where the Principal Officer were reimbursed for expenses incurred that did not form part of his remuneration/fees. This also includes fees paid on behalf of the Principal Officer (e.g. travelling, accommodation etc.).

Please note that penalties in part 4.16.26 should include those penalties paid to the Registrar.

Professional fees (4.16.31) relate to membership fees paid to associations in respect of individuals (i.e. accountants, nurses, doctors etc.).

Travel, accommodation and conferences (4.16.36) should include all cost incurred in respect of travel, accommodation and conferences. However, these costs should exclude the cost incurred with regards to the Principal Officer and trustees, which should be included in 4.16.29 and 4.16.37 respectively.

The trustee remuneration expenses in part 4.16.37 pulls automatically through from part 4.17.

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The scheme should not aggregate all its other administration expenses together in one line item in part 4.16.39. Every expense greater than 10% of the total administration expenses should be disclosed separately in part 4.16.39.

Where a scheme received a subsidy or refund from any third party for administration expenses incurred by the scheme, those subsidies should not be included in part 4.16.39. Any such subsidies should be included in 'other income' in part 6.17 of the return. The Office wants to see the total costs to administer the scheme in part 4.16.

Part 4.17 Trustee Remuneration and Considerations

The screenshot shows the CMS Annual Section interface in a Windows Internet Explorer browser. The page title is "Statutory Returns Portal - CMS Annual Section - Windows Internet Explorer". The URL is "http://cmsuat01/returns/annual.aspx?p=4&d=19". The page displays the CMS logo and navigation links: Home, Contact Us, Statutory Return, Print, Validate, Submit, Help, LogOut. Below the navigation links are tabs for Part 1 through Part 7. The current view is Part 4.17: TRUSTEE REMUNERATION AND CONSIDERATIONS. The form contains a table with the following data:

	Total trustee remuneration and considerations	Per trustee member LERATO SEHULARI
4.17.1 Fees for meeting attendance	575,468	96,725
4.17.2 Fees for holding of office	0	0
4.17.3 Fees for consultancy services	40,461	0
4.17.4 Allowances	0	0
4.17.5 Training	1,600	0
4.17.6 Conference fees	0	0
4.17.7 Telephone expenses	0	0
4.17.8 Accommodation, travelling and meals	0	0
4.17.9 Other disbursements and reimbursements	0	0
4.17.10 Total trustee remuneration and considerations	617,529	96,725
4.17.11 Fees received in respect of services rendered to related parties	107,200	7,000

At the bottom of the page, the status bar shows "Scheme : (MMED) Financial Year : (2010)", "Local intranet | Protected Mode: Off", and the system clock "10:35 AM 2011/02/18".

Please note that the names of the trustees automatically pull through from part 1.3. This would encompass the names of all the trustees that were trustees during the financial year, including those trustees that have resigned within the financial year. Trustees appointed in the new financial year (effective 1 January 2011), will not be reflected.

Per section 57(8) of the Medical schemes Act 131 of 1998 as amended, the members of the board of trustees shall disclose annually in writing to the Registrar any payment or considerations made to them in that particular year by the medical scheme. Therefore all scheme expenditure relating to trustees must be



disclosed per trustee member in this section, and not only trustee remuneration. The scheme should also ensure the correct disclosure of fees received by the trustees in respect of services rendered to related parties (i.e. subsidiaries, joint ventures, associates and significant control) to the scheme.

The scheme should further ensure that an accurate split is made between the different kinds of payments made in respect of the trustees, as requested in the return.



Part 4.18 Provision for impaired losses at year-end

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Part 8 | Part 9 | Part 10 | Part 11 | Part 1 | Part 2 | Part 3 | **Part 4** | Part 5 | Part 6 | Part 7

Part 4.1 | Part 4.2 | Part 4.3(a) | Part 4.3(b) | Part 4.4 | Part 4.5 | Part 4.6 | Part 4.7 | Part 4.8 | Part 4.9 | Part 4.10 | Part 4.11 | Part 4.12 | Part 4.13 | Part 4.14 | Part 4.15(a) | Part 4.15(b) | Part 4.16 | Part 4.17 | **Part 4.18** | Part 4.19 | Part 4.20 | Part 4.21 | Part 4.22 | Part 4.23 | Part 4.24 | Part 4.25 | Part 4.26

PART 4.18: PROVISION FOR IMPAIRED LOSSES AT YEAR-END

		Amount recognised in the income statement for the year					
	A	B	C	D	E	F	
	Provision for impaired losses at beginning of year	Unused amounts reversed during the year (credit in income statement)	Additional provisions made during the year (debit in income statement)	Amounts utilised during the year	Provision for impaired losses at year-end	Impaired losses recognised directly in the income statement (debit in income statement)	
	R	R	R	R	R	R	
Contributions owed by 4.18.1 members that are not collectable	11,251,717	(3,925,524)	0	0	7,326,193	177,750	

Scheme: (MMED) Financial Year: (2010)

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Part 4.18 requires a reconciliation of the provision for impaired losses for the year (columns A to E) and a breakdown of the amount recognised in the statement of comprehensive income (columns B, C, and F to H).

The columns should therefore be completed as follows:

- Column A: Positive amount – This represents the balance of the provision for impaired losses at the beginning of the year
- Column B: Negative amount – This represent unused provisions reversed during the year to the statement of comprehensive income.
- Column C: Positive amount – This represent additional provisions that were made during the year.
- Column D: Negative Amount – This represent provisions utilised during the year (amounts written off directly against the provision).
- Column E: Positive amount – This represents the balance of the provision for impaired losses at year-end.
- Column F: Positive amount – This represent impaired losses that were recognised directly in the statement of comprehensive income, and not against the provision.
- Column G: Negative amount – This column represents previous impairment losses that were recovered.
- Column H: This constitutes the net effect in the statement of comprehensive income, and can therefore be either positive or negative, depending on the nature of the transaction flows.



The amount per part 4.18.6 (Total) (column E) must agree with part 4.3.4.1.3 (provision for impaired losses at year end – commercial reinsurance contracts) plus part 4.3.4.2.3 (provision for impaired losses at year end - other risk transfer arrangements) plus part 4.3.14 (provision for impaired losses at year end (excluding risk transfer arrangements)).

The amount per part 4.18.6 (Total) (column H) must agree with the sum of part 4.23.24 (consolidated column – Net impairment losses: Trade and other receivables) and part 4.23.26 (consolidated column - Net impairment losses: Other).

Any other transactions not specifically provided for in part 4.18 should be captured in part 4.18.5 (other), such as impairment losses on risk transfer arrangements. Thus, the movement in the provision for impaired losses relating to risk transfer arrangements (please refer to 4.3.4.1.3 and 4.3.4.2.3) should also be included in 4.18.5 (other).

Please note that the value calculated in column E (Provision for impaired losses at year-end) is the sum of columns A to D. The value of column H (Total movement in statement of comprehensive income for the year) is calculated as the sum of columns B, C, F and G.

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Example:

20x0

Debtor X had an outstanding balance of R1 000 at 31 December 20x0.

- A provision for impaired losses in respect of debtor X was raised at 31 December 20x0 of R600.

The scheme's total provision for impaired losses at 31 December 20x0 was R5 000.

- R1 000 of this provision was in respect of debtor Y. (Amounts owed in respect of member's portions of claims that are not recoverable).
- R3 400 was in respect of amounts owed by service providers that are not recoverable.

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A minus should be placed in front of the figure.

	income statement		statement (debit in income statement)	
	R	R	R	R
Contributions owed by members that are not collectable	600	0	0	0
Amounts owed in respect of members' portions of claims that are not recoverable	1,000	0	0	0
Amounts owed by service providers that are not recoverable	3,400	0	0	0
Amounts owed				

Done

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20x1

1. During the 20x1 financial year debtor X was liquidated and the total amount of R1 000 was written off.
 - The amount of R600 included in the provision for impairment losses at 31 December 20x0 was written off directly against debtor X's account (Dt Provision for impaired losses R600, Ct Debtors R600).
 - The additional R400 was written off in the statement of comprehensive income in the 20x1 financial year (Dt I/S R400, Ct Debtors 400).

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Part 8 Part 9 Part 10 Part 11

Part 1 Part 2 Part 3 Part 4 Part 5 Part 6 Part 7

Part 4.1 Part 4.2 Part 4.3(a) Part 4.3(b) Part 4.4 Part 4.5 Part 4.6 Part 4.7 Part 4.8 Part 4.9 Part 4.10 Part 4.11 Part 4.12 Part 4.13 Part 4.14 Part 4.15(a) Part 4.15(b) Part 4.16 Part 4.17 Part 4.18 Part 4.19 Part 4.20 Part 4.21 Part 4.22 Part 4.23 Part 4.24 Part 4.25 Part 4.26

	Provision for impaired losses at beginning of year	Unused amounts reversed during the year (credit in income statement)	Additional provisions made during the year (debit in income statement)	Amounts utilised during the year	Provision for impaired losses at year-end	Impaired losses recognised directly in the income statement (debit in income statement)	Pre-impairment to rectify (credit in income statement)
	R	R	R	R	R	R	
Contributions owed by members that are not collectable	600	0	0	(600)	0	400	
Amounts owed in respect of members' portions of claims that are	1,000	0	0	0	1,000	0	

Done

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- The scheme recovered an amount of R300 in the 2010 financial year in respect of amounts previously written off (Dt Bank R300, Ct I/S R300) (Amounts owed by service providers that are not recoverable).

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Part 4.1 Part 4.2 Part 4.3(a) Part 4.3(b) Part 4.4 Part 4.5 Part 4.6 Part 4.7 Part 4.8 Part 4.9 Part 4.10 Part 4.11 Part 4.12 Part 4.13 Part 4.14 Part 4.15(a) Part 4.15(b) Part 4.16 Part 4.17 Part 4.18 Part 4.19 Part 4.20 Part 4.21 Part 4.22 Part 4.23 Part 4.24 Part 4.25 Part 4.26 Part 4.28

	income statement		statement		statement (debit in income statement)		income statement	
	R	R	R	R	R	R	R	R
Contributions received by members that are not recoverable	600	0	0	(600)	0	400	0	
Contributions received by members that are recoverable	1,000	0	0	0	1,000	0	0	
Contributions received by service providers that are not recoverable	3,400	0	0	0	3,400	0	(300)	

Done

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Debtor Y's repayment of debt improved substantially during the year, and the provision of R1 000 was written back (Dt Provision for impaired losses R1 000, Ct I/S R1 000).

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Part 8 Part 9 Part 10 Part 11

Part 1 Part 2 Part 3 Part 4 Part 5 Part 6 Part 7

Part 4.1 Part 4.2 Part 4.3(a) Part 4.3(b) Part 4.4 Part 4.5 Part 4.6 Part 4.7 Part 4.8 Part 4.9 Part 4.10 Part 4.11 Part 4.12 Part 4.13 Part 4.14 Part 4.15(a) Part 4.15(b) Part 4.16 Part 4.17 Part 4.18 Part 4.19 Part 4.20 Part 4.21 Part 4.22 Part 4.23 Part 4.24 Part 4.25 Part 4.26

		income statement	statement			statement (debit in income statement)	income statement
	R	R	R	R	R	R	R
Contributions paid by members that not deductible	600	0	0	(600)	0	400	0
Premiums owed in respect of members' policies that are recoverable	1,000	(1,000)	0	0	0	0	0
Premiums owed in respect of service providers that not recoverable	3,400	0	0	0	3,400	0	(300)

Done

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3. During the 20x1 financial year an additional provision in respect of the scheme's debtors (excluding debtors X and Y) of R1 500 was raised
(Dt I/S R1 500, Ct Provision for impaired losses R1 500).

	Income statement	statement	Income statement	statement	Income statement	statement
	R	R	R	R	R	R
Contributions d by members that not ptable	600	0	0	(600)	0	400
Contributions owed respect of members' ions of ms that are recoverable	1,000	(1,000)	0	0	0	0
Contributions owed service rders that not verable	3,400	0	1,500	0	4,900	(300)

The transactions will have to be included in the return as follows:

- Column A: R5 000 (balance at beginning of year)
- Column B: -R1 000 (debtor Y's unused amount reversed)
- Column C: R1 500 (additional provision during the year)
- Column D: -R600 (debtor X amount utilised during the year)
- Column E: $R5\ 000 - R1\ 000 + R1\ 500 - R600 = R4\ 900$ (balance at end of year)
- Column F: R400 (Debtor X's amount written off directly in the statement of comprehensive income)

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Column G: -R300 (previous impairment losses recovered)

Column H: $-R1\ 000 + R1\ 500 + R400 - R300 = R600$ (net effect in statement of comprehensive income)



Part 4.19 Other Investment Income

PART 4.19: OTHER INVESTMENT INCOME		Total
		R
4.19.1	Income from investments and property	335,045,493
4.19.1.1	- Interest	324,735,493
Note: Interest includes interest received from bank accounts		
4.19.1.2	- Dividends received	10,310,000
4.19.1.3	- Rentals	0
4.19.1.4	- Policy income	0
4.19.2	Other (specify)	4,480
4.19.3	Total other investment income	335,049,973

Please note that any fees paid to asset managers should be disclosed separately in part 6.14 (investment management fees).

Furthermore, the direct operating expenses on rental of investment property should also be included in part 6.15.

Important to note that realised gains/ (losses) on the disposal of investments should not form part of other investment income; all realised gains/ (loses) should be included in part 4.20.

For purposes of the return, please note that interest received on bank accounts should be included in part 4.19 (other investment income) and not part 6.17 (other income).

Important to note that any interest paid by the scheme on borrowings or credit balances as well as interest paid on savings plan accounts are disclosed as part of finance costs in part 4.22, and should not be deducted from investment income.

The scheme should furthermore not aggregate all its investment income in one line item in part 4.19.2. The scheme should ensure that they disclose every type of investment income separately in the specific line



provided for in part 4.19. Other investment income (4.19.2) should only be used if the return does not make provision for that type of investment income.

Part 4.20 Other Realised and Unrealised Gains/ (Losses)

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PART 4.20: OTHER REALISED AND UNREALISED GAINS/(LOSSES)

	Total R
4.20.1 Profit/(loss) on disposal of property, plant and equipment	0
4.20.2 Profit/(loss) on disposal of investment property	0
4.20.3 Realised gain/(loss) on disposal of available-for-sale investments	0
4.20.4 Unrealised gain/(loss) on revaluation of investment property	0
4.20.5 Net gain/(loss) on revaluation of investments carried at fair value through the income statement	135,708,107
4.20.6 Other (specify)	0
4.20.7 Total realised and unrealised gains/(losses)	135,708,107

Scheme: (MMED) Financial Year: (2010)

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Net gains and losses arising from changes in the fair value of investments held at fair value through profit or loss are included in the income statement in the period in which they arise. Unrealised gains and losses arising from changes in the fair value of the available-for-sale investments are included in the available-for-sale reserve and statement of other comprehensive income. Once an available-for-sale investment is sold, the realised fair value gain or loss on the changes in the fair value of the available-for-sale investments is included in the income statement.

Only the movement through the income statement is accounted for in this part.

The scheme should furthermore not aggregate all its realised and unrealised gains and losses in one line item in part 4.20.6. The scheme should ensure that they individually disclose all realised and unrealised gains and losses in the specific line provided for in part 4.20. Other (4.20.6) should only be used if the return does not make provision for that type of realised and unrealised gains and losses.



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Part 4.21 Own Facility Surplus/ (Deficit)

The screenshot shows the 'Statutory Returns Portal - CMS Annual Section' in a Windows Internet Explorer browser. The URL is <http://cmsuat01/returns/annual.aspx?p=4&d=23>. The page features the CMS Council for Medical Schemes logo and a navigation menu with links to Home, Contact Us, Statutory Return, Print, Validate, Submit, Help, and LogOut. Below the menu are buttons for Parts 1 through 11. The 'Part 4' button is highlighted, and a sub-menu for Part 4 is visible, including links to Part 4.1, Part 4.2, Part 4.3(a), Part 4.3(b), Part 4.4, Part 4.5, Part 4.6, Part 4.7, Part 4.8, Part 4.9, Part 4.10, Part 4.11, Part 4.12, Part 4.13, Part 4.14, Part 4.15(a), Part 4.15(b), Part 4.16, Part 4.17, Part 4.18, Part 4.19, Part 4.20, Part 4.21, Part 4.22, Part 4.23, Part 4.24, Part 4.25, and Part 4.26. The 'Part 4.21: OWN FACILITY SURPLUS/(DEFICIT)' form is displayed, showing a table with the following data:

	Total
	R
4.21.1 Income from services rendered to third parties	50,391,739
4.21.2 Less: Total cost incurred in operating own facility	(37,567,753)
4.21.2.1 Less: Total healthcare provider costs	0
4.21.2.2 Less: Changes in inventories	0
4.21.2.3 Less: Administration expenditure	(50,391,739)
4.21.2.4 Less: Other costs incurred in operating own facility	0
4.21.2.5 Add: Costs relating to members included in claims	12,823,986
4.21.3 Total own facility surplus/(deficit)	12,823,986

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

Total cost incurred in operating own facilities

Costs incurred by the healthcare funder in operating its own medical equipment, hospital, clinic, pathology laboratory and radiology facility or any other related service on behalf of members.

4.21.1 (Income from services rendered to third parties) arises from making the scheme's own facilities available and rendering services to third parties, and is recognised on an accrual basis. This will not include any income from the scheme's members; only the non-related contributions income and claims expenditure are disclosed as part of own facility surplus or deficit.

The claims related expenditure paid on behalf of the scheme's members is shown as part of claims incurred, and the contributions received are disclosed as part of gross contributions. Hence, the cost of services

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provided to members included in net claims incurred (4.21.2.5) automatically pulls through from part 4.11.1.7 (Services provided to members in own facilities (column A)).

The scheme should disclose the total costs of operating the own facility in part 4.21.2 (and not only those costs that relate to services rendered to third parties). The total cost incurred in operating own facility (4.21.2) consists of the sum of the following costs:

- 4.21.2.1 – total healthcare provider costs
- 4.21.2.2 – changes in inventories
- 4.21.2.3 – administrative expenditure
- 4.21.2.4 – other costs incurred in operating own facility

The administrative expenditure incurred in operating the own facility in part 4.21.2.3 automatically pulls through from part 4.16.40 (current year: own facility column). Please note that although it is shown as part of administration expenses in part 4.16, it will not be included in the statement of comprehensive income as part of the administration expense, but as part of the own facility surplus/ (deficit) in line 6.18.

Part 4.22 Finance Costs

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PART 4.22: FINANCE COSTS

	Total
	R
4.22.1 Borrowings	0
4.22.2 Interest paid on savings plan accounts	14,850,504
4.22.3 Other (specify)	59,320
4.22.4 Total finance costs	14,909,824

Scheme : (MMED) Financial Year : (2010)

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When considered to be material, finance costs are disclosed separately on the face of the statement of comprehensive income, and does not form part of investment income.

Finance costs include interest paid on savings plan accounts, and should not be netted off against interest received on savings plan accounts.

The scheme should not aggregate all its finance costs in one line item in part 4.22.3. The scheme should ensure that they disclose every type of finance costs separately in the specific line provided for in part 4.22. Other finance costs (4.22.3) should only be used if the return did not make provision for that type of finance cost.

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Part 4.23 Net Surplus/ (Deficit) per Benefit Option

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PART 4.23: NET SURPLUS/(DEFICIT) PER BENEFIT OPTION

	Consolidated Total	Other	Per benefit option OPTION A
	R	R	R
4.23.1 Gross contribution income	16,619,189,351	(459,951)	6,221,285,503
4.23.2 Less: Savings contribution income	(3,615,556,366)	60,047	(1,555,768,250)
Net contribution income	13,003,632,985	(399,904)	4,665,517,253
4.23.4 Gross claims paid and reported in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)	14,652,240,722	12,807,732	6,231,402,055
4.23.4.1 - Direct benefits for the period	11,069,667,943	(168,121)	4,695,291,009
4.23.4.2 - Direct benefits for the previous period	1,250,284,954	161,185	990,776,769
4.23.4.3 - Direct benefits reported not yet paid	201,522,856	(386)	85,373,026
4.23.4.4 - Managed care: healthcare benefits for the period (no transfer of risk)	2,117,940,983	(8,932)	459,961,251

Scheme: (MMED) Financial Year: (2010)

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The option names captured in part 1.2 automatically pulls through to part 4.23.

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

The results of each benefit option under a medical scheme are to be separately disclosed, and the accounting records are to be maintained in such a way that the financial results for each benefit option can be determined.

The other column provided should be used to capture any transactions in this financial year which relates to options that were discontinued at the beginning of the financial year, for which the scheme incurred some expenses or received some income.



Any other transactions not provided for in part 4.23.17.1 and part 4.23.17.2 should be captured in part 4.23.17.3 (other). The details of these transactions should be provided.

Details (per nature of transaction) of the following income and expenses should also be provided in the different parts:

- Net impairment losses: Other (4.23.26)
- Other income (4.23.31)
- Other expenses (4.23.33)

The consolidated column (the sum of the individual option results) in part 4.23 should agree on a line by line basis to the individual amounts in the income statement.

The consolidated column's lines should also agree to the following parts:

<i>Consolidated Column Line</i>	<i>Should agree to part</i>
4.23.1	4.10.1 - Gross contribution income
4.23.2	4.10.2 - Less: Savings plan account contribution income
4.23.4.1	4.11.1.1- Direct benefits for the period (Column B)
4.23.4.2	4.11.1.2- Direct benefits for the previous period (Column B)
4.23.4.3	4.11.1.3 - Direct benefits reported not yet paid (Column B)
4.23.4.4	4.11.1.4 - Managed care: healthcare benefits for the period (no transfer of risk) (Total)
4.23.4.5	4.11.1.5 - Managed care: healthcare benefits for the previous period (no transfer of risk) (Total)
4.23.4.6	4.11.1.6 - Managed care: healthcare benefits reported not yet paid (no transfer of risk) (Total)
4.23.4.7	4.11.1.7 - Services provided to members in own facilities (Total)
4.23.5	4.11.2 Less: Savings plan claims paid (Total)
4.23.6	4.11.3 - Less: Discount received on claims (Total)
4.23.7	4.11.4 - Less: Claims recoveries from third parties (Total)
4.23.9	4.11.6 - Provision for outstanding claims at the end of the financial year (Column B)
4.23.10	4.11.7 - Provision for outstanding claims at end of the previous year (Column B)
4.23.12.1	4.11.1.1- Direct benefits for the period (Column C)
4.23.12.2	4.11.1.2- Direct benefits for the previous period (Column C)
4.23.12.3	4.11.1.3 - Direct benefits reported not yet paid (Column C)
4.23.14	4.11.6 - Provision for outstanding claims at the end of the financial year (Column C)
4.23.15	4.11.7 - Provision for outstanding claims at end of the previous year (Column C)
4.23.17	4.13.4 – Net (income)/expense from other risk transfer arrangements (Consolidated total current year column)
4.23.17.1	4.13.1 - Premiums/fees paid (Capitation fees) (Consolidated total current year column)



<i>Consolidated Column Line</i>	<i>Should agree to part</i>
4.23.17.2	4.13.2 – Less: Claims recoveries in respect of related risk transfer arrangements (Consolidated total current year column)
4.23.17.3	4.13.3 - (Other) (Consolidated total current year column)
4.23.18	4.11.10 - Relevant healthcare expenditure (Total)
4.23.20	4.14.7 – Net income/(expense) from commercial reinsurance arrangements (Consolidated total)
4.23.21	4.12.31 - Managed care: management services (Total)
4.23.22.1	4.15.3(a) - Broker service fees
4.23.22.2	4.15.3(b) - Other distribution costs
4.23.23	4.16.41 - Administration expenses (Current year: Fund)
4.23.24 + 4.23.26	4.18.6 - Column H - Total movement in statement of comprehensive income for the year
4.23.27	4.19.3 - Total other investment income
4.23.30	4.20.7 - Total realised and unrealised gains/(losses)
4.23.32	4.21.3 - Total own facility surplus/(deficit)
4.23.34	4.22.4 - Total finance costs

For more information on “other” risk transfer arrangements to be included in 4.23.12 to 4.23.17.3, please refer to details provided in part 4.3 (Trade and other receivables), 4.9 (Outstanding claims provision), 4.11 (Net claims incurred) and 4.13 (Net income/ (expense) from other risk transfer arrangements (excluding commercial reinsurance contracts)).

The members and beneficiaries per benefit option in lines 4.23.38 and 4.23.39 are pulled through from part 2.1.

If no savings plan contributions were received during the year, and a savings plan liability still existed at year end, the scheme will be required to supply further information regarding the procedures in place to refund the monies, and the timing thereof.

Part 4.24 Guarantees Supplied to Registrar in Terms of the Act

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PART 4.24: GUARANTEES SUPPLIED TO REGISTRAR IN TERMS OF THE ACT

	Total
4.24.1 Name of Institution	R 20,000
4.24.2 Total guarantees	20,000

Scheme: (MMED) Financial Year: (2010)

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Where, in accordance with the Act, a third party has provided a guarantee to the scheme to ensure the financial soundness of the scheme and/or its benefit options, details of such guarantee is disclosed in this part.

This will be any guarantees supplied in terms of section 24(5) of the Act and/or regulation 2(1) (j) of the Regulations to the Act; and/or sections 33(3) and 44(9) (b) of the Act.

The scheme should also indicate the name of the institution which provided such guarantee to the scheme (i.e. a bank, the administrator etc.).

Part 4.25 Guarantees and Suretyships for Third Parties Liabilities (Including Contingent Liabilities)

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PART 4.25: GUARANTEES AND SURETYSHIPS FOR THIRD PARTIES LIABILITIES (INCLUDING CONTINGENT LIABILITIES)

	Guarantees	Suretyships	Encumbered Assets	Other
	R	R	R	R
4.25.1 To whom	10,000	20,000	30,000	40,000
4.25.2 Total	10,000	20,000	30,000	40,000

Were the guarantees, suretyship for third party liabilities or encumbered assets approved by Council?
Please also indicate the date of approval. [Click here](#)

Scheme: (MMED) Financial Year: (2010)

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Where the scheme has provided a guarantee and/or suretyship to a third party, details of such guarantee and/or suretyship should be disclosed, per individual party to which such guarantee or suretyship was given.

The scheme should also list all assets individually, which were encumbered at end of the financial year end.

Whenever a scheme has completed this part, further detail in respect of Council's approval in terms of section 35(6) will be required.

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Part 4.26 Related Party Transactions

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PART 4.26: RELATED PARTY TRANSACTIONS

	Name	Nature of related party relationship	Nature of transactions/balances at year-end	Was the transaction/balances at year-end at arms-length Click for Yes	Amount
					R
STATEMENT OF COMPREHENSIVE INCOME					
4.26.1	(transactions for the year (income statement))				1,764,516,608
4.26.1.1	Trustee remuneration & considerations	Board of Trustee	Key manager	Trustees' remun	617,529
4.26.1.2	Trustees: Fees received in respect of services rendered to related parties	Board of Trustee	Key manager	Services rendered	107,200
4.26.1.3	Principal Officer remuneration & considerations	Principal Officer	Key manager	Principal Officer	1,944,808
4.26.1.4	(Name of consolidated party (specify))				22,000,000
STATEMENT OF FINANCIAL POSITION					

Scheme: (MMED) Financial Year: (2010)

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Due to inconsistencies experienced in the past, no differentiation between income and expenditure, as well as debit and credit balances are required.

Potential related parties as well as related party disclosure are discussed in detail in the relevant Appendices to the SAICA Guide. In terms of IAS 24 – *Related Party Disclosure*, “a related party is a person or entity that is related to the entity that is preparing its financial statements:

- (a) A person or a close member of that person's family is related to a reporting entity if that person:
 - (i) has control or joint control over the reporting entity;
 - (ii) has significant influence over the reporting entity; or
 - (iii) is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
- (b) An entity is related to a reporting entity if any of the following conditions applies:



- (i) The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
- (ii) One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
- (iii) Both entities are joint ventures of the same third party.
- (iv) One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
- (v) The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
- (vi) The entity is controlled or jointly controlled by a person identified in (a).
- (vii) A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity)".

Based on the definition of related parties above, the scheme would need to select the appropriate nature of relationship from the drop-down menu supplied in part 4.26 for each individual transaction/balance:

- Associate
- Control
- Joint venture
- Key management personnel
- Significant influence
- Sponsoring employer
- Subsidiary
- Other (Specify)

The individual totals per this part should agree with the scheme's note in the audited financial statement with regards to related party transactions (in terms of IAS 24). The statement of comprehensive income transactions for the year should be disclosed per party and per nature of transaction in part 4.26.1. The scheme should not aggregate all the statement of comprehensive income related party transactions.

The balances owing to/from related parties at year-end should be disclosed in part 4.26.2. The statement of financial position balances for the year should be disclosed per party and per nature. The scheme should not aggregate all the related party balances.

The following are examples of the type of information that we require for purposes of part 4.26 when a scheme has identified an entity as a related party:

(Please note that the following examples are not considered to be an exhaustive list of all possible related parties and transactions.)



Board of trustees/Principal officer/Executive management and their close family members

(Key management personnel)

_Trustee remuneration and considerations will be pulled through as an aggregate from part 4.17.

- Fees received by trustees in respect of services rendered to related parties to the scheme will also pull through as an aggregate from part 4.17.
- Principal Officer remuneration and considerations will be pulled through from part 4.16.27 and part 4.16.28.
- Any other members of "executive" management's remuneration should be disclosed separately from the board of trustees and Principal Officers' remuneration.
- Gross contributions received (disclosed in aggregate)
- Gross claims paid (disclose in aggregate)
- Ex-gratia payments (disclose in aggregate)
- Any other transaction entered into between the scheme and one of the parties mentioned above (disclose per individual)
- Any transactions between the scheme and another entity that is controlled, jointly controlled or significantly influenced by one of the parties mentioned above (disclose per individual)
- Outstanding balances on savings accounts (disclosed in aggregate)
- Outstanding contributions payable to scheme (disclosed in aggregate)
- Outstanding claims due by the scheme (disclosed in aggregate)
- Outstanding balances with regards to any other transaction (disclose per individual)

Employer groups

(The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.)

- Grant received from employer
- Administration refund from employer
- Rent paid to the employer
- Administration fees paid if the employer group handles the administration function
- Site office costs
- Any other transactions
- Outstanding balances due by the scheme in respect of the above transactions
- Outstanding balances due to the scheme in respect of the above transactions

Administrators

(A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services.)

- Administration fees paid
- Administration fees recovered
- Site office costs
- Rent received (where administrator rents building from scheme)



- Rent paid (where scheme rents building from administrator)
- Any other transactions
- Outstanding balances due by the scheme in respect of the above transactions
- Outstanding balances due to the scheme in respect of the above transactions

Managed care organisations

(A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services.)

- Managed care fee (the total amount per party must be provided as the details would have been provided in 4.12).
- Outstanding balances due by the scheme in respect of the above transactions
- Outstanding balances due to the scheme in respect of the above transactions

Subsidiaries, Joint Ventures, and Associates

(These entities' names will pull through from question 7 in part 1.4. Additional entries for each related party can be created by clicking on the "Copy" button.)

- Any transactions
- Outstanding balances due by the scheme
- Outstanding balances due to the scheme

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Other - Windows Internet Explorer

Please supply a detailed list

Description	Name	Nature of related party relationship	Nature of transactions/balances at year-end	Was the transaction/balances at year-end at arms-length (Click for Yes)	Amount	
ABC Marketing -Pty	ABC Marketing -Pty	Subsidiary	Advertising expenditure	<input checked="" type="checkbox"/>	3,000,000	Copy Delete
ABC Marketing -Pty	ABC Marketing -Pty	Subsidiary	Marketing expenditure	<input checked="" type="checkbox"/>	7,000,000	Copy
DEF Investments -Pt	DEF Investments -Pt	Significant influence	Rent of property	<input checked="" type="checkbox"/>	12,000,000	Copy

Done

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4.28.1.3 Principal Officer remuneration & considerations

Principal Officer	Key manager	Principal Officer		Amount
			<input checked="" type="checkbox"/>	1,944,808

4.28.1.4 Name of consolidated party (specify)

22,000,000

STATEMENT OF FINANCIAL POSITION

Scheme: (MIMED) Financial Year: (2010)

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Details need to be provided where transactions did not occur on an arms-length basis.



The following are examples of how part 4.26 have to be completed:

		Name	Nature of Related party relationship	Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arms-length	Amount
					Y/N	R
STATEMENT OF COMPREHENSIVE INCOME						
4.26.1	Transactions for the year (statement of comprehensive income)					
4.26.1.1	Trustee remuneration & considerations	Board of Trustees	Key management personnel	Trustee remuneration	Yes	617,529
4.26.1.2	Trustees: Fees received in respect of services rendered to related parties	Board of Trustees	Key management personnel	Services rendered to related parties	Yes	203,152



		Name	Nature of Related party relationship	Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arms-length	Amount
4.26.1.3	Principal Officer remuneration & considerations	Principal Officer	Key management personnel	Principal Officer remuneration	Yes	1,944,808
4.26.1.4	AB Ltd	Subsidiary	Subsidiary	Rental	No	20,000
4.26.1.5	Contributions	Board of Trustees	Key management personnel	Trustee contributions	Yes	139,915
4.26.1.6	Contributions	Principal Officer	Key management personnel	Principal Officer contributions	Yes	13,275
4.26.1.7	Claims paid	Board of Trustees	Key management personnel	Trustee claims paid	Yes	38,219
4.26.1.8	Claims paid	Board of Trustees	Key management personnel	Trustee claims paid MSA	Yes	38,492
4.26.1.9	Claims paid	Principal Officer	Key management personnel	Principal Officer claims paid	Yes	102



		Name	Nature of Related party relationship	Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arms-length	Amount
4.26.1.10	Claims paid	Principal Officer	Key management personnel	Principal Officer claims paid MSA	Yes	3,656
4.26.1.11	A Smit Medical practice	Board of Trustees	Key management personnel	Healthcare provider fees paid	Yes	333,833
4.26.1.12	AB Administrators (Pty) Ltd	Administrator	Key management personnel	Administration fees	Yes	2,500,000
4.26.1.13	AB Administrators (Pty) Ltd	Administrator	Key management personnel	Interest received on monthly balances	Yes	491,652
4.26.1.14	AB Administrators (Pty) Ltd	Administrator	Key management personnel	Interest paid on monthly balances	Yes	48,679
4.26.1.15	AB Administrators (Pty) Ltd	Managed care organisation	Key management personnel	Managed care fees	Yes	419,503,072
4.26.1.16	Employer Group ABC	Employer group	Sponsoring employer	Grant received	Yes	5,000,000
STATEMENT OF FINANCIAL POSITION						



		Name	Nature of Related party relationship	Nature of transactions/ balances at year-end	Was the transaction/ balances at year-end at arms-length	Amount
4.26.2	Balances at year end (statement of financial position)					
4.26.2.1	AB Ltd	Subsidiary	Subsidiary	Rental owed	No	40,000
4.26.2.2	Contributions debtor	Principal Officer	Key management personnel	Principal Officer contribution debtor	Yes	1,093
4.26.2.3	Savings plan liability	Principal Officer	Key management personnel	Savings plan liability	Yes	1,683
4.26.2.4	Contributions debtor	Board of Trustees	Key management personnel	Trustee contributions debtors	Yes	5,397
4.26.2.5	Savings plan liability	Board of Trustees	Key management personnel	Savings plan liability	Yes	9,556
4.26.2.6	AB Administrators (Pty) Ltd	Administrator	Key management personnel	Administration fees payable	Yes	188,529,398



PART 5 STATEMENT OF FINANCIAL POSITION

	Current year	Previous year (LOCKED)
	R	R
5.1 ASSETS		
5.1.1 Non-current assets	666,130,869	663,617,432
5.1.1.1 Property, plant & equipment	11,033,437	8,520,000
5.1.1.2 Investments	654,997,432	654,997,432
5.1.1.3 Other non-current assets (specify)	100,000	100,000
5.1.2 Current assets	4,703,841,103	5,841,292,740
5.1.2.1 Inventories	7,006	6
5.1.2.2 Trade and other receivables	679,542,728	679,542,728
5.1.2.3 Investments	3,471,460,576	3,471,460,576
5.1.2.4 Cash and cash equivalents	552,830,793	552,830,793
5.1.2.5 Other current assets (specify)	0	1,137,458,637
5.1.3 Total assets	5,369,971,972	6,504,910,172

With reference to Circulars 38 of 2011 and its clarifying circular issued in February 2012 schemes should note that the relevant changes to the annual statutory return will only be made in respect of the 2012 annual statutory return; this is due to the fact that schemes would not have been able to make the necessary system changes and disinvestment of assets by 31 December 2011. The savings plan assets and liabilities will therefore still be included as part of the scheme assets and liabilities in the 2011 return.

Most of the statement of financial position balances for the current year pulls automatically through from the individual parts, completed in part 4 and part 7 of the return; except for other non-current assets, inventories, other current assets, minority interest (where a scheme completes consolidated financial statements) and other current liabilities.

Details of other non-current and current assets should be provided in the description line provided for in part 5.1.1.3 and 5.1.2.5 respectively; all the scheme's non-current and current assets should not be aggregated and disclosed as a single line in part 5.1.1.3 and 5.1.2.5. The same applies to the other current liabilities in part 5.2.3.4.

The majority of the scheme's previous year's figures are automatically pulled through from the previous year's return. The scheme has the option to unlock these amounts and edit them in instances where changes occurred. When changes are made to these figures, the scheme would be required to provide



more information on the reasons for these adjustments. The following lines pull through from opening balances in parts 4 and 7:

- Property, plant and equipment;
- Accumulated funds;
- Revaluation reserve – investments;
- Revaluation reserve – property, plant and equipment;
- Reserves set aside for specific purposes;
- Other reserves;
- Savings plan liability; and
- Outstanding claims provision.

The savings plan liability is a current liability, due to the fact that if the members of the scheme leave tomorrow, their credit savings account balances must be transferred or paid out immediately in terms of Regulation 10 of the Act.

Details of other current liabilities should be provided in the description line provided for in part 5.2.3.4; all the scheme's current liabilities should not be aggregated and disclosed as a single line in part 5.2.3.4.

The total assets in part 5.1.3 must agree with the total funds and liabilities in part 5.3 (both current and prior year columns).



PART 6 STATEMENT OF COMPREHENSIVE INCOME

Part 6.1 Statement of Comprehensive Income

		Current year	Previous year (LOCKED)
		R	R
0.1.1	Gross contribution income	16,619,189,351	16,619,189,351
0.1.2	Less: Savings contribution income	(3,615,556,366)	(3,615,556,366)
0.1.3	Net contribution income	13,003,632,985	13,003,632,985
0.1.4	Relevant healthcare expenditure	(11,296,455,565)	(11,296,455,565)
0.1.4.1	Net claims incurred	(11,320,284,851)	(11,320,284,851)
0.1.4.2	Net (income)/expense on risk transfer arrangements	23,829,286	23,829,286
0.1.5	Gross healthcare result	1,707,177,420	1,707,177,420
0.1.6	Net income/(expense) on commercial reinsurance	19,527	19,527
0.1.7	Less: Managed care: management services	(419,763,072)	(419,763,072)
0.1.8.1	Less: Broker service fees	(404,562,667)	(404,562,667)
0.1.8.2	Less: Other distribution costs	(7,000)	(7,000)
0.1.9	Less: Administration expenses	(1,979,036,322)	(1,979,036,322)
0.1.10	Net impairment losses: Trade and other receivables	(16,327,046)	(16,327,046)
0.1.11	Net healthcare result	(1,112,499,160)	(1,112,499,160)
0.1.12	Net impairment losses: Other (specify)	(4,000)	(4,000)
0.1.13	Other investment income	335,049,973	335,049,973
0.1.14	Less: Investment management fees	(9,354,280)	(9,354,280)
0.1.15	Less: Operating expenses on rental of investment property	(5,000)	(5,000)
0.1.16	Other realised and unrealised gains/(losses)	135,708,107	135,708,107
0.1.17	Other income (specify)	822,230,896	822,230,896

The current year income statement pulls through from the consolidated amounts as captured in part 4.23 of the return.

The other comprehensive income should agree with the net movements in the different reserve accounts (excluding movements due to amalgamations), for both the current and previous financial year. The reclassification adjustment as per line 6.1.26 relates to gain/ loss on sale of available-for sale investments which is taken to the income statements within "Investment income".

The prior year figures are automatically pulled through from the previous year's annual statutory return, except for line 6.4.2 which pulls through from line 4.13.4's previous year consolidated total column, and line 6.9 which pulls through from line 4.16.41's previous year fund total column. The user has the option to unlock these amounts for editing when prior year adjustments/restatements occurred. When changes are made to these figures, the scheme would be required to provide more information on the reasons for these adjustments.

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Details (per nature of transaction) of the following income and expenses should be provided in the different parts:

- Net impairment losses: Other (6.12)
- Other income (6.17)
- Other expenses (6.19)
- Other comprehensive income (6.28)

Where the scheme receives a grant from a sponsor, an employer, third party fund administrator, etc., whether to comply with Regulation 29 of the Regulations to the Act, namely, minimum accumulated funds to be maintained by the scheme, or for any other reason, the grant is shown separately under "Other income" in part 6.17. Such grants do therefore not form part of the scheme's net healthcare result.

Part 6.2 Monthly Statement of Net Healthcare Result

		Year To Date	January	February	March
		R	R	R	R
6.2.1	Gross contribution income	16,619,189,351	1,361,573,258	1,365,481,863	1,371,005,594
6.2.2	Less: Savings contribution income	(3,615,556,366)	(296,214,500)	(297,064,829)	(298,266,534)
6.2.3	Net contribution income	13,003,632,985	1,065,358,758	1,068,417,034	1,072,739,060
6.2.4	Relevant healthcare expenditure	(11,296,455,565)	(790,751,890)	(564,822,779)	(451,858,223)
6.2.4.1	Net claims incurred	(11,320,284,851)	(792,419,940)	(566,014,243)	(452,811,394)
6.2.4.2	Net income/(expense) on risk transfer arrangements	23,829,286	1,668,050	1,191,464	953,171
6.2.5	Gross healthcare result	1,707,177,420	274,606,868	503,594,255	620,880,837
6.2.6	Net income/(expense) on commercial reinsurance contracts	19,527	1,600	1,604	1,611
6.2.7	Less: Managed care: management services	(419,763,072)	(34,390,256)	(34,488,978)	(34,628,495)
6.2.7.1	Managed care: management services: paid to administrator and its related parties	(107,072)	(8,772)	(8,797)	(8,833)
6.2.7.2	Managed care: management services: paid to other third parties	(419,656,000)	(34,381,484)	(34,480,181)	(34,619,662)
6.2.8.1	Less: Broker service fees	(404,562,667)	(33,144,920)	(33,240,068)	(33,374,533)
6.2.8.2	Less: Other distribution costs	(7,000)	(573)	(575)	(577)
6.2.9	Less: Administration expenses	(1,979,036,322)	-162138049	-162603490	-163261265
6.2.9.1	Administration fees and indirect fees paid to the administrator	(1,764,004,641)	(144,520,981)	(144,935,850)	(145,522,154)
6.2.9.2	Co-administration fees	(30,000)	(2,458)	(2,465)	(2,475)

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

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The total amount for the year to date income statement should at all times agree on a line for line basis with the amounts as per part 6.1. The year to date managed care: management services amount paid to the administrator and its related parties should agree with the amount as per part 4.12.30 (Administrator / Self-administration column).



PART 7 STATEMENT OF CHANGES IN FUNDS AND RESERVES

Part 7.1 Accumulated Funds

	Current year R	Previous year R
7.1.1 Balance at the beginning of the year	7,088,573,690	3,130,729,383
7.1.1.1 - As previously reported	4,273,533,598	7,088,573,690
7.1.1.2 - Prior year adjustment (including effect of first time adoption of IFRS)	2,815,040,092	(3,957,844,307)
7.1.2 Surplus/(Deficit) for the year	169,059,698	1,145,370,895
7.1.3 Transfer to/(from) accumulated funds	0	(2,846,680)
7.1.3.1 - Due to amalgamation	60,000	0
7.1.3.2 - Due to re-measurement property, plant and equipment	70,000	0
7.1.5 Balance at the end of the year	3,130,581,232	4,273,533,598

The opening balance as previously reported at the beginning of the previous year (7.1.1.1), pulls automatically through from the previous year's annual return (7.1.1). Therefore, the scheme should restate the prior year's figures (where applicable) on the return by making use of line 7.1.1.2.

The closing balance of the previous year (7.1.5) pulls automatically through to the opening balance of the current year (as previously reported - 7.1.1.1). The current year's figure will therefore automatically incorporate any restatements of prior year balances.

The net surplus/ (deficit) after consolidation for the year in part 7.1.2 pulls through from part 6.23, for both the current and previous financial year.

The scheme should provide the exact nature of any amounts included in part 7.1.4. The scheme should only complete this part if the return does not cater specifically for that kind of transaction elsewhere in part 7.1.

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The following reason box should be completed (if the specifications are met):

Specification	Reason box wording
Previous year figures were restated/reclassified in line 7.1.1.2 (both current year and previous year columns).	Please provide the reasons for any prior year restatements/reclassifications.

Part 7.2 Revaluation Reserve (Financial Instruments)

The screenshot shows the CMS Statutory Returns Portal interface. The main content area displays 'PART 7.2: REVALUATION RESERVE (INVESTMENTS)'. Below this is a table with two columns: 'Current year' and 'Previous year', both with a sub-column 'R'. The table contains the following rows:

	Current year R	Previous year R
7.2.1 Balance at the beginning of the year	4,080,000	0
7.2.1.1 - As previously reported	4,080,000	0
7.2.1.2 - Prior year adjustment (including the first time adoption of IFRS)	0	0
7.2.2 Unrealised gains/(losses) on revaluation of investments	5,000,000	5,000,000
7.2.3 Realised (gains)/losses on derecognition of investments	(1,000,000)	(1,000,000)
7.2.4 Revaluation adjustment	60	70,000
7.2.5 Transfer (to)/from reserves	1,999,940	10,000
7.2.5.1 Due to amalgamation	0	80,000
7.2.5.2 Other (specify)	1,999,940	(70,000)
7.2.6 Balance at the end of the year	10,080,000	4,080,000

Below the table, there is a text box labeled 'Please provide the reasons for any prior year restatements/reclassifications:' with a 'Click here' button next to it.

The opening balance as previously reported at the beginning of the previous year (7.2.1.1), automatically pulls through from the previous year's annual return (7.2.1). Therefore, the scheme should restate the prior year's figures (where applicable) on the return by making use of line 7.2.1.2.

The closing balance of the previous year (7.2.7) pulls automatically through to the opening balance of the current year (as previously reported – 7.2.1.1). Hence, the current year's figure will automatically incorporate any restatements of prior year's balances.

The unrealised gains/losses on revaluation of investments (7.2.2) automatically pull through from 6.25, for both the current and previous financial year.

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The realised (gains)/losses on derecognition of investments (7.2.3) automatically pulls through from 6.26, for both the current and previous financial year.

The scheme should provide the exact nature of any amounts included in part 7.2.6. The scheme should only complete this part if the return does not cater specifically for that kind of transaction elsewhere in part 7.2.

The following reason box should be completed (if the specifications are met):

Specification	Reason box wording
Previous year figures were restated/reclassified in line 7.2.1.2 (both current year and previous year columns).	Please provide the reasons for any prior year restatements/reclassifications.

Part 7.3 Revaluation Reserve (Property, Plant and Equipment)

The screenshot shows the CMS Statutory Returns Portal interface. The main content area displays 'PART 7.3: REVALUATION RESERVE (PROPERTY, PLANT AND EQUIPMENT)'. Below this is a table with two columns: 'Current year' and 'Previous year', both with a sub-column 'R'. The table rows are as follows:

	Current year R	Previous year R
7.3.1 Balance at the beginning of the year	7,000,000	0
7.3.1.1 - As previously reported	7,000,000	0
7.3.1.2 - Prior year adjustment (including the first time adoption of IFRS)	0	0
7.3.2 Unrealised gains/(losses) on revaluation of property, plant and equipment	7,000,000	7,000,000
7.3.3 Revaluation adjustment	3,070,000	80,000
7.3.4 Transfer (to)/from reserves	5,000,000	(80,000)
7.3.4.1 Due to amalgamation	0	0
7.3.4.2 Other (specify)	5,000,000	(80,000)
7.3.5 Balance at the end of the year	22,070,000	7,000,000

Below the table, there is a section titled 'Please provide the reasons for any prior year restatements/reclassifications:' with a 'Click here' button.

The opening balance as previously reported at the beginning of the previous year (7.3.1.1), pulls automatically through from the previous year's annual return (7.3.1). Therefore, the scheme should restate



the prior year's figures (where applicable) on the return. The scheme should please use 7.3.1.2 for any restatements.

The closing balance of the previous year (7.3.6) pulls automatically through to the opening balance of the current year (as previously reported – 7.3.1.1). Hence, the current year's figure will automatically incorporate any restatements of prior year's balances.

The unrealised gains/losses on revaluation of property, plant and equipment (7.3.2) automatically pulls through from 6.27, for both the current and previous financial year.

The scheme should provide the exact nature of any amounts included in part 7.3.5. The scheme should only complete this part if the return does not cater specifically for that kind of transaction elsewhere in part 7.3.

The following reason box should be completed (if the specifications are met):

<i>Specification</i>	<i>Reason box wording</i>
Previous year figures were restated/reclassified in line 7.3.1.2 (both current year and previous year columns).	Please provide the reasons for any prior year restatements/reclassifications.

Part 7.4 Reserves Set Aside for Specific Purposes

The scheme should complete this part per individual reserve set aside for specific purposes. The following screen will appear, to enable the scheme to capture the individual reserves:

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After capturing all the reserves set aside for specific purposes the user should press the 'done' button. The reserves captured will then automatically pull through to part 7.4.

Help File: 2011 Annual Statutory Return



http://cmsuat02>Returns/annual.aspx?p=7&d=4 Statutory Returns Portal - C...

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Part 8 Part 9 Part 10 Part 11
Part 1 Part 2 Part 3 Part 4 Part 5 Part 6 Part 7

Part 7.1 Part 7.2 Part 7.3 Part 7.4 Part 7.5

PART 7.4: RESERVES SET ASIDE FOR SPECIFIC PURPOSES

Add reserve

Per reserve
Test reserve A

	Current year		Previous year	
	Consolidated	Per Reserve	Consolidated	Per Reserve
	R	R	R	R
7.4.1 Balance at the beginning of the year	(11,945)	0	(6,000)	5,945
7.4.1.1 - As previously reported	(83,000)	(71,055)	(6,000)	(3,000)
7.4.1.2 - Prior year adjustment (including the first time adoption of IFRS)	71,055	71,055	0	8,945
7.4.2 Transfer (to)/from reserves	(500,200)	0	(77,000)	(77,000)
7.4.2.1 Due to amalgamation	0	0	(78,000)	(77,000)
7.4.2.2 Other (specify)	(500,200)	0	1,000	0
7.4.4 Balance at the end of the year	(512,145)	0	(83,000)	(71,055)

Please provide the reasons for any prior year restatements/reclassifications: [Click here](#)

The consolidated balance at the beginning of the previous year (7.4.1.1) automatically pulls through from the scheme's previous' annual return (7.4.1). Therefore, the scheme should restate the prior year's figures (where applicable) on the current year's return.

The data should be captured per individual reserve, as the consolidated column sums the total of all the individual reserves.

The closing balance of the previous year (7.4.4) pulls automatically through to the opening balance of the current year (as previously reported – 7.4.1.1). Hence, the current year's figure will automatically incorporate any restatements of prior year's balances.

The scheme should provide the exact nature of any amounts included in part 7.4.3. The scheme should also only complete this part, if the return does not cater specifically for that kind of transaction elsewhere in part 7.4.

It should be noted that reserves set aside for specific purposes are excluded from the scheme's solvency ratio in terms of Regulation 29.

Help File: 2011 Annual Statutory Return



The following reason box should be completed (if the specifications are met):

Specification	Reason box wording
Previous year figures were restated/reclassified in line 7.4.1.2 (both current year and previous year consolidated columns).	Please provide the reasons for any prior year restatements/reclassifications.

Part 7.5 Other Reserves

The scheme should complete this part per individual other reserve. The following screen will appear, to enable the scheme to capture the individual reserves:

The screenshot shows the 'Statutory Returns Portal - CMS Annual Section' in a Windows Internet Explorer browser. The URL is <http://cmsuat01/returns/annual.aspx?p=7&d=5>. The page features the CMS logo and navigation links: Home, Contact Us, Statutory Return, Print, Validate, Submit, Help, and LogOut. A series of buttons labeled Part 1 through Part 11 are visible, with Part 7 highlighted. Below the navigation, the 'PART 7.5: OTHER RESERVES' section is active. It contains a 'Please add Reserve Name' label and a 'Done' button. A list of reserves is shown, including 'Test reserve B' and 'Test reserve A', each with a 'Delete' button. A 'save' button is also present at the bottom of the list.

After capturing all the other reserves, the user should press the 'done' button. The reserves captured will then automatically pull through to part 7.5.

Help File: 2011 Annual Statutory Return



		Current year		Previous year	
		Consolidated R	Per Reserve R	Consolidated R	Per Reserve R
7.5.1	Balance at the beginning of the year	2,000	3,000	2,000	3,000
7.5.1.1	- As previously reported	2,000	3,000	2,000	3,000
7.5.1.2	- Prior year adjustment (including the first time adoption of IFRS)	0	0	0	0
7.5.2	Transfer (to)/from reserves	(1,300,000)	700,000	0	0
7.5.2.1	Due to amalgamation	0	0	(2,000)	(3,000)
7.5.2.2	Other (specify)	(1,300,000)	700,000	2,000	3,000
7.5.3	Balance at the end of the year	(1,298,000)	703,000	2,000	3,000

Please provide the reasons for any prior year restatements/reclassifications: [Click here](#)

The consolidated balance at the beginning of the previous year (7.5.1.1) automatically pulls through from the scheme's previous' annual return (7.5.1). Therefore, the scheme should restate the prior year's figures (where applicable) on the current year's return.

The data should be captured per individual reserve, as the consolidated column sums the total of all the individual reserves.

The closing balance of the previous year (7.5.4) pulls automatically through to the opening balance of the current year (as previously reported – 7.5.1.1). Hence, the current year's figure will automatically incorporate any restatements of prior year's balances.

The scheme should provide the exact nature of any amounts included in part 7.5.3. The scheme should also only complete this part, if the return does not cater specifically for that kind of transaction elsewhere in part 7.5.

It should be noted that other reserves are included from the scheme's solvency ratio in terms of Regulation 29.

Help File: 2011 Annual Statutory Return



The following reason box should be completed (if the specifications are met):

<i>Specification</i>	<i>Reason box wording</i>
Previous year figures were restated/reclassified in line 7.5.1.2 (both current year and previous year consolidated columns).	Please provide the reasons for any prior year restatements/reclassifications.



PART 8 CASH FLOW STATEMENT

All investment income received should for return purposes be accounted for under part 8.2 "Cash flows from investing activities" in the relevant lines.

The Council requires schemes to use the direct method in disclosing its cash flows for the period for return purposes.

	Current year R	Previous year R
8.1 Cash flows from operating activities		
8.1.1 Cash receipts from members and providers	16,651,784,797	16,651,784,797
8.1.1.1 Cash receipts from members – contributions	16,619,189,351	16,619,189,351
8.1.1.2 Cash receipts from members and providers – other	32,595,446	32,595,446
<i>Note: This will include co-payments from members and recoveries from third parties.</i>		
8.1.2 Cash paid to providers, employees and others	(18,064,828,790)	(18,064,828,790)
8.1.2.1 Cash paid to providers and members	(15,126,758,557)	(15,126,758,557)
8.1.2.2 Cash paid to providers and employees	(2,803,981,757)	(2,803,981,757)
8.1.2.3 Cash paid to members – savings plan	(134,088,476)	(134,088,476)
8.1.3 Cash generated from operations	(1,413,043,993)	(1,413,043,993)
8.1.4 Interest paid	(24,432,218)	(24,432,218)
8.1.5 Other (specify)	36,013,332,428	36,013,332,428
8.1.6 Net cash from operating activities	34,575,856,217	34,575,856,217
8.2 Cash flows from investing activities		
8.2.1 Purchase of property, plant and equipment	(7,853,954)	0
8.2.2 Proceeds on disposal of property, plant and equipment	8,523,642	0
8.2.3 Purchase of investment property	(663,463)	0
8.2.4 Proceeds on disposal of investment property	163,463	0

Where a line starts with the word 'Less', the scheme should place a minus in front of the figure.

The scheme should also include the cash flow statement's comparative figures in the return.



Cash receipts from members and providers – other (line 8.1.1.2) will include co-payments from members as well as recoveries from third parties.

Details (per nature of transaction) of the following income and expenses should be provided in the different parts:

- Other cash flows from operating activities (8.1.5)
- Other cash flows from investing activities (8.2.10)
- Other cash flows from financing activities (8.3.2)
- Other net increases in cash and cash equivalents (8.6)

The cash and cash equivalents at the end of the current year in part 8.8, should agree with the total cash and cash equivalents per statement of financial position in part 4.4.7 less any bank overdrafts in part 4.8.5. The cash and cash equivalents at the end of the previous year in part 8.8, should either agree with or be less than part 5.1.2.4 (previous year column)

The cash and cash equivalents at the beginning of the previous year (8.5.1) pull automatically through from the scheme's previous year's annual return (8.5). The closing balance at the end of the previous year (8.8) pulls then automatically through to opening cash and cash equivalent for the current year in part 8.5.1.

The following reason box should be completed (if the specifications are met):

<i>Specification</i>	<i>Reason box wording</i>
Previous year figures were restated/reclassified in line 8.5.2 (both current year and previous year columns).	Please provide the reasons for any prior year restatements/reclassifications.

**PART 9 INVESTMENT ANALYSIS****Part 9(a) Assets Held in the Republic**

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Part 9(a) Assets Held in the Republic in terms of Regulation 30 in conjunction with Annexure B to the Regulations

Hide Notice

Please refer to our website for the following guidelines on the categorisation of assets in terms of Annexure B as at 31 December 2011:

- 1) List of registered banks as at 31 December 2011: categorisation for Annexure B purposes;
- 2) Instruments listed on BESA as at 31 December 2011: categorisation for Annexure B purposes;
- 3) Instruments listed on the JSE as at 31 December 2011: categorisation for Annexure B purposes;
- 4) List of registered insurers as at 31 December 2011;

Name and Description	Direct Investment	Underlying assets of Policies of Insurance	Underlying assets of Equity Unit Trusts or Pooled Equity Managed Funds	Total Fair Value
9.1 CATEGORY ONE - Deposits and balances in current and savings accounts, negotiable deposits, money market instruments, structured bank notes, margin deposits with SAFEX and collateralised deposits.				
1(a)(i) BANKS with net qualifying capital and reserve funds > R5 billion				
Per Bank - Name (specify)	2,165,017,634	2,000	1,000	2,165,020,634
Other (specify)	1,150,464	333	1,000	1,151,797
SUB TOTAL: Category 1(a)(i)	2,166,168,098	2,333	2,000	2,166,172,431
1(a)(ii) BANKS with net qualifying capital and reserve funds > R100 million				
Per Bank - Name (specify)	153,598,847	667	1,000	153,600,514
Other (specify)	1,000	444	1,000	2,444
SUB TOTAL: Category 1(a)(ii)	153,599,847	1,111	2,000	153,602,958

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2012/02/20

With reference to Circulars 38 of 2011 and its clarifying circular issued in February 2012 schemes should note that the relevant changes to the annual statutory return will only be made in respect of the 2012 annual statutory return; this is due to the fact that schemes would not have been able to make the necessary system changes and disinvestment of assets by 31 December 2011. The savings plan assets and liabilities will therefore still be included as part of the scheme assets and liabilities in the 2011 return; similarly compliance to Annexure B will be tested on the total scheme assets which includes the savings plan assets. In the event that the scheme has been able to invest their savings plan monies separately from scheme assets by 31 December 2011, it is recommended that a letter to this effect is submitted together with the return (part 9A) to explain such deviation from the limitations imposed by Annexure B.

Where a description field starts with a "Less: ...", a minus should be placed in front of the figure.



Please note that the definitions of the fair values of assets as set out in Regulation 30(4) may in some instances not be in line with International Financial Reporting Standards (IFRS). However, in terms of Regulation 30(7) the Registrar directs medical schemes to calculate the fair value of assets as prescribed by the International Financial Reporting Standards.

The bank institutions for all cash investments (including all current bank accounts), should be provided in category 9.1 of part 9(a) the return. These balances should take the effect of outstanding cheques into account as per part 4.4.9. Please note that should the investment portfolios have a 'trading account', the scheme should indicate at which bank institution these accounts are held.

The names of all the registered banks will appear in a drop down list and the scheme should simply choose the institution required. Please note that only one institution can be selected at a time. The amount invested in any one institution should be in aggregate.

Please refer to the published guideline on our website that provides a listing of all registered banks; mutual banks; local branches of foreign banks; and foreign banks with approved local representative offices as per the South African Reserve Banks' Banks Supervision Unit. The guideline further sub-categorises these banks in terms of Category 1 of Annexure B to the Regulations.

The names of the institutions which issued all bills, bonds, securities or any other money market investments should be selected/captured in 9.2 of part 9(a) of the return.

The names of all the listed entities which are classified in categories 2(a)(i) – 2(a)(xiv) and 2(b) will appear in a drop down list and the scheme should simply choose the institution required. Please note that only one institution can be selected at a time. The amount invested in any one institution should be in aggregate. Where the scheme has investments in other entities than those listed, the "other" button provided in the drop down list should be used, clearly indicating the nature of these investments.

Please refer to the published guideline on our website that provides a detailed listing of all listed instruments on the Bond Exchange of South Africa (BESA). The guideline further categorises these instruments in the different sub-categories to category 2 of Annexure B to the Regulations.



A detailed list of every single property investment should be captured in category 9.3 of part 9(a) of the return, including the names of all property companies (again listed in a drop down list) in which the scheme invests. The amounts can be aggregated per company or per property. These also include owner occupied properties. The said drop down list only indicate listed property companies, any other investments (i.e. owner occupied buildings, etc.) should be entered by making use of the "other" button within the drop down list. For investments in listed securities please refer to the published guideline on our website that provides a categorisation of listed instruments on the Johannesburg Stock Exchange (JSE).

Part 9(a) subtotal: Category 3(a) must be equal or greater than the total investment property (part 4.2.1) plus the net carrying amount of the land and buildings at end of year (part 4.1.3).

A detailed list of all the companies in which any equity investments are held should be captured in category 9.4 of part 9(a) of the return. These amounts must be aggregated per company. The scheme should simply choose the institution required from the applicable drop down lists. The amount invested in any one institution should be in aggregate. Where the scheme has investments in other entities than those listed, the "other" button provided in the drop down list should be used, clearly indicating the nature of these investments.

Please refer to the published guideline on our website that provides information on the categorisation of all listed instruments on both the JSE and BESA in accordance to the requirements of Annexure B to the Regulations in the different sub-categories of categories 2 (bonds), 3 (property), 4 (shares), 5 (debentures) and 7 (other assets). All these guidelines have been incorporated in the drop down lists in the relevant categories.

The underlying assets of all equity unit trusts, pooled equity managed funds and policies of insurance should be provided separately from the direct investment in the relevant columns of the part. These underlying assets should be disclosed to the same extent as the other individual investments described above, in categories 1 - 7 of part 9(a) of the return.

The total of the amounts captured in the relevant columns for the underlying assets of the equity unit trusts or pooled equity managed funds and policies of insurances should agree with the totals captured in the direct investment column's categories 4(a)(iv), 4(a)(v) and 6 respectively. In order to prevent double counting, any amounts captured in these columns will not be included in the total net assets per Regulation 30 in category 9.9 of part 9(a) of the return.

This will effect the requirements of explanatory note 8 to Annexure B: "Unit trusts and policies of insurance may not be utilised to circumvent the limitations of these regulations. Medical schemes are required to



demonstrate on a "look-through" basis that such avenues have not been utilised to bypass the limitations imposed by Annexure B".

Please refer to the list of insurers registered in the Republic that is published on our website.

Some investment portfolios refer to percentage holdings in 'other assets' or 'international assets', please note that the full details of these investments should be provided per asset class in the return.

Part 9(a) subtotal: Category 7(a) (i) must agree with the current year's inventories (part 5.1.2.1).

The following assets in category 7(a) (iii) pulls through automatically:

Asset	Pull through from
Property, plant and equipment: computer equipment and software (direct investment)	4.1.3 - Net Carrying amount at end of year (Computer Equipment and Software)
Property, plant and equipment: furniture and fittings (direct investment)	4.1.3 - Net Carrying amount at end of year (Furniture and Fittings)
Property, plant and equipment: motor vehicles (direct investment)	4.1.3 - Net Carrying amount at end of year (Motor Vehicles)
Property, plant and equipment: other (direct investment)	4.1.3 - Net Carrying amount at end of year (Other)

Part 9(a) subtotal: category 7(a)(iii) must be equal to or greater than the net carrying amount the computer equipment, Furniture & fittings, Motor vehicles column and Other assets at end of year (part 4.1.3).

The total net assets per Regulation 30 in line 9.9 of part 9(a) of the return is the sum of all the amounts captured under categories 9.1 – 9.7 (all the grey headings), less assets encumbered which pulls through from part 4.25.2 (Total encumbered assets and Total suretyships columns) of the return.

Trade and other receivables in category 9.12 of part 9(a) (direct investment) of the return automatically pulls through from part 5.1.2.2 of the statement of financial position.

In the event that the scheme amalgamated during the year, it will still need to complete part 9(a) in detail as at the date of the amalgamation. The total assets transferred to another scheme will then be deducted in line 9.13.



The total assets in category 9.14 of part 9(a) of the return is the sum of the total net assets per Regulation 30 in line 9.9, plus the aforementioned encumbered assets, intangible assets, and trade and other receivables less the total assets transferred to another scheme upon amalgamation (during the year). This total should agree with the sum of the total assets in part 5.1.3 of the statement of financial position and outstanding cheques per part 4.4.8.

Part 9(b) Assets Held in the Republic in Terms of Regulation 30 in Conjunction with Annexure B to the Regulations

Name of the person/company/institution managing the investments	Person/company/institution responsible for the investment management		
	Managed on behalf of the scheme R	Managed by the scheme R	Total R
9.2.1 Managed by the scheme <input type="text" value="Specify..."/>	4,678,388,807	10,997,437	4,689,386,244
9.2.2 Total net assets per Regulation 30	4,678,388,807	10,997,437	4,689,386,244

This part should be completed per person/company/institution managing the investments of the scheme, whether it is managed on behalf of the scheme or by the scheme itself.

Important to note that only FAIS registered entities are allowed to manage investments on behalf of a medical scheme.

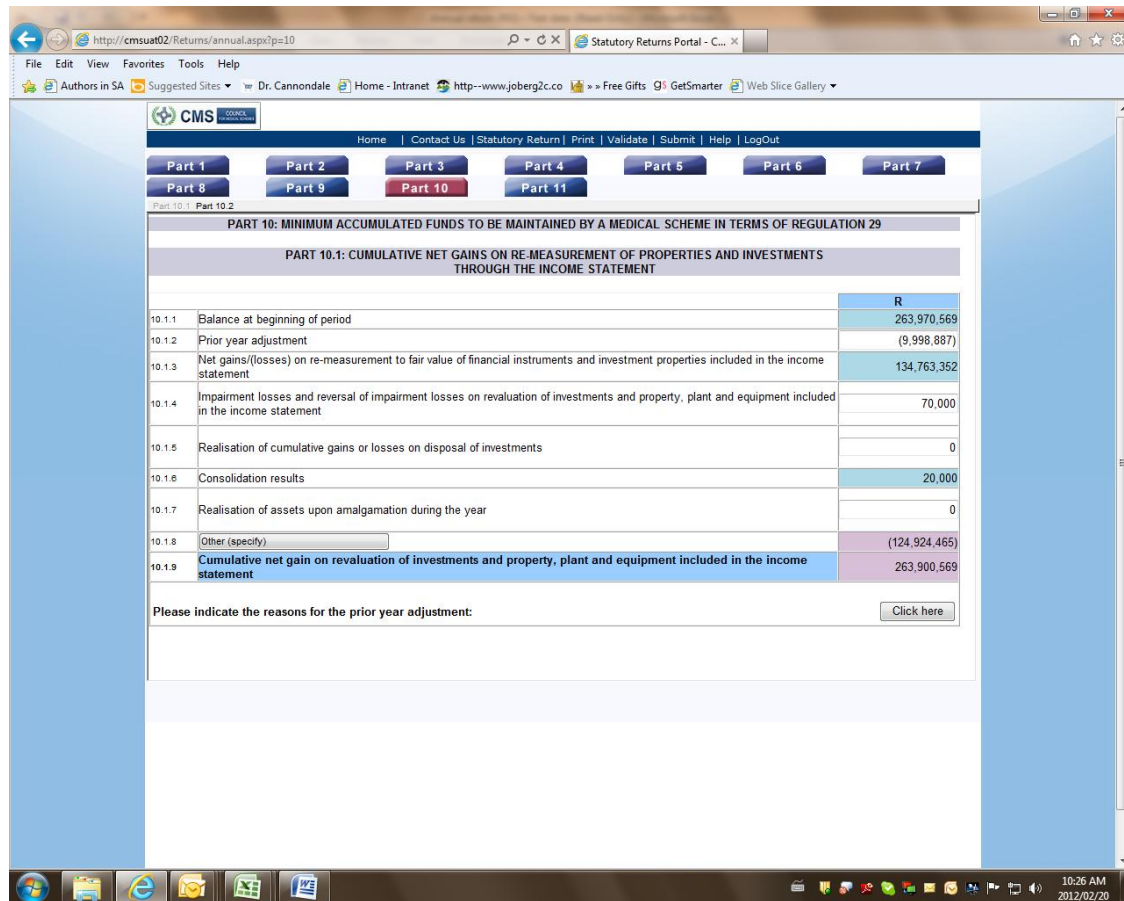


Please refer to the Financial Services Board's website (www.fsb.co.za) for more details on registered Financial Service Providers. A list of these providers as at 31 December is also published on our website.

The total net assets per Regulation 30 in Part 9(b) must agree with the total net assets per Regulation 30 in Part 9(a).9.

PART 10 MINIMUM ACCUMULATED FUNDS TO BE MAINTAINED

Part 10.1 Cumulative Net Gain on Re-measurement of Properties and Investments



Part 10: MINIMUM ACCUMULATED FUNDS TO BE MAINTAINED BY A MEDICAL SCHEME IN TERMS OF REGULATION 29

Part 10.1: CUMULATIVE NET GAINS ON RE-MEASUREMENT OF PROPERTIES AND INVESTMENTS THROUGH THE INCOME STATEMENT

	R
10.1.1 Balance at beginning of period	263,970,569
10.1.2 Prior year adjustment	(9,998,887)
10.1.3 Net gains/(losses) on re-measurement to fair value of financial instruments and investment properties included in the income statement	134,763,352
10.1.4 Impairment losses and reversal of impairment losses on revaluation of investments and property, plant and equipment included in the income statement	70,000
10.1.5 Realisation of cumulative gains or losses on disposal of investments	0
10.1.6 Consolidation results	20,000
10.1.7 Realisation of assets upon amalgamation during the year	0
10.1.8 Other (specify)	(124,924,465)
10.1.9 Cumulative net gain on revaluation of investments and property, plant and equipment included in the income statement	263,900,569

Please indicate the reasons for the prior year adjustment: [Click here](#)

Part 10.1 is only applicable to those kind of investments, where it is/was the scheme's accounting policy to take any unrealised gains/(losses) on the re-measurement of investments to the income statement (accumulated funds); as all other unrealised gains will be accommodated in the revaluation reserves in part 7.2 and part 7.3 (and as part of the statement of other comprehensive income). Any consolidated results are also included in this part, in order to ensure that the solvency calculation is based on scheme-only results.

Part 10.1 starts with the net gains/ (losses) on the re-measurement of properties and investments to fair value, which were previously included in accumulated funds. This balance at the beginning of the year (10.1.1) pulls automatically through from the scheme's previous year's annual return.

In the event that there is an adjustment to the opening balance, the scheme would be required to provide details in respect of this adjustment in the reason box.



Part 10.1 continues to extract all the net unrealised gains/ (losses) included in the current year's income statement.

The unrealised gains/ (losses) on revaluation of investments and property, plant and equipment included in the income statement in part 10.1.2 pulls automatically through from part 4.20.4 (unrealised gains/ (losses) on revaluation of investment property), and part 4.20.5 (net gains/ (losses) on revaluation of investments carried at fair value through the income statement) as well as part 7.1.3.2 (due to re-measurement of investments and property, plant and equipment).

Part 10.1.3 summarise the total gross unrealised gains/ (losses) in the current year's accumulated funds.

However, to ensure that only the net unrealised gains/ (losses) are deducted from the solvency ratio, the scheme should capture any permanent impairment losses and reversal of impairment losses on revaluation of investments and property, plant and equipment included in the income statement in part 10.1.4. This amount should be captured as a negative amount, to ensure that it is deducted from the gross unrealised gains.

Furthermore, the scheme should deduct all realised portions of any unrealised gains/(losses), which were previously included in the accumulated funds (income statement), in part 10.1.5; this will ensure that only the net unrealised gain/(loss) is deducted from the solvency calculation.

The scheme's consolidated results are excluded in line 10.1.6 (automatic pull through from line 6.22).

In the event that a scheme amalgamated during the year, the scheme should ensure the accurate completion of this part up to the date of amalgamation. As the return is prepared as at 31 December, the realised amount upon amalgamation should be excluded in line 10.1.7.

A detailed description of any transaction included in part 10.1.8 should be provided; as this will have a direct impact on the solvency calculation of the scheme at year-end.

Help File: 2011 Annual Statutory Return



Part 10.2 Solvency Ratio

PART 10.2: SOLVENCY RATIO	
	R
10.2.1 Total members' funds per balance sheet	3,145,152,232
10.2.2 Less: Unrealised non-distributable reserve	(21,070,000)
10.2.3 Less: Funds set aside for specific purposes	2,002,000
10.2.4 Less: Cumulative net gains on revaluation of investments and property, plant and equipment included in the income statement	(263,970,569)
10.2.5 Less: Specific assets encumbered for third party liabilities	(50,000)
10.2.6 Less: Minority interest	(501,000)
10.2.7 Add: Sub-ordinated loan as approved by the Council	6,998,000
10.2.8 Total net assets	2,868,560,663
10.2.9 TOTAL NET ASSETS	2,868,560,663
10.2.10 GROSS CONTRIBUTIONS	16,619,189,351
10.2.11 SOLVENCY RATIO	17.26%

Accumulated funds in terms of Regulation 29

Accumulated funds represent the net asset value of the scheme excluding funds set-aside for specific purposes, unrealised non-distributable reserves and encumbered assets. Therefore, the total members' funds in 10.2.1 pulls automatically through from part 5.2.1 of the return.

Unrealised non-distributable reserves

Both the revaluation reserve for investments (part 7.2) as well as the revaluation reserve for property, plant and equipment (part 7.3) should be deducted from the total members' funds for solvency purposes; to ensure that unrealised non-distributable reserves are excluded.

Therefore, part 10.2.2 automatically pulls through from (part 5.2.1.2 (revaluation reserve for investments) plus part 5.2.1.3 (revaluation reserve for property, plant and equipment)).



Funds set aside for specific purposes

All funds set aside for future claims, whatever they are called, should be included in accumulated funds. This has the effect of looking at the nature of the fund, rather than the name.

However, funds “set aside for specific *non-claims* purposes” should be excluded from accumulated funds.

It is therefore recommended that schemes classify their reserves properly keeping in mind the Regulation 29 prescriptions.

Part 10.2.3 pulls automatically through from part 5.2.1.4 (reserves set aside for specific purposes).

Cumulative net gains on revaluation of investments and property, plant and equipment included in the income statement

Part 10.2.4 automatically pulls through from part 10.1.6; should part 10.1.6 be an unrealised gain. Where part 10.1 resulted in a net cumulative unrealised loss, it is ignored and not pulled through to part 10.2; as net unrealised losses are not added to accumulated funds to calculate solvency.

However, in some instances it was noted that a scheme’s accounting policy states that for some investments the unrealised gains/ (losses) on the re-measurement of that investment are taken to the income statement (i.e. investment property), and for its other investments the unrealised gain/ (loss) on the re-measurement of that investment to fair value are taken to a revaluation reserve (i.e. available-for-sale investments).

Therefore, to ensure that only the net unrealised gains are deducted from solvency, the formula in part 10.2.4 also determines whether the scheme had any revaluation reserves in part 10.2.2. Where a scheme had a positive revaluation reserve (hence an unrealised gain) in the statement of financial position, as well as an unrealised loss in part 10.1.6, the formula in part 10.2.4 will add back the unrealised loss in part 10.1.6, limited to the revaluation reserve amount in part 10.2.2. This will ensure that only unrealised gains are deducted from the solvency ratio, and that no unrealised losses are added to the solvency ratio.

Important to note that, where a scheme had a revaluation reserve (unrealised gain) in part 10.2.2 as well as a cumulative net unrealised gain in part 10.1.6 the full unrealised gain will pull through to part 10.2.4.

Encumbered assets

Section 35(4) of the Act states: “A medical scheme shall not be deemed to hold an asset for the purposes of this Act to the extent that such asset is encumbered”. In addition, section 35(6) (c) states that a medical scheme shall not directly or indirectly borrow money without the prior approval of the Council or subject to such directives as the Council may issue.

Therefore, where a specific asset is encumbered in respect of obligations between other persons (third party liability), there is a risk of loss to the scheme. For example, a cession of share certificates or insurance policy as collateral for a third party loan. In such a case, the liability will be in the third party’s books. Such encumbered assets should be deducted from the accumulated funds. Should other variants of encumbrances present themselves to medical schemes, the underlying principles, including risk of loss and



location of liability, should be considered. The final effect should not be an iniquitous position for the scheme.

However, where an encumbered asset is in respect of a liability that is in the scheme's statement of financial position, the encumbered assets should not be deducted from accumulated funds. This would be the case, for instance, in a finance lease or instalment sale agreement where computer equipment has been purchased. If the encumbered assets were to be deducted, the net effect would be a net liability, which is tantamount to double accounting.

The amount in line 10.2.5 pulls automatically through from part 4.25.2 in respect of total encumbered assets and total suretyships.



Minority interest

Only scheme-specific funds are taken into account in the solvency calculation. Minority interests in consolidated parties are therefore deducted from the total members' funds per statement of financial position. The amount in line 10.2.6 automatically pulls through from line 5.2.1.6 (minority interest).

Subordinated loans

The scheme should only add a subordinated loan in part 10.2.7 if Council has approved the subordinated loan, and gave approval that the specific loan can be treated as equity.

Annualised gross contributions

It should be noted that the gross annual contributions includes the annual contributions to members' savings accounts. Hence, the annualised gross contributions in part 10.2.10 pulls automatically through from part 6.1 of the return.

Where a scheme did not meet the required minimum solvency level of 25%, as set out in Regulation 29, they should complete the reason box at the bottom of part 10.2; indicating the reasons for not meeting the 25% solvency level, how many days the solvency level was below 25%, and whether a business plan was submitted to Council in terms of section 35(11) and Regulation 29(4)).



PART 11 REPORTING BY THE AUDITORS IN TERMS OF SECTIONS 36, 37 & 39 OF THE ACT

Please note that these reports need to be amended by the auditor, printed on the auditor's letterhead and signed by the auditor.

Part 11(a) – Auditor's report

The screenshot displays the CMS Statutory Returns Portal in a web browser. The URL is <http://cmsuat02/Returns/annual.aspx?p=11>. The page features a navigation bar with links: Home, Contact Us, Statutory Return, Print, Validate, Submit, Help, and LogOut. Below the navigation bar, there are buttons for Parts 1 through 11. Part 11 is highlighted in red. The main content area is titled 'Part 11(a) Part 11(b)' and contains the following text:

Part 11 A
ISA 800 Audit Report in terms of Sections 36, 37 and 39 on Parts 4 to 10 of the Annual Statutory Return
REPORT OF THE INDEPENDENT AUDITOR OF MMED TO THE REGISTRAR OF MEDICAL SCHEMES ON PARTS 4 TO 10 OF THE ANNUAL STATUTORY RETURN AS REQUIRED BY SECTIONS 36, 37 AND 39 OF THE MEDICAL SCHEMES ACT NO. 131 OF 1998

We have audited Parts 4 to 10 of the annual statutory return (the Return) of MMED (the Scheme) for the year ended 31 December 2011, comprising information from the annual financial statements, prepared in accordance with International Financial Reporting Standards, and additional historical financial information extracted from the underlying accounting records of the Scheme for the purpose of reporting to the Registrar of Medical Schemes (the Registrar), as required by Sections 36, 37 and 39 of the Medical Schemes Act No. 131 of 1998 (the Act), whether Parts 4 to 10 of the Return have been prepared in all material respects, in accordance with the provisions of the Act, related Regulations, the Guidance Manual for the completion of the Return and the applicable Circulars issued by the Council for Medical Schemes (the Act and related Regulations).

Trustees' Responsibility for the Return
The trustees are responsible for the preparation of Parts 4 to 10 of the Return from the annual financial statements and information contained in the underlying accounting records of the Scheme and for such internal control as they determine is necessary to ensure Parts 4 to 10 of the Return is prepared in accordance with the Act and related Regulations, and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility as required by Sections 36(8), 37(3) read in conjunction with 37(2), and 39(3) of the Act is to express our opinion on whether Parts 4 to 10 of the Return have been prepared in all material respects in compliance with the provisions of the Act and related Regulations based on our audit. We completed our audit of the annual financial statements of the Scheme for the year ended 31 December 2011 on which we issued an *unmodified / modified* [1] opinion on *<insert date of audit report>*. Our audit of the annual financial statements was conducted in accordance with International Standards on Auditing.

Our audit involved performing procedures to obtain audit evidence about the amounts and disclosures in Parts 4 to 10 of the Return. The procedures selected depended on our judgment, including the assessment of the risks of material misstatement of the Return, whether due to fraud or error. In making these risks

This part is a normal audit report, where the auditor signs off on parts 4 to 10 of the annual return. Auditors can also refer to our website for the guideline containing this report.

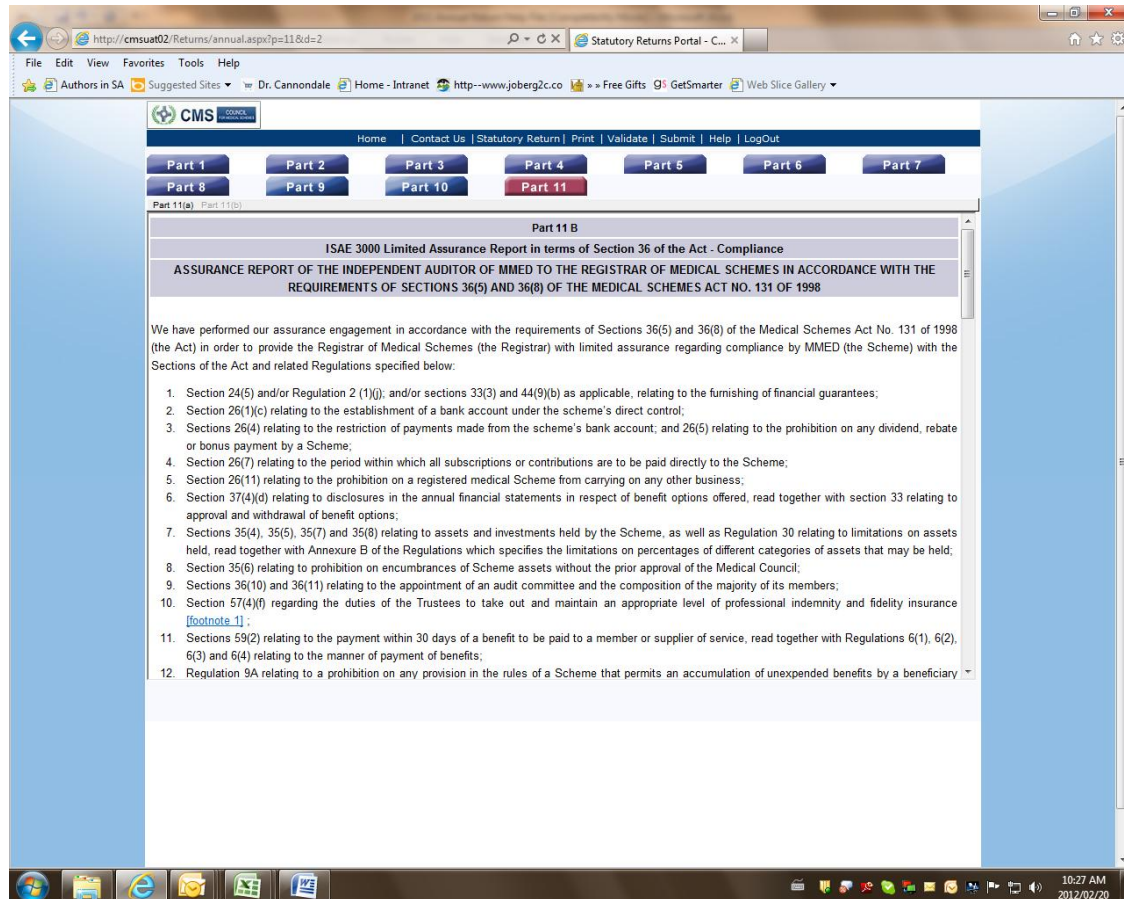
It should be noted that this report should be amended and printed on the auditor's letterhead; and signed.

Part 11(b) – Limited assurance report

Help File: 2011 Annual Statutory Return



This part contains the agreed upon procedure report to be signed off by the auditor. Auditors can also refer to our website for the guideline containing this report.



This part requires the auditor to report on certain non-compliance matters with regards to the Medical Schemes Act 131 of 1998, which were noted during the performance of their normal audit procedures. Any non-compliance matters should be reported within the limited assurance conclusion section of the report.

In determining compliance to Section 57(4)(f) regarding the duties of the Trustees to take out and maintain an appropriate level of professional indemnity and fidelity insurance, the auditor is referred to the following audit procedures:

- Inspect the fidelity guarantee and professional indemnity policy and confirm the policy number and R-value of the cover taken out by the scheme in accordance with Section 57(4)(f) of the Act;
- Inspect the appropriate documentation and enquire from the scheme's administrator and management whether the premiums were fully paid up; and



- Inspect the minutes of meetings to confirm that cover was assessed for appropriateness by Board of Trustees.

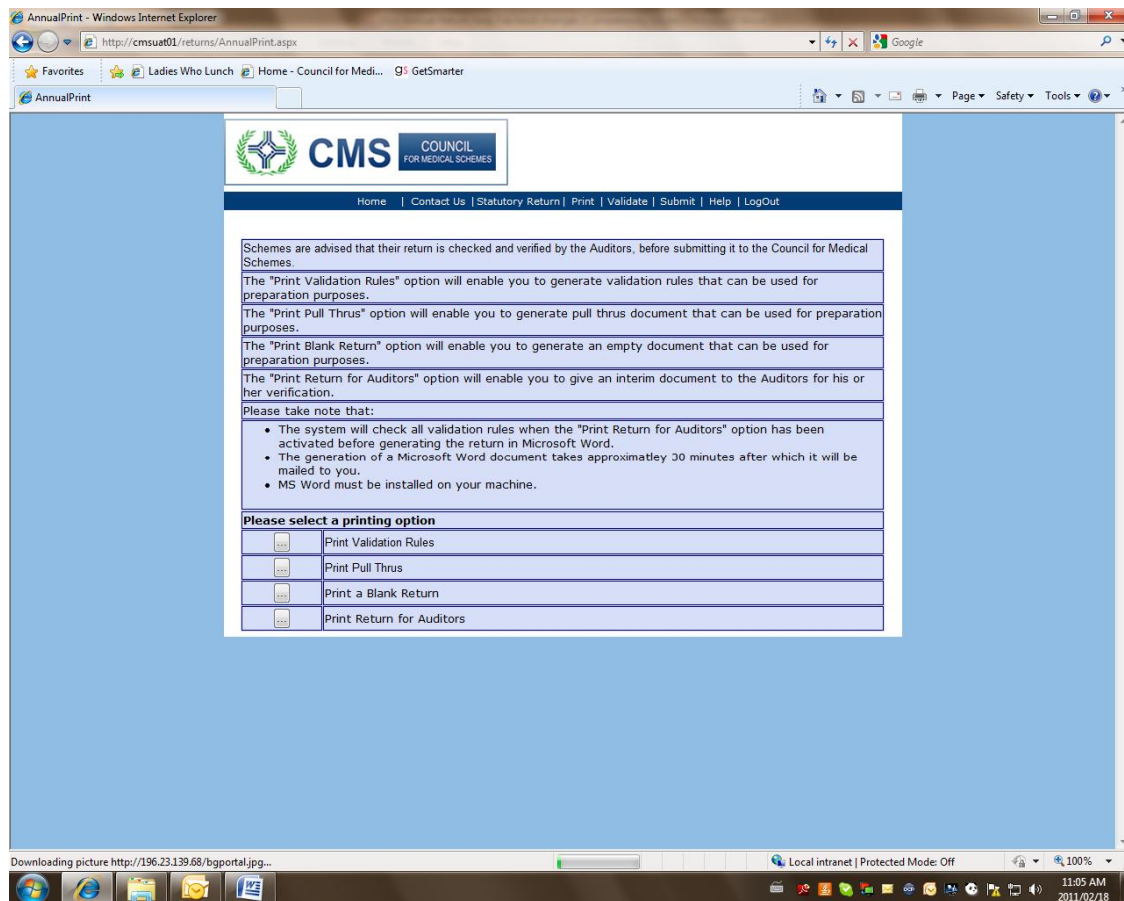
The auditor should ensure that all the necessary tests are performed during the course of the audit, to be able to sign off on this report.

It is also very important that the auditor specifies all the exceptions noted.



PRINT REQUEST FOR RETURN

To access the print options available, the user should click on the "print" option available on the task bar. The following screen will appear:



This page explains in detail the different print options available to the user as well as the procedures to be followed.

Hence, the user has the following print options:

- Print validation rules: A list of all the validation rules applicable to that specific year's statutory return will be e-mailed to the user.
- Print pull throughs: A list of all the pull throughs applicable for that specific year's statutory return will be e-mailed to the user.
- Print a blank return: A blank word document for that specific year's statutory return will be e-mailed to the user.

Help File: 2011 Annual Statutory Return



- Print return for auditors: A draft word document, which contains all the information currently captured on the return, will be e-mailed to the user.

It should be noted that all print requests are sent to the Office's generators, which are processed on a first come first serve basis. Hence, all requests are queued at the generators to be processed. Please note that it takes approximately 30 minutes for an annual statutory return word document to be generated.

Therefore, should you be third in the queue, you will only receive your word document (whether it is a final or draft copy) in an hour and a half's time.

Also important to note that print requests will be e-mailed to the user as well as to the Principal Officer, Chairperson and Trustee signature. The data captured in part 1.1 of the return will be used to obtain the e-mail addresses of the relevant people.

Help File: 2011 Annual Statutory Return



VALIDATION OF RETURN

To validate a return, please click on the 'validate' option on the task bar. The following screen will appear:

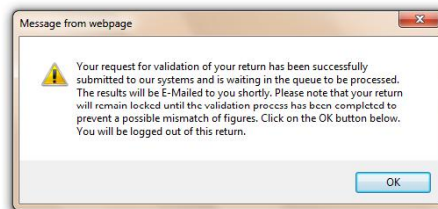
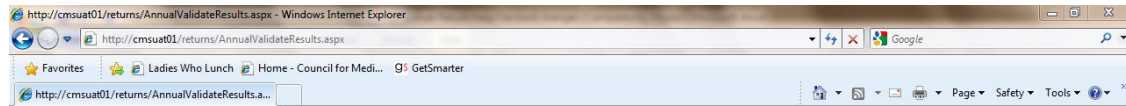


This page explains in detail the validation process. It should be noted that all validation requests are sent to the Office's generators, which are processed on a first come first serve basis. Hence, all requests are queued at the generators to be processed. Please note that it takes approximately 5 minutes to validate an annual statutory return. Therefore, should you be third in the queue, you will only receive your validation results via e-mail in 15 minutes' time.

Help File: 2011 Annual Statutory Return



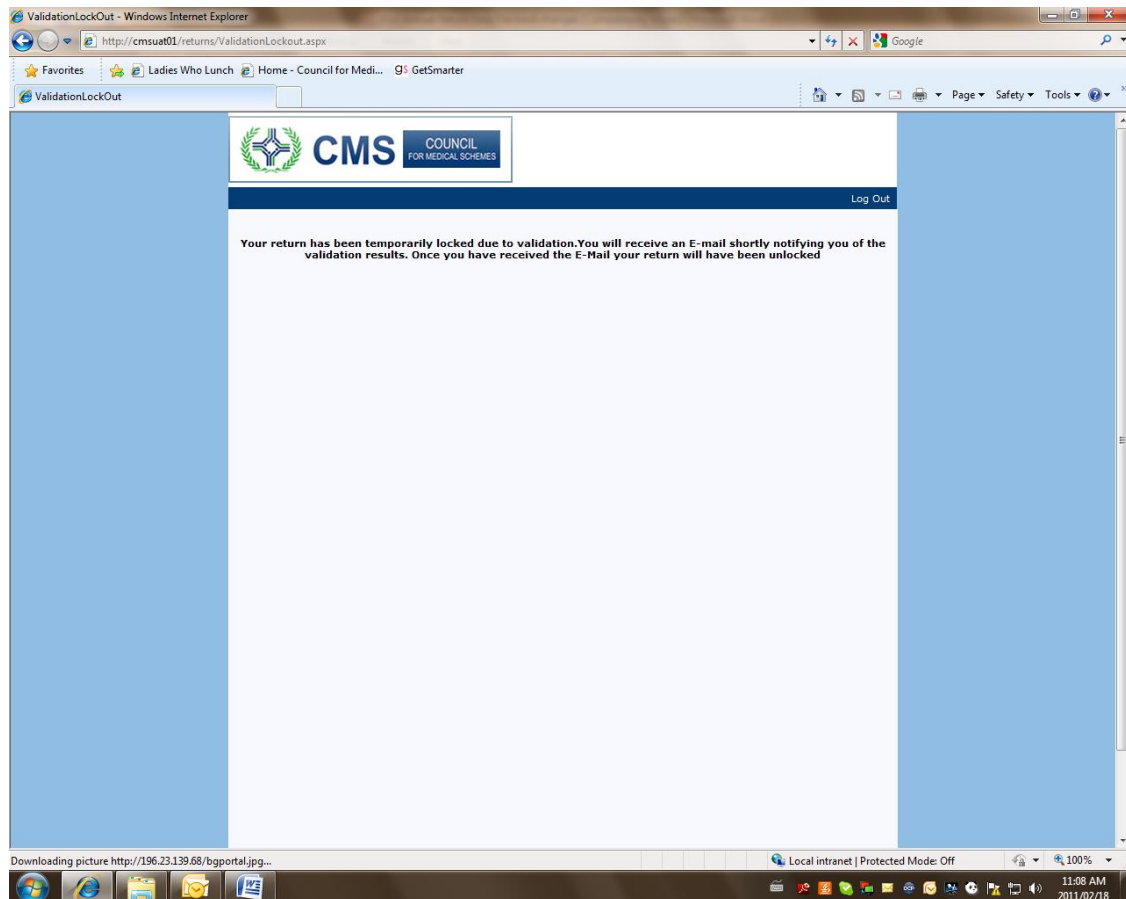
After clicking on the validate button the following screen appears, which only explains the validation process further. The user should click on OK.



Help File: 2011 Annual Statutory Return



It should be noted that the user will not be able to access the online statutory return, whilst the return is in the queue to be validated. The following screen will appear, if the user tries to access the online statutory return, whilst the return is busy validating:



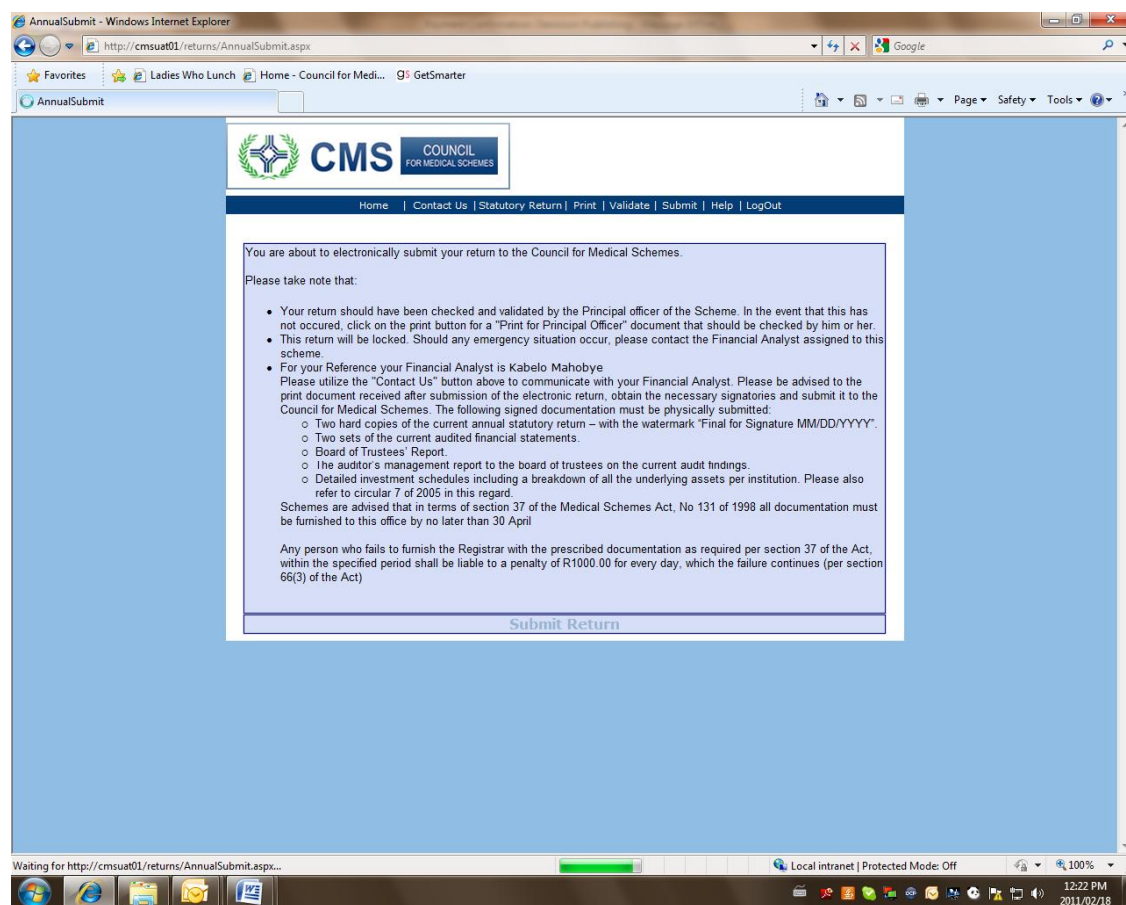
Help File: 2011 Annual Statutory Return



SUBMISSION OF RETURN

When the return has been completed in its entirety, the auditors and the board of trustees had approved the draft word document and all validation rules have successfully passed, the user can submit the return, which will ensure that a final word document is e-mailed to the scheme.

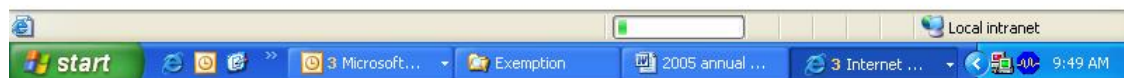
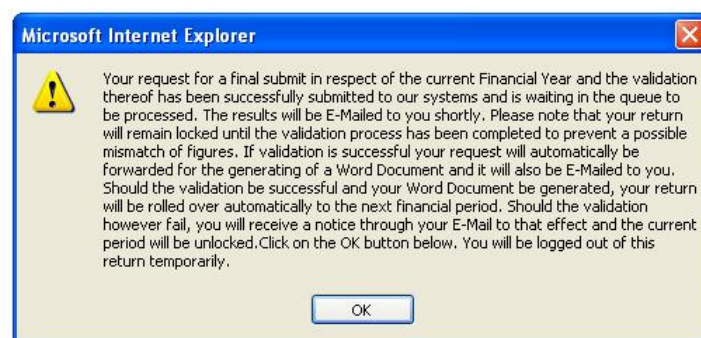
The user should use the 'submit' option on the task bar, to submit the return. The following screen will appear:



Help File: 2011 Annual Statutory Return



The user should now click on the 'Submit Return' button at the bottom of the page. The following screen will appear:



The user should now only click on the OK button.

Important to note that when the return has been submitted it will automatically be sent to the validation generators, to ensure that the final return has successfully validated. If all the validation rules passed successfully, the system will automatically send the return to the word document generator, where it will be queued for processing of the final word document.

Again, as stated under the print function, all print requests are sent to the Office's generators, which are processed on a first come first serve basis. Hence, all requests are queued at the generators to be processed. Please note that it takes approximately 30 minutes for an annual statutory return word document to be generated. Therefore, should you be third in the queue, you will only receive your word document (whether it is a final or draft copy) in an hour and a half's time.



It should also be noted that after the return has been submitted, it will be locked and the user will not be able to make any further adjustments to the return. Hence, before the user does a final submission of the return, he or she should ensure that both the board of trustees and auditors are in agreement that no further changes are required to the online statutory return.

Help File: 2011 Annual Statutory Return

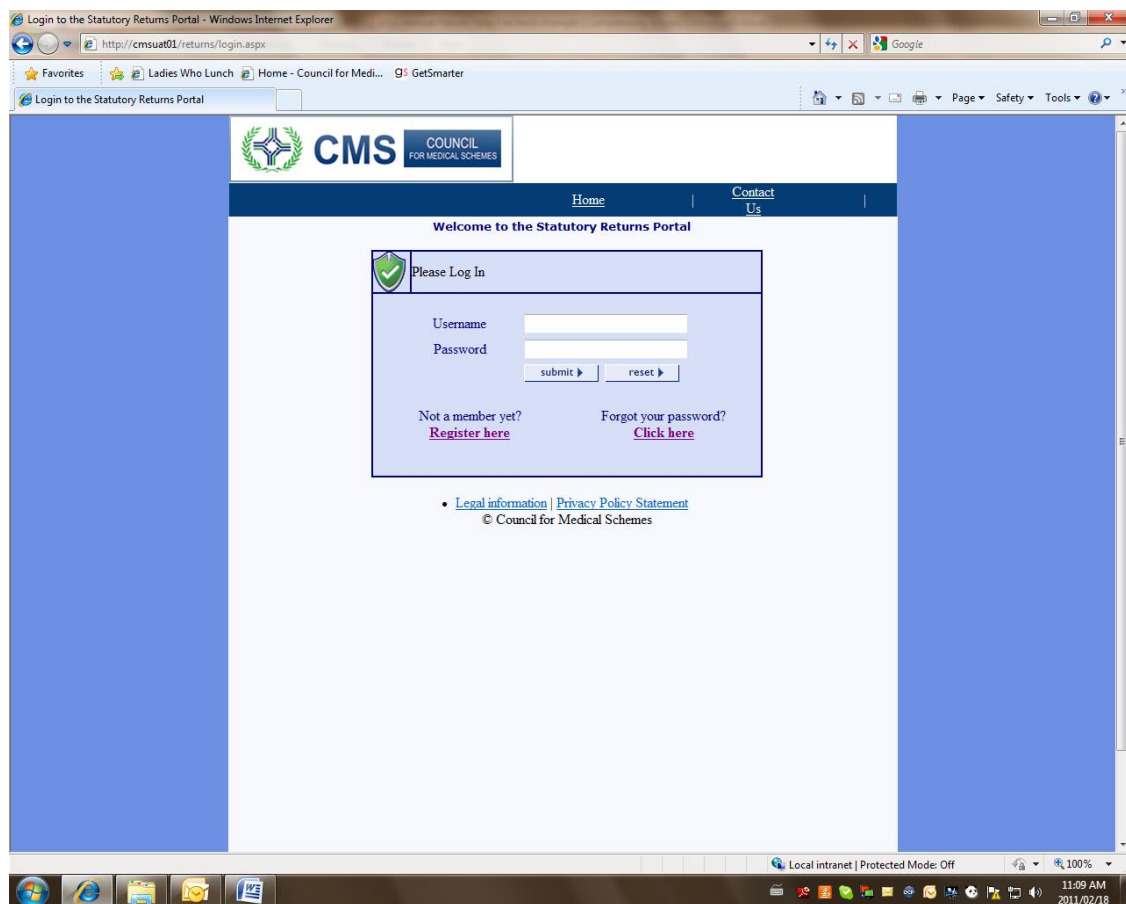


HELP FUNCTION

This document will be available from the 'Help' function on the task bar.

LOG OUT FUNCTION

As soon as the user presses the "Log out" button on the task bar, it will go back to the login screen:



Medical Scheme:
Ref No.:
Quarter Period End:



**QUARTERLY STATUTORY RETURN IN TERMS OF SECTION
37 OF THE MEDICAL SCHEMES ACT 131 OF 1998**

Medical Scheme:

Quarter Period End:

Medical Scheme:
Ref No.:
Financial Year End:



PART 1.1

DETAILS OF MEDICAL SCHEME AND CERTIFICATION OF RETURN

Name of Medical Scheme:	
Type of Scheme:	
Type of Administration:	
Change in Administrator:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Administrator:	
Change in Administrator effective from:	dd/mm/yyyy
Amalgamated:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Scheme Amalgamated with:	
Amalgamation Effective From:	dd/mm/yyyy
Liquidated:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liquidation Effective From:	dd/mm/yyyy
Under Curatorship:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Curatorship Effective From:	dd/mm/yyyy
Name Change:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Name:	
Name Change Effective From:	dd/mm/yyyy
Financial Period End:	dd/mm/ 2012
Ref No.:	
1. Initials and Surname of Principal Officer:	
1.1 Postal Address:	
1.2 Telephone Number:	
1.3 Cell Phone Number:	
1.4 Fax:	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



1.5 Email Address:	
2. Initials and Surname of Chairperson:	
2.1 Postal Address:	
2.2 Telephone Number:	
2.3 Cell Phone Number:	
2.4 Fax:	
2.5 Email Address:	
3. Initials and Surname of Trustee Signatory:	
3.1 Postal Address:	
3.2 Telephone Number:	
3.3 Cell Phone Number:	
3.4 Fax:	
3.5 Email Address:	
4. Registered Office of the Medical Scheme in the RSA (Physical Address):	
4.1 Postal Address:	
4.2 Telephone Number:	
4.3 Fax:	
4.4 Website Address:	
4.5 Email Address:	
5. Name of Administrator:	
5.1 Postal Address:	
5.2 Telephone Number:	
5.3 Fax:	
5.4 Website Address:	
5.5 Email Address:	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



6. Name of Co- Administrator:	
6.1 Postal Address:	
6.2 Telephone Number:	
6.3 Fax:	
6.4 Website Address:	
6.5 Email Address:	
7. Person (Fund manager) Responsible for the Medical Scheme:	
7.1 Telephone Number:	
7.2 Cell phone Number:	
7.3 Fax:	
7.4 Email Address:	
8. Name of Person Responsible for the Completion of the Return:	
8.1 Telephone Number:	
8.2 Cell phone Number:	
8.3 Fax:	
8.4 Email Address:	
9.1 Auditors:	
9.1.1 Name of Audit Firm(s):	
9.1.2 Initials and Surname of the Responsible Partner(s):	
9.1.3 Telephone Number:	
9.1.4 Cell phone Number:	
9.1.5 Fax:	
9.1.6 Email Address:	
9.2 Auditors:	
9.2.1 Name of Audit Firm(s):	
9.2.2 Initials and Surname of the Responsible Partner(s):	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



9.2.3 Telephone Number:	
9.2.4 Cell phone Number:	
9.2.5 Fax:	
9.2.6 Email Address:	
10. Initials and Surname of the Liquidator :	
10.1 Telephone Number:	
10.2 Cell phone Number:	
10.3 Fax:	
10.4 Email Address:	
11. Initials and Surname of the Curator:	
11.1 Telephone Number:	
11.2 Cell phone Number:	
11.3 Fax:	
11.4 Email Address:	

WE (I – If Curator), THE UNDERSIGNED, CERTIFY THAT, TO THE BEST OF OUR KNOWLEDGE, THE PARTICULARS CONTAINED IN THIS RETURN ARE EXTRACTED FROM THE BOOKS, RECORDS AND RECONCILE TO THE FINANCIAL STATEMENTS/MANAGEMENT ACCOUNTS OF THE SCHEME AND THAT THE INFORMATION IS CORRECT.

Principal Officer (Curator):	
Signature:
Date:	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



Chairperson:	
Signature:
Date:	
Trustee Signatory:	
Signature:
Date:	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 1.2

BENEFIT OPTION(S)

No of benefit option(s) reported on:	
List benefit options by name:	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 1.3

BOARD OF TRUSTEE MEMBERS AT THE END OF THE QUARTER

No of board of trustee members:	
List board of trustees by name:	

Initials of Principal Officer: _____

Medical Scheme:
 Ref No.:
 Financial Year End:



PART 2.1

MEMBERSHIP AT THE END OF THE QUARTER

	Benefit Options	Members	Adult Dependants	Child Dependants	Beneficiaries
2.1.1.1					
2.1.1.2					
2.1.2	Consolidated Total				

Please provide the reasons, should the members and/or adult and/or child dependants be zero for any option:

Please provide the reasons, and actions to be taken, should the principal members be less than 6 000 members:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 2.2

AGE ANALYSIS OF BENEFICIARIES AS AT THE END OF THE QUARTER

		Consolidated Total		Benefit Options Total	
		Male	Female	Male	Female
2.2.1	Less than one year				
2.2.2	1-4 years				
2.2.3	5-9 years				
2.2.4	10-14 years				
2.2.5	15-19 years				
2.2.6	20-24 years				
2.2.7	25-29 years				
2.2.8	30-34 years				
2.2.9	35-39 years				
2.2.10	40-44 years				
2.2.11	45-49 years				
2.2.12	50-54 years				

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



2.2.13	55-59 years				
2.2.14	60-64 years				
2.2.15	65-69 years				
2.2.16	70-74 years				
2.2.17	75-79 years				
2.2.18	80-84 years				
2.2.19	85 years +				
2.2.20	Total				
	CUMULATIVE TOTAL				
	65 years + ratio			%	%
	Average age per beneficiary				

Please provide the reasons, should the total males or females be zero for any option:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 2.3

MEMBER MOVEMENT FOR THE QUARTER

		Number of new members transferring from other schemes	Number of new members not transferring from other schemes	Number of new dependants transferring from other schemes	Number of new dependants not transferring from other schemes	Number of members leaving the scheme	Number of dependants leaving the scheme
2.3.1	First Quarter						
2.3.2	Second Quarter						
2.3.3	Third Quarter						
2.3.4	Fourth Quarter						

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 2.4

WAITING PERIODS APPLIED DURING THE CURRENT QUARTER

		Number of new beneficiaries to whom general waiting periods were imposed		Number of new beneficiaries to whom pre-existing condition exclusions were imposed		Number of new beneficiaries to whom late joiner penalties were imposed	
		New beneficiaries	Transferred beneficiaries	New beneficiaries	Transferred beneficiaries	New beneficiaries	Transferred beneficiaries
2.4.1	Less than one year						
2.4.2	1-4 years						
2.4.3	5-9 years						
2.4.4	10-14 years						
2.4.5	15-19 years						
2.4.6	20-24 years						
2.4.7	25-29 years						
2.4.8	30-34 years						
2.4.9	35-39 years						
2.4.10	40-44 years						
2.4.11	45-49 years						
2.4.12	50-54 years						
2.4.13	55-59 years						
2.4.14	60-64 years						
2.4.15	65-69 years						
2.4.16	70-74 years						
2.4.17	75-79 years						
2.4.18	80-84 years						
2.4.19	85 years +						
2.4.20	Total						

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



Please provide reasons why no general waiting periods were imposed:

Please provide reasons why no pre-existing condition exclusions were imposed:

Please provide reasons why no late joiner penalties were imposed:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 2.5

NUMBER OF REGISTERED MEMBERS AND DEPENDANTS AT THE END OF EACH MONTH

		Members	Adult Dependants	Child Dependants	Beneficiaries	Dependant Ratio
2.5.1	January					
2.5.2	February					
2.5.3	March	Part 2.1.2 - Consolidated total of Members Quarter 1	Part 2.1.2 - Consolidated total of Adult Dependants Quarter 1	Part 2.1.2 - Consolidated total of Child Dependants Quarter 1		
2.5.4	April					
2.5.5	May					
2.5.6	June	Part 2.1.2 - Consolidated total of Members Quarter 2	Part 2.1.2 - Consolidated total of Adult Dependants Quarter 2	Part 2.1.2 - Consolidated total of Child Dependants Quarter 2		
2.5.7	July					
2.5.8	August					
2.5.9	September	Part 2.1.2 - Consolidated total of Members Quarter 3	Part 2.1.2 - Consolidated total of Adult Dependants Quarter 3	Part 2.1.2 - Consolidated total of Child Dependants Quarter 3		
2.5.10	October					
2.5.11	November					
2.5.12	December	Part 2.1.2 - Consolidated total of Members Quarter 4	Part 2.1.2 - Consolidated total of Adult Dependants Quarter 4	Part 2.1.2 - Consolidated total of Child Dependants Quarter 4		
2.2.13	Total					

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



2.2.14	Average					
---------------	----------------	--	--	--	--	--

Please provide the reasons, should the members and/or adult and/or child dependants be zero in any month:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 2.6

DISTRIBUTION OF MEMBERSHIP AT THE END OF THE QUARTER PERIOD

	Consolidated	Members	Adult Dependants	Child Dependants	Beneficiaries
2.6.1	Gauteng				
2.6.2	Limpopo				
2.6.3	Mpumalanga				
2.6.4	North West				
2.6.5	Free State				
2.6.6	Kwa-Zulu Natal				
2.6.7	Western Cape				
2.6.8	Eastern Cape				
2.6.9	Northern Cape				
2.6.10	Outside the Republic				
2.6.11	Consolidated Total				

Please indicate how the scheme is collecting the data for this part:			
	Members	Adult Dependants	Child Dependants
Private Postal Address	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Business Postal Address	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Employer (Pay Point)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other (specify)			

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3

NOTES TO THE FINANCIAL STATEMENTS

PART 3.1

INVESTMENTS

	Investment classes per Annexure B	Previous Quarter		Current Quarter	
		Long Term	Short Term	Long Term	Short Term
		R	R	R	R
3.1.1	Deposits and balances in current and savings accounts, negotiable deposits, money market instruments, structured bank notes, margin deposits with SAFEX and collateralised deposits.				
3.1.1.1	<i>Inside the Republic</i>				
3.1.1.1.1	Registered banks with net qualifying capital and reserve funds > R5 billion (specify)				
3.1.1.1.2	Registered banks with net qualifying capital and reserve funds > R100 billion (specify)				
3.1.1.1.3	Other (specify)				
3.1.1.2	<i>Territories outside the Republic</i>				
3.1.2	Bills, bonds and securities issued or guaranteed by and loans to or guaranteed by.				
3.1.2.1	<i>Inside the Republic</i>				
3.1.2.1.1	Per registered bank (specify)				
3.1.2.1.2	Other (specify)				
3.1.2.2	<i>Territories outside the Republic</i>				
3.1.3	Immovable property, units in unit trust schemes in property shares, shares & loans to & debentures in property companies.				
3.1.3.1	<i>Inside the Republic (specify per property)</i>				
3.1.3.2	<i>Territories outside the Republic</i>				
3.1.4	Shares, convertible debentures, exchange traded funds, units in equity				

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.1

INVESTMENTS

	Investment classes per Annexure B	Previous Quarter		Current Quarter	
		Long Term	Short Term	Long Term	Short Term
		R	R	R	R
	unit trust schemes and equity linked policies of insurance.				
3.1.4.1	<i>Inside the Republic</i>				
3.1.4.1.1	Unlisted shares, unlisted debentures and shares listed in the Development Capital and Venture Capital sectors of the JSE.				
3.1.4.1.2	Shares listed on the JSE, exchange traded funds, units in equity unit trusts and equity linked policies of insurance (specify)				
3.1.4.2	<i>Territories outside the Republic</i>				
3.1.5	Listed and unlisted debentures				
3.1.5.1	<i>Inside the Republic</i>				
3.1.5.2	<i>Territories outside the Republic</i>				
3.1.6	Policies of insurance				
3.1.6.1	Policies of insurance where the policy proceeds are not directly linked to the market value of the underlying assets				
3.1.6.2	Policies of insurance where policy proceeds are directly linked to the market value of the underlying assets (specify per insurer)				
3.1.7	Other assets not referred to elsewhere in this section				
3.1.7.1	Other assets inside the Republic (specify)				
3.1.7.2	Derivatives (inside the Republic):				
3.1.7.2.1	- Cash, Bills, Bonds, Securities and Loans				
3.1.7.2.2	- Property				
3.1.7.2.3	- Shares and Convertible Debentures (excl. shares in property companies)				
3.1.7.2.4	- Debentures				
3.1.7.2.5	- Other derivative asset class (specify)				
3.1.7.3	Other assets in territories outside the Republic				

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.1

INVESTMENTS

	Investment classes per Annexure B	Previous Quarter		Current Quarter	
		Long Term	Short Term	Long Term	Short Term
		R	R	R	R
3.1.8	Transfer of assets due to amalgamation				
3.1.9	Total investments				
3.1.10	Outstanding cheques				
3.1.11	Total investments for purposes of Annexure B				

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.2

TRADE AND OTHER RECEIVABLES

		Previous Quarter	Current Quarter
		R	R
3.2.1	<i>Contributions outstanding:</i>		
3.2.1.1	- current		
3.2.1.2	- 30 days		
3.2.1.3	- 60 days		
3.2.1.4	- 90 days		
3.2.1.5	- 120 days +		
3.2.2	<i>Recoveries from members for payments paid and payable (except for contributions, loans and savings plan account advances)</i>		
3.2.2.1	- current		
3.2.2.2	- 30 days		
3.2.2.3	- 60 days		
3.2.2.4	- 90 days		
3.2.2.5	- 120 days +		
3.2.3	<i>Savings plan account advances</i>		
3.2.3.1	- current		
3.2.3.2	- 30 days		
3.2.3.3	- 60 days		
3.2.3.4	- 90 days		
3.2.3.5	- 120 days +		
3.2.4	<i>Risk transfer arrangements</i>		
3.2.4.1	<i>Commercial reinsurance contracts</i>		
3.2.4.1.1	Share of outstanding claims provision		
3.2.4.1.2	Share of claims reported not yet paid		
3.2.4.1.3	Less: Provision for impaired losses at quarter end		

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



3.2.4.2	<i>Other risk transfer arrangements</i>		
3.2.4.2.1	Share of outstanding claims provision		
3.2.4.2.2	Share of claims reported not yet paid		
3.2.4.2.3	Less: Provision for impaired losses at quarter end		
3.2.5	Prepaid expenses on risk transfer arrangements		
3.2.6	Prepaid expenses on managed care arrangements		
3.2.7	Prepaid expenses		
3.2.8	Loans to members		
3.2.8.1	Loans to members – Capital		
3.2.8.2	Loans to members – Interest		
3.2.9	Accrued interest		
3.2.10	Member balances		
3.2.11	Provider balances		
3.2.12	<i>Amounts owing by:</i>		
3.2.12.1	- Administrators		
3.2.12.2	- Reinsurer (other than claim recoveries)		
3.2.12.3	- Managed care organisations (other than claim recoveries)		
3.2.12.4	- Brokers		
3.2.12.5	- Other related parties (specify)		
3.2.13	Sundry debtors (specify)		
3.2.14	Savings plan debtors (specify)		
3.2.15	Less: Provision for impaired losses at quarter end (excluding risk transfer arrangements)		
3.2.16	Trade and other receivables of group companies on consolidation		
3.2.17	Transfer of assets due to amalgamation during the year		
3.2.18	<i>Total trade and other receivables</i>		

Please indicate whether the scheme has any agreements in place with employers / members to pay their contributions after 3 days of it becoming due:

--

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



Please indicate the remedial actions taken by the scheme where contributions were received after three days of it becoming due:
What is the nature of/reasons for the amount owed by the administrator?
What is the nature of/reasons for the amount owed by reinsurers (other than claims recoveries)?
What is the nature of/reasons for the amount owed by managed care organisations (other than claims recoveries)?
What is the nature of/reasons for the amount owed by brokers?
What is the nature of/reasons for the amount owed by other related parties?

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.3

TRADE AND OTHER PAYABLES

		Previous Quarter	Current Quarter
		R	R
3.3.1	<i>Reported claims not yet paid</i>		
3.3.1.1	Reported claims not yet paid –due to members (including outstanding cheques)		
3.3.1.1	Reported claims not yet paid –due to providers (including outstanding cheques)		
3.3.2.1	Stale cheques for claims expenses		
3.3.2.2	Stale cheques for expenses other than claims		
3.3.3	Net contributions received in advance		
3.3.4	<i>Payments received in advance under risk transfer arrangements</i>		
3.3.4.1	Payments received in advance under commercial reinsurance contracts		
3.3.4.2	Payments received in advance under other risk transfer arrangements		
3.3.5	Bank overdraft (current account)		
3.3.6	<i>Amounts owing to:</i>		
3.3.6.1	- Administrator		
3.3.6.2	- Reinsurer		
3.3.6.3	- Brokers		
3.3.6.4	- Managed care organisations		
3.3.6.5	- Other related parties (specify)		
3.3.7	Current portion of non-current borrowings and other non-current liabilities		
3.3.8	Amounts owing to members (excluding reported claims not yet paid –due to members)		
3.3.9	Unallocated deposits		
3.3.10	Post retirement benefits		
3.3.11	Other payables & accrued expenses (specify)		
3.3.12	Savings plan creditors (specify)		
3.3.13	Balances of group companies on consolidation		
3.3.14	Transfer of liability due to amalgamation during the year		
3.3.15	Total trade and other payables		

What is the nature of/the reasons for the amount owed to the administrator? The amount owed is larger than the average fee per month.

What is the nature of/the reasons for the amount owed to brokers? The amount owed is larger than the average fee per month.

What is the nature of/the reasons for the amount owed to managed care organisations? The amount owed is larger than the average fee per month.

What is the nature of/the reasons for the unallocated deposits? The amount owed is larger than the average gross contributions per month.

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



In respect of which employees are the post retirement benefits due?
Please indicate whether the scheme obtained approval from Council to directly or indirectly borrow money, as is required by section 35(6)(c) of the Medical Schemes Act:

PART 3.4

MANAGED CARE: MANAGEMENT SERVICES

		Current Quarter		
		Self/3 rd Party Administrator	Other Third Parties per contract	Total
		R	R	R
3.4.1	Asthma programme			
3.4.2	Case management			
3.4.3	Chronic medicine management			
3.4.4	Clinical review/auditing			
3.4.5	Dental benefit management			
3.4.6	Disease management			
3.4.7	Disease/prescribed minimum benefit management			
3.4.8	Drug utilisation review			
3.4.9	Female Wellness programme			
3.4.10	Fraud hotline			
3.4.11	Health advice line			
3.4.12	HIV management			
3.4.13	Managed health services, ambulance and helpline			
3.4.14	Managed hospital care			
3.4.15	Maternity programme			
3.4.16	Medical advisors			
3.4.17	Medicine bag management			
3.4.18	Member counselling, compliance monitoring & risk assessment			
3.4.19	Mental health programme			
3.4.20	Mother-to-be programme			
3.4.21	Network management			
3.4.22	Oncology utilisation management			
3.4.23	Optical management			
3.4.24	Pathology benefit management			
3.4.25	Pharmacy benefit management			
3.4.26	Primary care provider management			
3.4.27	Radiology benefit management			
3.4.28	Specialist, hospital referrals and pre-authorisation			
3.4.29	Other (specify)			
3.4.30	Total managed care: management services			

Why is the amount paid not split between the different services provided?

Initials of Principal Officer: _____



PART 3.5.1

NETT (INCOME)/EXPENSES FROM OTHER RISK TRANSFER ARRANGEMENTS (EXCLUDING COMMERCIAL REINSURANCE CONTRACTS)

		Current Quarter	
		Consolidated total	Per contract
		R	R
3.5.1.1	Premiums/fees paid (capitation fee)		
3.5.1.2	Less: Claims recoveries in respect of related risk transfer arrangements		
3.5.1.3	Other (specify)		
3.5.1.4	<i>Nett (income)/expenses from other risk transfer arrangements</i>		

Please provide the basis for the calculation of the estimated claims recoveries in respect of related risk transfer arrangements per contract:

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.5.2

NETT INCOME/(EXPENSES) FROM RISK TRANSFER ARRANGEMENTS: COMMERCIAL REINSURANCE CONTRACTS

		Consolidated total	Per contract
		R	R
3.5.2.1	Reinsurance premiums paid		
3.5.2.2	Less: Reinsurance claims recovered		

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



3.5.2.3	Less: Provision for reinsurance claims recovered		
3.5.2.4	Profit/(Loss) on reinsurance arrangements		
3.5.2.5	Commissions on reinsurance agreements		
3.5.2.6	Discounts received		
3.5.2.7	<i>Nett income/(expense) from commercial reinsurance</i>		

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.6 ADMINISTRATION EXPENSES

		Year to Date	Current Quarter
		R	R
3.6.1	Actuarial fees		
3.6.2	Administration fees:		
3.6.2.1	- Fees paid to the administrator		
3.6.2.2	- Indirect fees paid to the administrator		
3.6.3	Advertising		
3.6.4	Annual general meeting costs		
3.6.5	Association fees		
3.6.6	Audit expenses:		
3.6.6.1	- Audit services		
3.6.6.2	- Audit expenses		
3.6.6.3	- Audit committees		
3.6.6.4	- Over/(under) provision of prior year's audit fees		
3.6.6.5	- Other non-audit expenses (specify)		
3.6.7	Bank charges		
3.6.8	Call centre fees		
3.6.9	Co-administration fees paid for ongoing services provided by third parties		
3.6.10	Computer expenses		
3.6.11	Consultancy fees (not the contracted administrator)		
3.6.12	Council for Medical Schemes expenses		
3.6.13	Debt collection fees		
3.6.14	Depreciation		
3.6.15	Electronic checking fees		
3.6.16	Entertainment		
3.6.17	Fidelity guarantee insurance premiums		
3.6.18	Insurance fees		
3.6.19	Internal audit fees		
3.6.20	Investigation fees		
3.6.21	Legal fees		
3.6.22	Marketing expenses		
3.6.23	MVA administration fees		
3.6.24	Operating leases and other rentals (incl. property rentals)		
3.6.25	Other levies		
3.6.26	Penalties (including CMS penalties)		

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.6 ADMINISTRATION EXPENSES

		Year to Date	Current Quarter
		R	R
3.6.27	Pharmacy administration fees		
3.6.28	Principal Officer fees and remuneration		
3.6.29	Principal Officer other considerations		
3.6.30	Printing and stationery		
3.6.31	Professional fees		
3.6.32	Professional indemnity insurance premiums		
3.6.33	Repairs and maintenance		
3.6.34	Staff remuneration		
3.6.35	Telephone, postage and fax		
3.6.36	Travel, accommodation and conferences		
3.6.37	Trustee remuneration and considerations		
3.6.38	Water and electricity		
3.6.39	Other administration expenses (specify)		
3.6.40	Less: Administration expenses recoverable from savings plan accounts		
3.6.41	Total administration expenses		

Kindly provide the reasons why no fidelity or professional indemnity insurance was accounted for in the current year?

Kindly provide information on the nature of the co-administration services rendered to the scheme, including the name of the provider:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.7

OTHER REALISED AND UNREALISED GAINS/(LOSSES)

		Year to Date	Current Quarter
		R	R
3.7.1	Profit/(loss) on disposal of property, plant and equipment		
3.7.2	Profit/(loss) on disposal of investment property		
3.7.3	Realised gains/(losses) on disposal of available-for-sale investments		
3.7.4	Unrealised gains/(losses) on revaluation of investment property		
3.7.5	Net gains/(losses) on revaluation of investments carried at fair value through the income statement		
3.7.6	Other (specify)		
3.7.7	Total realised and unrealised gains/(losses)		

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.8

GUARANTEES AND SURETYSHIP FOR THIRD PARTY LIABILITIES (INCLUDING CONTINGENT LIABILITIES) AT THE END OF THE QUARTER PERIOD

		Guarantees	Suretyships	Encumbered Assets	Other
		R	R	R	R
3.8.1	To whom				
3.8.2	Total				

Were the guarantees, suretyship for third party liabilities or encumbered assets approved by Council?

Initials of Principal Officer: _____



PART 3.9

RELATED PARTY TRANSACTIONS: YEAR TO DATE

		Name	Nature of related party relationship	Nature of transactions/ balances	Was the transaction/ balances at arm's-length	Amount
					(Y/N)	R
3.9.1	<i>Transactions for the year (income statement)</i>					
3.9.1.1	Trustee remuneration & considerations	Board of Trustees	Key management personnel			3.6.37 - Year to date - Trustee remuneration and considerations
3.9.1.2	Principal Officer remuneration & considerations	Principal Officer	Key management personnel			3.6.28 - Year to date - Principal Officer fees and remuneration + 3.6.29 Year to date Principal Officer other considerations
3.9.1.3	Name of Consolidated Party (specify)					
3.9.2	<i>Balances at quarter end (balance sheet)</i>					
3.9.2.1	Name of Consolidated Party (specify)					

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



--	--	--	--	--	--	--

Please provide the reasons for the transactions during the quarter /balances not at arm's-length:

PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
		R	R	R	R	R	R
3.10.1	Gross contribution income						
3.10.2	Less: Savings contribution income						
3.10.3	<i>Nett contribution income</i>						

Initials of Principal Officer: _____



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
3.10.4	<i>Gross claims paid and reported in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)</i>						
3.10.4.1	- Direct benefits for the period						
3.10.4.2	- Direct benefits for the previous financial year						
3.10.4.3	- Direct benefits reported not yet paid						
3.10.4.4	- Managed care: healthcare benefits for the period (no transfer of risk)						
3.10.4.5	- Managed care: healthcare benefits for the previous financial year (no transfer of risk)						
3.10.4.6	- Managed care: healthcare benefits						

Initials of Principal Officer: _____



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
	reported not yet paid (no transfer of risk)						
3.10.4.5	- Services provided to members in own facilities						
3.10.5	Less: Savings plan claims paid						
3.10.6	Less: Discount received on claims						
3.10.7	Less: Claims recoveries from third parties						
3.10.8	<i>Nett actual claims paid and reported in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)</i>						
3.10.9	Provision for outstanding claims at the end of the period						
3.10.10	Less: Provision for outstanding claims at	2011 Annual Return - part					

Initials of Principal Officer: _____



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
	end of the previous period	4.9.8 Columns B (Outstanding claims provision not covered by risk transfer arrangements) and C (Outstanding claims provision covered by commercial reinsurance)					
3.10.11	<i>Nett claims incurred in respect of risk carried by the scheme (including claims incurred in respect of commercial reinsurance contracts)</i>						



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
3.10.12	<i>Gross claims paid and reported in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)</i>						
3.10.12.1	- Direct benefits for the period						
3.10.12.2	- Direct benefits for the previous financial year						
3.10.12.3	- Direct benefits reported not yet paid						
3.10.13	<i>Nett actual claims paid and reported in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)</i>						
3.10.14	Provision for outstanding claims at the end of the period						

Initials of Principal Officer: _____



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
3.10.15	Less: Provision for outstanding claims at end of the previous period	2011 Annual Return - part 4.9.8 Column D (Outstanding claims provision covered by risk transfer arrangements)					
3.10.16	<i>Nett claims incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)</i>						
3.10.17	Nett (income)/expense on other risk transfer arrangements						
3.10.17.1	Premiums/ fees paid (Capitation fees)						

Initials of Principal Officer: _____



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
3.10.17.2	Less: Estimated claims recoveries						
3.10.17.3	Other						
3.10.18	<i>Total nett claims incurred in respect of related risk transfer arrangements (excluding claims incurred in respect of commercial reinsurance contracts)</i>						
3.10.19	<i>Relevant healthcare expenditure</i>						
3.10.20	Gross healthcare result						
3.10.21	Nett income/(expense) on commercial reinsurance contracts						



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
3.10.22	Less: Managed care: management services						
3.10.23	<i>Less: Broker service fees</i>						
3.10.23.1	- Broker fees						
3.10.23.2	- Other distribution costs paid to brokers						
3.10.24	Less: Administration expenses						
3.10.25	Less: Nett impairment losses: Trade and other receivables						
3.10.26	Net healthcare result						
3.10.27	Less: Nett impairment losses: Other (specify)						
3.10.28	Other investment income						

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
3.10.29	Other realised and unrealised gains/(losses)						
3.10.30	Other income (specify)						
3.10.31	Own facility surplus/(deficit)						
3.10.32	Less: Other expenses (specify)						
3.10.33	Less: Finance costs						
3.10.34	Less: Investment management fees						
3.10.35	Less: Operating expenses on rental of investment property						
3.10.36	Surplus/(Deficit) for the year						

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.10
SURPLUS/(DEFICIT) PER BENEFIT OPTION
ACTUALS

		Consolidated Total		Other		Benefit Options	
		Year to Date	Current Quarter	Year to date	Current Quarter	Year to date	Current Quarter
3.10.37	- Number of members at the end of the period	2.1.2 Consolidated Total Members	2.1.2 Consolidated Total Members			2.1.2 Per Option Members	2.1.2 Per Option Members
3.10.38	- Number of beneficiaries at the end of the period	2.1.2 Consolidated Total Beneficiaries	2.1.2 Consolidated Total Beneficiaries			2.1.2 Per Option Beneficiaries	2.1.2 Per Option Beneficiaries

Please provide the reasons if gross contributions are zero:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



Please provide reasons for any outstanding claims (under)/over provision which is more than 10% of the previous year's provision:

Why do the broker fees per average member per month exceed the statutory limit of R 74.84 (incl VAT)?

Why do the broker fees exceed the statutory limit of 3.42% of gross contributions?

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Consolidated	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
3.11.1	Gross contribution income													
3.11.2	Less: Savings contribution income													
3.11.3	Nett contribution income													
3.11.4	Less: Relevant healthcare expenditure													
3.11.4.1	Nett claims incurred in respect of risk carried by the scheme (including claims incurred in respect of commercial													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Consolidated	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
	<i>reinsurance contracts)</i>													
3.11.4.2	<i>Premiums/ fees paid (Capitation fees)</i>													
3.11.5	Nett income/(expense) on commercial reinsurance contracts													
3.11.6	Less: Managed care: management services													
3.11.7	<i>Less: Broker service fees</i>													
3.11.7.1	- Broker fees													
3.11.7.2	- Other distribution costs paid to brokers													
3.11.8	Less: Administration expenses													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Consolidated	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
3.11.9	Less: Nett impairment losses: Trade and other receivables													
3.11.10	Net healthcare result													
3.11.11	Less: Nett impairment losses: Other (specify)													
3.11.12	Other investment income													
3.11.13	Other realised and unrealised gains/(losses)													
3.11.14	Other income (specify)													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Consolidated	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
3.11.15	Own facility surplus/(deficit)													
3.11.16	Less: Other expenses (specify)													
3.11.17	Less: Finance costs													
3.11.18	Less: Investment management fees													
3.11.19	Less: Operating expenses on rental of investment property													
3.11.20	Surplus/(Deficit) for the year													
3.11.21	<i>Balance at the beginning of the year:</i>													
3.11.21.1	- As previously		2011 Annual											

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Consolidated	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
	reported		Return - part 7.1.5 current year column											
3.11.21.2	- Prior year adjustment													
3.11.22	Transfer to/(from) accumulated funds													
3.11.22.1	- Due to amalgamation													
3.11.22.2	- Due to re-measurement of investments and property, plant and equipment													
3.11.22.3	- Other transfers													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Consolidated	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
3.11.23	Other (specify)													
3.11.24	Balance at the end of the year													
3.11.25	Number of members at the end of the period													
3.11.26	Number of beneficiaries at the end of the period													

Reasons provided for unlocking:

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Per benefit option	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
3.11.1	Gross contribution income													
3.11.2	Less: Savings contribution income													
3.11.3	<i>Nett contribution income</i>													
3.11.4	<i>Less: Relevant healthcare expenditure</i>													
3.11.4.1	<i>Nett claims incurred in respect of risk carried by the scheme (including claims</i>													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Per benefit option	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
	<i>incurred in respect of commercial reinsurance contracts)</i>													
3.11.4.2	<i>Premiums/ fees paid (Capitation fees)</i>													
3.11.5	Nett income/(expense) on commercial reinsurance contracts													
3.11.6	Less: Managed care: management													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Per benefit option	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
	services													
3.11.7	<i>Less: Broker service fees</i>													
3.11.7.1	- Broker fees													
3.11.7.2	- Other distribution costs paid to brokers													
3.11.8	Less: Administration expenses													
3.11.9	Less: Nett impairment losses: Trade and													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Per benefit option	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
	other receivables													
3.11.10	Net healthcare result													
3.11.11	Less: Nett impairment losses: Other (specify)													
3.11.12	Other investment income													
3.11.13	Other realised and unrealised gains/(losses)													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Per benefit option	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
3.11.14	Other income (specify)													
3.11.15	Own facility surplus/(deficit)													
3.11.16	Less: Other expenses (specify)													
3.11.17	Less: Finance costs													
3.11.18	Less: Investment management fees													
3.11.19	Less: Operating expenses on rental of													

Initials of Principal Officer: _____



PART 3.11

SURPLUS/(DEFICIT) FROM OPERATIONS PER BENEFIT OPTION

BUDGET

		Per benefit option	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R
	investment property													
3.11.20	Surplus/(Deficit) for the year													
3.11.21	Number of members at the end of the period													
3.11.22	Number of beneficiaries at the end of the period													



PART 4 INCOME STATEMENT

PART 4.1 INCOME STATEMENT *ACTUAL*

		Year to date	Current quarter
		R	R
4.1.1	Gross contribution income	3.10.1 YTD Gross contribution income	3.10.1 Current Quarter Gross contribution income
4.1.2	Less: Savings contribution income	3.10.2 YTD Less: Savings contribution income	3.10.2 Current Quarter Less: Savings contribution income
4.1.3	<i>Nett contribution income</i>		
4.1.4	<i>Relevant healthcare expenditure</i>	3.10.19 YTD Relevant healthcare expenditure	3.10.19 Current Quarter Relevant healthcare expenditure
4.1.5	Gross healthcare result		

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



4.1.6	Nett income/(expense) on commercial reinsurance contracts	3.10.21 YTD Net income/(expense) on commercial reinsurance contracts	3.10.21 Current Quarter Net income/(expense) on commercial reinsurance contracts
4.1.7	Less: Managed care: management services	3.10.22 YTD Less: Managed care: management services	3.10.22 Current Quarter Less: Managed care: management services
4.1.8	Less: Broker service fees	3.10.23.1 YTD Less: Broker service fees + 3.10.23.2 YTD Less: Broker service fees	3.10.23.1 Current Quarter Less: Broker service fees + 3.10.23.2 Current Quarter Less: Other distribution costs
4.1.9	Less: Administration expenses	3.10.24 YTD Less: Administration expenses	3.10.24 Current Quarter Less: Administration expenses
4.1.10	Less: Nett impairment losses: Trade and other receivables	3.10.25 YTD Less: Nett impairment losses: Trade and other receivables	3.10.25 Current Quarter Less: Nett impairment losses: Trade and other receivables
4.1.11	Net healthcare result		

PART 4.1
INCOME STATEMENT
ACTUAL

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



		Year to date	Current quarter
		R	R
4.1.12	Less: Nett impairment losses: Other (specify)	3.10.27 YTD Less: Nett impairment losses: Other (specify)	3.10.27 Current Quarter Less: Nett impairment losses: Other (specify)
4.1.13	Other investment income	3.10.28 YTD Other investment income	3.10.28 Current Quarter Other investment income
4.1.14	Other realised and unrealised gains/(losses)	3.10.29 YTD Other realised and unrealised gains/(losses)	3.10.29 Current Quarter Other realised and unrealised gains/(losses)
4.1.15	Other income (specify)	3.10.30 YTD Other income (specify)	3.10.30 Current Quarter Other income (specify)
4.1.16	Own facility surplus/(deficit)	3.10.31 YTD Own facility surplus/(deficit)	3.10.31 Current quarter Own facility surplus/(deficit)
4.1.17	Less: Other expenses (specify)	3.10.32 YTD Less: Other expenses (specify)	3.10.32 Current Quarter Less: Other expenses (specify)
4.1.18	Less: Finance costs	3.10.33 YTD Less: Finance costs	3.10.33 Current Quarter Less: Finance costs
4.1.19	Less: Investment management fees	3.10.34 YTD Less: Investment management fees	3.10.34 Current Quarter Less: Investment management fees
4.1.20	Less: Operating expenses on rental of investment property	3.10.35 YTD Less: Operating expenses on rental of investment property	3.10.35 Current Quarter Less: Operating expenses on rental of investment property

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



4.1.21	Surplus/(Deficit) for the year		
4.1.22	Projected annual gross contribution income		

Please provide more information on how the projected annual gross contribution was calculated:

Initials of Principal Officer: _____



PART 4.2

INCOME STATEMENT

PRIOR YEAR'S ACTUAL

		YTD per 2011 annual return	Total	January	Februar y	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R	R
4.2.1	Gross contribution income	2011 Annual Return - part 6.1.1 Current year column		2011 Annual Return - part 6.2.1 January	2011 Annual Return - part 6.2.1 Februar y	2011 Annual Return - part 6.2.1 March	2011 Annual Return - part 6.2.1 April	2011 Annua l Return - part 6.2.1 May	2011 Annual Return - part 6.2.1 June	2011 Annual Return - part 6.2.1 July	2011 Annual Return - part 6.2.1 August	2011 Annual Return - part 6.2.1 September	2011 Annual Return - part 6.2.1 October	2011 Annual Return - part 6.2.1 November	2011 Annual Return - part 6.2.1 December
4.2.2	Less: Savings contribution income	2011 Annual Return - part 6.1.2 Current year column		2011 Annual Return - part 6.2.2 January	2011 Annual Return - part 6.2.2 Februar y	2011 Annual Return - part 6.2.2 March	2011 Annual Return - part 6.2.2 April	2011 Annua l Return - part 6.2.2 May	2011 Annual Return - part 6.2.2 June	2011 Annual Return - part 6.2.2 July	2011 Annual Return - part 6.2.2 August	2011 Annual Return - part 6.2.2 September	2011 Annual Return - part 6.2.2 October	2011 Annual Return - part 6.2.2 November	2011 Annual Return - part 6.2.2 December
4.2.3	<i>Nett contribution income</i>														

Medical Scheme:
Ref No.:
Financial Year End:



4.2.4	<i>Less: Relevant healthcare expenditure</i>	2011 Annual Return - part 6.1.4 Current year column		2011 Annual Return - part 6.2.4 January	2011 Annual Return - part 6.2.4 February	2011 Annual Return - part 6.2.4 March	2011 Annual Return - part 6.2.4 April	2011 Annual Return - part 6.2.4 May	2011 Annual Return - part 6.2.4 June	2011 Annual Return - part 6.2.4 July	2011 Annual Return - part 6.2.4 August	2011 Annual Return - part 6.2.4 September	2011 Annual Return - part 6.2.4 October	2011 Annual Return - part 6.2.4 November	2011 Annual Return - part 6.2.4 December
4.2.5	Gross healthcare result														
4.2.6	Nett income/(expense) on commercial reinsurance contracts	2011 Annual Return - part 6.1.6 Current year column		2011 Annual Return - part 6.2.6 January	2011 Annual Return - part 6.2.6 February	2011 Annual Return - part 6.2.6 March	2011 Annual Return - part 6.2.6 April	2011 Annual Return - part 6.2.6 May	2011 Annual Return - part 6.2.6 June	2011 Annual Return - part 6.2.6 July	2011 Annual Return - part 6.2.6 August	2011 Annual Return - part 6.2.6 September	2011 Annual Return - part 6.2.6 October	2011 Annual Return - part 6.2.6 November	2011 Annual Return - part 6.2.6 December

PART 4.2
INCOME STATEMENT
PRIOR YEAR'S ACTUAL

		YTD per 2011 annual return	Total	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R	R

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



4.2.7	Less: Managed care: management services	2011 Annual Return - part 6.1.7 Current year column		2011 Annual Return - part 6.2.7 January	2011 Annual Return - part 6.2.7 February	2011 Annual Return - part 6.2.7 March	2011 Annual Return - part 6.2.7 April	2011 Annual Return - part 6.2.7 May	2011 Annual Return - part 6.2.7 June	2011 Annual Return - part 6.2.7 July	2011 Annual Return - part 6.2.7 August	2011 Annual Return - part 6.2.7 September	2011 Annual Return - part 6.2.7 October	2011 Annual Return - part 6.2.7 November	2011 Annual Return - part 6.2.7 December
4.2.8	Broker service fee														
4.2.8.1	Less: Broker service fees	2011 Annual Return - part 6.1.8.1 Current year column		2011 Annual Return - part 6.2.8.1 January	2011 Annual Return - part 6.2.8.1 February	2011 Annual Return - part 6.2.8.1 March	2011 Annual Return - part 6.2.8.1 April	2011 Annual Return - part 6.2.8.1 May	2011 Annual Return - part 6.2.8.1 June	2011 Annual Return - part 6.2.8.1 July	2011 Annual Return - part 6.2.8.1 August	2011 Annual Return - part 6.2.8.1 September	2011 Annual Return - part 6.2.8.1 October	2011 Annual Return - part 6.2.8.1 November	2011 Annual Return - part 6.2.8.1 December
4.2.8.2	Less: Other distribution costs	2011 Annual Return - part 6.1.8.2 Current year column		2011 Annual Return - part 6.2.8.2 January	2011 Annual Return - part 6.2.8.2 February	2011 Annual Return - part 6.2.8.2 March	2011 Annual Return - part 6.2.8.2 April	2011 Annual Return - part 6.2.8.2 May	2011 Annual Return - part 6.2.8.2 June	2011 Annual Return - part 6.2.8.2 July	2011 Annual Return - part 6.2.8.2 August	2011 Annual Return - part 6.2.8.2 September	2011 Annual Return - part 6.2.8.2 October	2011 Annual Return - part 6.2.8.2 November	2011 Annual Return - part 6.2.8.2 December
4.2.9	Less: Administration expenses	2011 Annual Return - part 6.1.9 Current year column		2011 Annual Return - part 6.2.9 January	2011 Annual Return - part 6.2.9 February	2011 Annual Return - part 6.2.9 March	2011 Annual Return - part 6.2.9 April	2011 Annual Return - part 6.2.9 May	2011 Annual Return - part 6.2.9 June	2011 Annual Return - part 6.2.9 July	2011 Annual Return - part 6.2.9 August	2011 Annual Return - part 6.2.9 September	2011 Annual Return - part 6.2.9 October	2011 Annual Return - part 6.2.9 November	2011 Annual Return - part 6.2.9 December

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



4.2.10	Nett impairment losses: Trade and other receivables	2011 Annual Return - part 6.1.10 Current year column		2011 Annual Return - part 6.2.10 January	2011 Annual Return - part 6.2.10 February	2011 Annual Return - part 6.2.10 March	2011 Annual Return - part 6.2.10 April	2011 Annual Return - part 6.2.10 May	2011 Annual Return - part 6.2.10 June	2011 Annual Return - part 6.2.10 July	2011 Annual Return - part 6.2.10 August	2011 Annual Return - part 6.2.10 September	2011 Annual Return - part 6.2.10 October	2011 Annual Return - part 6.2.10 November	2011 Annual Return - part 6.2.10 December
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PART 4.2
INCOME STATEMENT
PRIOR YEAR'S ACTUAL

		YTD per 2011 annual return	Total	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R	R
4.2.11	Net healthcare result														
4.2.12	Nett impairment losses: Other (specify)	2011 Annual Return - part 6.1.12 Current year column													
4.2.13	Other investment income	2011 Annual Return - part 6.1.13 Current year column													

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



4.2.14	Less: Investment management fees	2011 Annual Return - part 6.1.14 Current year column													
4.2.15	Less: Operating expenses on rental of investment property	2011 Annual Return - part 6.1.15 Current year column													
4.2.16	Other realised and unrealised gains/(losses)	2011 Annual Return - part 6.1.16 Current year column													
4.2.17	Other income (specify)	2011 Annual Return - part 6.1.17 Current year column													
4.2.18	Own facility surplus/(deficit)	2011 Annual Return - part 6.1.18 Current year column													
4.2.19	Less: Other expenses (specify)	2011 Annual Return - part 6.1.19 Current year column													

PART 4.2

INCOME STATEMENT

Initials of Principal Officer: _____



PRIOR YEAR'S ACTUAL

		YTD per 2011 annual return	Total	January	Februar y	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R	R
4.2.20	Less: Finance costs	2011 Annual Return - part 6.1.20 Current year column													
4.2.21	Surplus/(Deficit) for the year														
4.2.22	<i>Balance at the beginning of the year:</i>														
4.2.22.1	- As previously reported	2011 Annual Return - part 7.1.1.1 Current year column		2011 Annual Return - part 7.1.1.1 Current year column											
4.2.22.2	- Prior year adjustment	2011 Annual Return - part 7.1.1.2 Current year column													

Medical Scheme:
Ref No.:
Financial Year End:



4.2.23	Transfer to/(from) accumulated funds														
4.2.23.1	- Due to amalgamation	2011 Annual Return - part 7.1.3.1 Current year column													
4.2.23.2	- Due to re-measurement of investments and property, plant and equipment	2011 Annual Return - part 7.1.3.2 Current year column													

PART 4.2
INCOME STATEMENT
PRIOR YEAR'S ACTUAL

		YTD per 2011 annual return	Total	January	February	March	April	May	June	July	August	September	October	November	December
		R	R	R	R	R	R	R	R	R	R	R	R	R	R
4.2.23.3	- Other transfers	2011 Annual Return - part 7.1.3.3 Current year column													

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



4.2.24	Other	2011 Annual Return - part 7.1.4 Current year column													
4.2.25	Balance at the end of the year														

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 5.1

ACCUMULATED FUNDS

		Previous quarter	Current quarter	Year to date
		R	R	R
5.1.1	<i>Balance at the beginning of the year:</i>			
5.1.1.1	- As previously reported		Q1 = 2011 Annual Return - part 7.1.5 Current year column; Q2 - Q4: line 5.1.5 previous quarter column.	2011 Annual Return - part 7.1.5 Current year column
5.1.1.2	- Prior year adjustment			
5.1.2	Surplus/(Deficit) for the year		4.1.21 Current Quarter Surplus/(Deficit) for the year before consolidation	4.1.21 YTD Surplus/(Deficit) for the year before consolidation
5.1.3	<i>Transfer to/(from) accumulated funds</i>			
5.1.3.1	- Due to amalgamation			
5.1.3.2	- Due to re-measurement and property, plant and equipment			
5.1.3.3	- Other transfers (specify)			
5.1.4	Other (specify)			
5.1.5	<i>Balance at the end of the period</i>			

Please provide the reasons for any prior year adjustment:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 6

BALANCE SHEET

		Previous Quarter	Current Quarter
		R	R
6.1	ASSETS		
6.1.1	Non-current assets		
6.1.1.1	Land & Buildings (specify)		
6.1.1.2	Plant & Equipment		
6.1.1.3	Investments		3.1.9 Current Quarter Long Term Total investments
6.1.1.4	Other non-current assets (specify)		
6.1.2	Current assets		
6.1.2.1	Inventories		
6.1.2.2	Trade and other receivables		3.2.18 Current Quarter Total trade and other receivables
6.1.2.3	Investments		3.1.9 Current Quarter Short Term, Total investments - 3.1.1 Current Quarter Short Term, Deposits and balances in current and savings accounts, negotiable deposits, money market instruments, structured bank notes, margin deposits with SAFEX and collateralised deposits.
6.1.2.4	Cash and cash equivalents		IF 6.2.3.1 >0 then 6.1.2.4 = (3.1.1 Current Quarter Short Term, Deposits and balances in current and savings accounts, negotiable deposits, money market instruments, structured bank notes, margin deposits with SAFEX and collateralised deposits + 7.1.6 Current Quarter Total Investments at the end of the period). IF 6.2.3.1 = 0, 6.1.2.4 = 3.1.1 Current Quarter Short Term, Deposits and balances in current and savings accounts, negotiable deposits, money market instruments, structured bank notes, margin deposits with SAFEX and collateralised deposits.

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



6.1.2.5	Other current assets (specify)		
6.1.3	Total assets		
6.2	FUNDS AND LIABILITIES		
6.2.1	Members' funds		
6.2.1.1	Accumulated funds		5.1.5 Current Quarter Balance at the end of the period
6.2.1.2	Revaluation Reserve - Investments		
6.2.1.3	Revaluation Reserve - Property, plant and equipment		
6.2.1.4	Reserves set aside for specific purposes (specify)		
6.2.1.5	Other reserves (specify)		
6.2.1.6	Minority interest		

PART 6

BALANCE SHEET

		Previous Quarter	Current Quarter
		R	R
6.2.2	Non-current liabilities		
6.2.2.1	Borrowings		

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



6.2.2.2	Other non-current liabilities (specify)		
6.2.3	Current liabilities		
6.2.3.1	Savings plan liability		IF (7.1.6 Current Quarter Total Investments at the end of the period + 3.2.14 Current Quarter Interest accrued not yet allocated to savings plan- 3.3.12 Current Quarter Savings accounts expenses not yet recovered from savings investments) is = 7.2.16 Total Balance of savings plan liability at the end of the period (credit balance) then 6.2.3.1 should be 0, otherwise should be = 7.2.16 Total Balance of savings plan liability at the end of the period (credit balance)
6.2.3.2	Trade and other payables		3.3.15 Current Quarter Total trade and other payables
6.2.3.3	Outstanding claims provision		3.3.9 Current Quarter Provision for outstanding claims at the end of the period + 3.3.14 Current Quarter Provision for outstanding claims at the end of the period
6.2.4	Total funds and liabilities		

Please indicate when the scheme obtained approval from Council to directly or indirectly borrow money, as is required by section 35(6)(c) of the Medical Schemes Act.

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 7.1

SAVINGS PLAN INVESTMENTS

	Description	Current Quarter
		R
7.1.1	Call accounts	
7.1.2	Current accounts	
7.1.3	Fixed deposits	
7.1.4	Other (specify)	
7.1.5	Total investments at the end of the period	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 7.2

SAVINGS PLAN LIABILITY

		Total
		R
7.2.1	Balance on savings plan liability at the beginning of the year (credit balance)	4.5.16 - 2011 annual return - Savings plan liability credit balance at the end of the year
7.2.2	Prior year adjustment	
7.2.3	Less: Advances on savings plan accounts	4.5.15 * -1 - 2011 annual return - Advances on savings plan accounts included in accounts receivable
7.2.4	Balance on savings plan liability at the beginning of the year (net balance)	
7.2.5	Savings plan account contributions received or receivable	
7.2.5.1	- For the current year	3.10.2 *-1 - Less: Consolidated Year to Date – Less: Savings plan account contribution income
7.2.5.2	- Received in advance	
7.2.5.3	- Allocated to settle prior year advances	
7.2.6	Transfers from other schemes	
7.2.7	Savings plan liabilities transferred to/(from) the scheme upon amalgamation	
7.2.8	Interest paid on savings plan accounts	
7.2.9	Less: Transfers to other schemes	
7.2.10	Less: Claims paid on behalf of members	
7.2.11	Less: Administration expenses	3.6.40 Year to date column - Less: Administration expenses recoverable from savings plan accounts
7.2.12	Less: Refunds on death or resignation	
7.2.13	Other (specify)	
7.2.14	Net balance at the end of the year	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 7.2

SAVINGS PLAN LIABILITY

		Total
		R
7.2.15	Add: Advances on savings plan accounts	
7.2.16	Balance of savings plan liability at the end of the year (credit balance)	
7.2.17	Ageing of savings plan liability at the end of the year	
7.2.17.1	Current Members	
7.2.17.2	Resigned members	
7.2.17.2.1	- 0 - 6 months	
7.2.17.2.2	- 6 months +	

Please provide reasons for any prior year adjustments:
What procedures are in place to follow-up on members that need to be refunded?

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 8.1

GENERAL ASSUMPTIONS USED IN THE BUDGET

	Description	Consolidated	Per benefit option
		%	%
8.1.1	Contribution increase		
8.1.2	Claims increase		
8.1.3	Managed care: healthcare expenses (capitation fee)		
8.1.4	Membership growth		
8.1.5	<i>Non-health expenditure</i>		
8.1.5.1	Administration fees		
8.1.5.2	Other administration costs		
8.1.5.3	Managed care: management services		
8.1.5.4	Broker fees		
8.1.5.5	Investment return		
8.1.5.6	Other (specify)		
8.1.6	Reserve building		

Reasons for any decreases and/or increases greater than 10%:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 9

MINIMUM ACCUMULATED FUNDS TO BE MAINTAINED BY A MEDICAL SCHEME IN TERMS OF REGULATION 29

PART 9.1

CUMULATIVE NETT GAIN ON RE-MEASUREMENT OF PROPERTIES AND INVESTMENTS

		Year to Date
		R
9.1.1	Balance at beginning of period	2011 Annual Return - line 10.1.9
9.1.2	Net gains/(losses) on revaluation of investments and property, plant and equipment included in the income statement	3.7.4 Year to date Unrealised gains/(losses) on revaluation of investment property + 3.7.5 Year to date Net gains/(losses) on revaluation of investments carried at fair value through the statement of comprehensive income +5.1.3.2 Year to date - Due to re-measurement and property, plant and equipment
9.1.3	Impairment losses and reversal of impairment losses on revaluation of investments and property, plant and equipment included in the income statement	
9.1.4	Realisation of cumulative gains or losses recognised in the income statement on disposal of investments	
9.1.5	Realisation of assets upon amalgamation during the year	
9.1.6	Other (specify)	
9.1.7	Cumulative net gain on revaluation of investments and property, plant and equipment included in the income statement	

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



PART 9.2

SOLVENCY RATIO

		R
9.2.1	Total members' funds per balance sheet	6.2.1 Current Quarter Members' funds
9.2.2	Less: Unrealised non-distributable reserve	IF 6.2.1.2 Current Quarter Revaluation Reserve - Investments + 6.2.1.3 Revaluation Reserve - Property plant and equipment is >0 , then = 6.2.1.2 Current Quarter Revaluation Reserve - Investments + 6.2.1.3 Revaluation Reserve - Property plant and equipment*-1
9.2.3	Less: Funds set aside for specific purposes	6.2.1.4 Current Quarter Reserves set aside for specific purposes (specify)
9.2.4	Less: Cumulative net gains on revaluation of investments and property, plant and equipment included in the income statement	9.1.7 - Cumulative net gain on revaluation of investments and Property, plant and equipment included in the income statement > 0 *-1; however if 9.2.2 < 0 AND 9.1.7 < 0 then 9.2.4 = 9.1.7 * -1, limited to 9.2.2 *-1
9.2.5	Less: Specific Assets Encumbered for third party liabilities	3.8.2 Suretyship Total + 3.8.2 Encumbered Total
9.2.6	Add: Sub-ordinated loan as approved by the Council	
9.2.7	Total nett assets	
9.2.8	TOTAL NETT ASSETS	9.2.7 Total nett assets
9.2.9	ANNUALISED GROSS CONTRIBUTIONS	4.1.22 Projected annual gross contribution income
9.2.10	SOLVENCY RATIO	%

Reason box:
Please indicate the reasons for not meeting the 25% statutory solvency:

Initials of Principal Officer: _____

Medical Scheme:
Ref No.:
Financial Year End:



How many days was the solvency less than 25%?
When was/will the business plan be submitted to the Council for Medical Schemes (in terms of section 35 (11) and Regulation 30(4))?

Initials of Principal Officer: _____



VALIDATION RULES		
Part	Description	Validation rule words
2.1	Members per option should be > 1.	Part 2.1: Please provide the reasons, should the number of members be zero for any option.
2.1	Adult dependants per option should be > 1.	Part 2.1: Please provide the reasons, should the number of adult dependants be zero for any option.
2.1	Child dependants per option should be > 1.	Part 2.1: Please provide the reasons, should the number of child dependants be zero for any option.
2.1	Total principle members should be > 6 000 members for open schemes.	Part 2.1: Please provide the reasons, and actions to be taken, should the principle members be less than 6 000 members.
2.2	The consolidated cumulative total for male and female in Part 2.2. must agree with the consolidated total of beneficiaries in part 2.1.2.	Part 2.2: The cumulative total for the consolidated males and females does not agree with the consolidated total beneficiaries in part 2.1.2.
2.2	The total beneficiaries per option for male and female in Part 2.2.20 must agree with the total beneficiaries per option in part 2.1.2.	Part 2.2 The cumulative total beneficiaries per option (both males and females) does not agree with the total beneficiaries per option in part 2.1.2.
2.2	Total males and females for any option should be >1.	Part 2.2: Please provide the reasons, should the number of males or females be zero for any option.



2.3	2.5.3 - beneficiaries less: 2.1.2 - Beneficiaries (2010 annual return) = 2.3.1's "Number of new members transferring from other schemes" column + "Number of new members not transferring from other schemes" column + "Number of new dependants transferring from other schemes" column + "Number of new dependants not transferring from other schemes" column - "Number of Members Leaving the Scheme" column - "Number of Dependants Leaving the Scheme" column.	The Quarter 1 member movement in Part 2.3 does not agree with the beneficiary movement from Previous Year December to March as captured in Part 2.5 of the return.
2.3	2.5.6 - beneficiaries less: 2.5.3 - Beneficiaries = 2.3.2's "Number of new members transferring from other schemes" column + "Number of new members not transferring from other schemes" column + "Number of new dependants transferring from other schemes" column + "Number of new dependants not transferring from other schemes" column - "Number of Members Leaving the Scheme" column - "Number of Dependants Leaving the Scheme" column.	The Quarter 2 member movement in Part 2.3 does not agree with the beneficiary movement from March to June as captured in Part 2.5 of the return.
2.3	2.5.9 - beneficiaries less: 2.5.6 - Beneficiaries = 2.3.3's "Number of new members transferring from other schemes" column + "Number of new members not transferring from other schemes" column + "Number of new dependants transferring from other schemes" column + "Number of new dependants not transferring from other schemes" column - "Number of Members Leaving the Scheme" column - "Number of Dependants Leaving the Scheme" column.	The Quarter 3 member movement in Part 2.3 does not agree with the beneficiary movement from June to September as captured in Part 2.5 of the return.



2.3	2.5.12 - beneficiaries less: 2.5.9 - Beneficiaries = 2.3.4's "Number of new members transferring from other schemes" column + "Number of new members not transferring from other schemes" column + "Number of new dependants transferring from other schemes" column + "Number of new dependants not transferring from other schemes" column - "Number of Members Leaving the Scheme" column - "Number of Dependants Leaving the Scheme" column.	The Quarter 4 member movement in Part 2.3 does not agree with the beneficiary movement from September to December Current Year as captured in Part 2.5 of the return.
2.4	"Number of New Beneficiaries to whom General Waiting Periods were Imposed", both columns line 2.4.20 > 0.	Part 2.4: Please provide reasons why no general waiting periods were imposed.
2.4	"Number of New Beneficiaries to whom Pre-existing Condition Exclusions were Imposed" both columns line 2.5.20 > 0.	Part 2.4: Please provide reasons why no pre-existing condition exclusions were imposed.
2.4	Number of New Beneficiaries to whom General Waiting Periods were Imposed" both columns line 2.4.20 > 0.	Part 2.4: Please provide reasons why no late joiner penalties were imposed.
2.5	Members per month should be > 1.	Part 2.5: Please provide the reasons should the number of members be zero in any month.
2.5	Adult dependants per month should be > 1.	Part 2.5: Please provide the reasons should the number of adult dependants be zero in any month.
2.5	Child dependants per month should be > 1.	Part 2.5: Please provide the reasons should the number of child dependants be zero in any month.
2.6	The total members in part 2.6.11 should agree with the consolidated members in part 2.1.2.	Part 2.6: The total members in part 2.6.11 does not agree with the consolidated total members in part 2.1.2.



2.6	The total adult dependants in part 2.6.11 should agree with the consolidated adult dependants in part 2.1.2.	Part 2.6: The total adult dependants in part 2.6.11 does not agree with the consolidated total adult dependants in part 2.1.2.
2.6	The total child dependants in part 2.6.11 should agree with the consolidated child dependants in part 2.1.2.	Part 2.6: The total child dependants in part 2.6.11 does not agree with the consolidated total child dependants in part 2.1.2.
2.6	Scheme has not completed any tick boxes for how the scheme is collecting member data.	Part 2.6: Please indicate how the scheme is collecting member data for the completion of this part.
2.6	Scheme has not completed any tick boxes for how the scheme is collecting adult dependant data.	Part 2.6: Please indicate how the scheme is collecting adult dependant data for the completion of this part.
2.6	Scheme has not completed any tick boxes for how the scheme is collecting child dependant data.	Part 2.6: Please indicate how the scheme is collecting child dependant data for the completion of this part.
3.2	There are values in 3.2.1.2; 3.2.1.3; 3.2.1.4; or 3.2.1.5.	Part 3.2.1: Please indicate whether the scheme has any agreements in place with employers / members to pay their contributions after 3 days of it becoming due and also indicate the remedial actions taken by the scheme where contributions were received after three days of it becoming due.
3.2	There are values in 3.2.1.2; 3.2.1.3; 3.2.1.4; or 3.2.1.5.	Part 3.2.1: Please indicate the remedial actions taken by the scheme where contributions were received after three days of it becoming due.
3.2	3.2.12.1 Administrator > 0.	Part 3.2.12.1: What is the nature of/reasons for the amount owed by the administrator?



3.2	3.2.12.2 Reinsurer (other than claim recoveries) > 0.	Part 3.2.12.2: What is the nature of/reasons for the amount owed by reinsurers (other than claim recoveries)?
3.2	3.2.12.3 Managed care organisations (other than claim recoveries) > 0.	Part 3.2.12.3: What is the nature of/reasons for the amount owed by managed care organisations (other than claim recoveries)?
3.2	3.2.12.4 Brokers > 0.	Part 3.2.12.4: What is the nature of/reasons for the amount owed by brokers?
3.2	3.2.12.5 Other related parties (specify) > 0.	Part 3.2.12.5: What is the nature of/reasons for the amount owed by other related parties?
3.3	3.3.6.1 > (3.6.2 YTD column/(Q1 = 3; Q2 = 6; Q3 = 9; Q4 = 12)).	Part 3.3.6.1: Administration fees owed is larger than the average fees per month.
3.3	If 3.3.6.3 > (-3.10.23.1 YTD column/(Q1 = 3; Q2 = 6; Q3 = 9; Q4 = 12)).	Part 3.3.6.3: Broker fees owed is larger than the average fees per month.
3.3	3.3.6.4 > ((-4.1.7 YTD column + 3.10.17.1 YTD column)/(Q1 = 3; Q2 = 6; Q3 = 9; Q4 = 12)).	Part 3.3.6.4: Fees owed to managed care organisations are larger than the average fees per month.
3.3	3.3.9 > (4.1.1 YTD column/(Q1 = 3; Q2 = 6; Q3 = 9; Q4 = 12)).	Part 3.3.9: Unallocated deposits are larger than average gross contributions per month.
3.3	Third party administered (selected in part 1) and 3.3.10 > R0.	Part 3.3.10: In respect of which employees are the post retirement benefits due?
3.3	3.3.5 - Bank Overdraft + 3.3.7 - Current portion of non-current borrowings > 0.	Part 3.3: Please indicate whether the scheme obtained approval from Council to directly or indirectly borrow money, as is required by section 35(6)(c) of the Medical Schemes Act.
3.4	If 3.4.29 > R0, and 3.4.1 to 3.4.28 = R0)	Part 3.4: Why are the managed care: management services fees not broken down into the different types of services delivered?



3.5.1	$(3.5.1.1 + 3.5.1.2)/3.5.1.1 > 50\%$ or $< -50\%$ per contract	Part 3.5.1: Please provide the basis for the calculation of the estimated claims recoveries in respect of related risk transfer arrangements per contract.
3.6	$3.6.17 \text{ YTD} + 3.6.32 \text{ YTD} = 0$.	Part 3.6: Kindly provide the reasons why no fidelity or professional indemnity insurance was accounted for in the current year?
3.6	$3.6.9 > 0$, no co-administrator in Part 1.1	Part 3.6: Kindly provide information on the nature of the co-administration services rendered to the scheme, including the name of the provider.
3.8	3.8.2 Guarantees $> R0$, or 3.8.2 Suretyships $> R0$, or 3.8.2 Encumbered $> R0$, or if 3.8.2 Other $> R0$.	Part 3.8: Were the guarantees, suretyship for third party liabilities or encumbered assets approved by Council?
3.9	"No" in "Was the transaction/balances at year-end at arms-length?" column in any of the lines (created or supplied)	Part 3.9: If the transactions/balances at year-end were not at arms length, the reason box must be completed.
3.10	If $3.10.31 \neq 0$ then 3.10.4.7 must be completed.	The scheme has completed part 3.10.31 (own facility surplus/(deficit)) but part 3.10.4.7 has not been completed.
3.10	If part 3.10.10 (Consolidated YTD column) $\neq 0$ then part $3.10.4.2 + 3.10.4.4$ (Consolidated YTD column) must be $\neq 0$.	The scheme had a provision for outstanding claims at the end of the previous period (3.10.10); however, part 3.10.4.2 and/or part 3.10.4.4 have not been completed.



3.10	If $3.10.15 < 0$, then $3.10.12.2 > 0$.	Part 3.10: Although the scheme had a provision for outstanding claims in respect of related risk transfer arrangements at the end of the previous period in line 3.10.15, no payments in respect of this provision were accounted for in line 3.10.12.2.
3.10	3.10.10"s consolidated current quarter total = 3.10.10 consolidated year to date total.	Q1 only validation: Part 3.10.10"s consolidated current quarter total should agree with the consolidated year to date total.
3.10	3.10.15 consolidated current quarter total should agree with the consolidated year to date total.	Q1 only validation: Part 3.10.15"s consolidated current quarter total should agree with the consolidated year to date total.
3.10	3.10.22 - Consolidated total Current Quarter Managed care: Management services *-1 = 3.4.30 Total - Managed care: management services.	Part 3.10.22 - Consolidated total Current Quarter Managed care: Management services *-1 must agree with part 3.4.30 Total - Managed care: management services.
3.10	3.10.24 - Consolidated total YTD Administration expenses *-1 = part 3.6.41 YTD Administration expenses.	Part 3.10.24 - Consolidated total YTD Administration expenses *-1 must agree with part 3.6.41 YTD Administration expenses.
3.10	3.10.29 - Consolidated total YTD Other realised and unrealised gains/(losses) = 3.7.7 YTD Total realised and unrealised gains/(losses)	Part 3.10.29 - Consolidated total YTD Other realised and unrealised gains/(losses) must agree with part 3.7.7 YTD Total realised and unrealised gains/(losses)
3.10	3.10.17 Consolidated total Current Quarter =3.5.1.4 Consolidated total Net (income)/expense on other risk transfer arrangements	Part 3.10.17 Consolidated total Current Quarter Net (income)/expense on other risk transfer arrangements must agree with 3.5.1.4 Consolidated total Net (income)/expense on other risk transfer arrangements



3.10	3.10.17.1 Consolidated total current quarter Premiums/fees paid (Capitation fees) = 3.5.1.1 - Consolidated total current quarter Premiums/fees paid (Capitation fees)	Part 3.10.17.1 Consolidated total Current Quarter Premiums/fees paid (Capitation fees) must agree with 3.5.1.1 - Consolidated total Premiums/fees paid (Capitation fees)
3.10	3.10.17.2 - Consolidated total Current Quarter Less: Estimated claims recoveries = 3.5.1.2 - Consolidated total Claims recoveries in respect of related risk transfer arrangements	Part 3.10.17.2 - Consolidated total Current Quarter Less: Estimated claims recoveries must agree with 3.5.1.2 - Consolidated total Claims recoveries in respect of related risk transfer arrangements
3.10	Part 3.10.17.3 Consolidated total Current Quarter Other = 3.5.1.3 Consolidated total Other	Part 3.10.17.3 Consolidated total Current Quarter Other must agree with 3.5.1.3 Consolidated total Other
3.10	3.10.21 Consolidated total Current Quarter Net income/(expense) from commercial reinsurance arrangements = 3.5.2.7 Consolidated total Net income/(expense) from commercial reinsurance arrangements	Part 3.10.21 Consolidated total Current Quarter Net income/(expense) from commercial reinsurance arrangements must agree with 3.5.2.7 Consolidated total Net income/(expense) from commercial reinsurance arrangements
3.10	YTD consolidated column 3.10.1 = 0.	Part 3.10: Please provide the reasons if the gross contributions are zero.
3.10	YTD Consolidated column $\{((3.10.4.2+3.10.4.5)+3.10.10)/3.10.10\} > 10\%$ or YTD Consolidated column $\{((3.10.4.2+3.10.4.5)+3.10.10)/43.10.10\} < -10\%$.	Part 3.10: Please provide reasons for any outstanding claims (under)/over provision which is more than 10% of the previous year's provision.
3.10	3.10.23.1 / (Q1 = 3; Q2 = 6; Q3 = 9; Q4 = 12) / 2.5.14 (Members) > R74.84 (incl VAT).	Part 3.10: The broker fees per average member per month exceeds the statutory limit of R74.84 (incl VAT).



3.10	3.10.23.1 consolidated YTD column > (3.10.1 consolidated YTD column x 3.42%).	Part 3.10: The broker fees exceeds the statutory limit of 3.42% of gross contributions.
3.11	Validation rule for Q1 only: If the following lines in part 3.11 are not completed for all twelve months (per benefit option), then the return should not validate: 3.11.1 / 3.11.4 / 3.11.8 / 3.11.21 / 3.11.22.	Part 3.11 is not completed per option, for all twelve months.
3.11	3.11.24 - Balance at the end of the year (Consolidated YTD) column = 3.11.24 (Consolidated December column).	3.11.24 - Balance at the end of the year (Consolidated YTD) column must agree with part 3.11.24 (Consolidated December column).
3.11	3.11.21 (per benefit option) - Any month total < 1	Part 3.11: Monthly member figures were not supplied.
3.11	3.11.22 (per benefit option) - Any month total < 1	Part 3.11: Monthly beneficiary figures were not supplied.
4.1	4.1.22 not = 1) Line 4.1.1 YTD + (Q1 part 3.11 columns April to December; Q2 part 3.11 columns July - December; Q3 part 3.11 columns October - December; Q4 zero); OR 2) Line 4.1.1 YTD / (Q1: 3; Q2: 6; Q3: 9; Q4: 12) x 12; OR 3) Line 4.1.1 YTD + (Q1 part 4.2 columns April to December; Q2 part 4.2 columns July to December; Q3 part 4.2 columns October to December; Q4 zero) +/- R5000	Part 4.1: Please provide more information on how the projected annual gross contribution income was calculated.
4.1	Part 4.1.22 Projected annual gross contribution income < 1.	Part 4.1.22 should be greater than zero.
4.2	4.2.12 "Per the 2011 annual return" = 4.2.12 "Total" column	Part 4.2.12 "Per the 2011 annual return" column should agree with the "Total" column



4.2	4.2.13 "Per the 2011 annual return" = 4.2.13 "Total" column	Part 4.2.13 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.14 "Per the 2011 annual return" = 4.2.14 "Total" column	Part 4.2.14 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.15 "Per the 2011 annual return" = 4.2.15 "Total" column	Part 4.2.15 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.16 "Per the 2011 annual return" = 4.2.16 "Total" column	Part 4.2.16 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.17 "Per the 2011 annual return" = 4.2.17 "Total" column	Part 4.2.17 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.18 "Per the 2011 annual return" = 4.2.18 "Total" column	Part 4.2.18 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.19 "Per the 2011 annual return" = 4.2.19 "Total" column	Part 4.2.19 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.20 "Per the 2011 annual return" = 4.2.20 "Total" column	Part 4.2.20 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.22.1 "Per the 2011 annual return" = 4.2.22.1 "Total" column	Part 4.2.22.1 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.22.2 "Per the 2011 annual return" = 4.2.22.2 "Total" column	Part 4.2.22.2 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.23.1 "Per the 2011 annual return" = 4.2.23.1 "Total" column	Part 4.2.23.1 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.23.2 "Per the 2011 annual return" = 4.2.23.2 "Total" column	Part 4.2.23.2 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.23.3 "Per the 2011 annual return" = 4.2.23.3 "Total" column	Part 4.2.23.3 "Per the 2011 annual return" column should agree with the "Total" column
4.2	4.2.24 "Per the 2011 annual return" = 4.2.24 "Total" column	Part 4.2.24 "Per the 2011 annual return" column should agree with the "Total" column



4.2	4.2.25 "Per the 2011 annual return" = 4.2.25 "Total" column	Part 4.2.25 "Per the 2011 annual return" column should agree with the "Total" column
5	5.1.1.2 Current Quarter >0	Part 5: Please provide the reasons for any prior year adjustment
6	6.1.3 - Total assets (current quarter column) = 6.2.4- Total funds and liabilities (current quarter column)	Part 6.1.3 - Total assets (current quarter column) must agree with part 6.2.4 - Total funds and liabilities (current quarter column).
6	6.1.3 -Total assets (previous quarter column) = 6.2.4 - Total funds and liabilities (previous quarter column)	Part 6.1.3 - Total assets (previous quarter column) must agree with part 6.2.4 - Total funds and liabilities (previous quarter column).
6	6.2.2.1 Borrowings >0.	Part 6.1: Please indicate whether the scheme obtained approval from Council to directly or indirectly borrow money, as is required by section 35(6)(c) of the Medical Schemes Act.
7.2	7.2.16 = 7.2.17	Part 7.2: 7.2.16 - Balance of savings plan liability at the end of the period (credit balance) = 7.2.17 - Ageing of savings plan liability at the end of the period.
7.2	7.2.2 > 0	Part 7.2: Please provide reasons for any prior year adjustments
7.2	7.2.17.2.2 > 0	Part 7.2: What procedures are in place to follow-up on members that need to be refunded
8.1	Columns Consolidated and Per benefit option and lines 8.1.1 - 8.1.7 = 0.	Part 8.1 was not completed.
8.1	Consolidated column's % value in one of lines (8.1.1 - 8.1.4 or 8.1.5.1 - 8.1.7) > 10% or <-10%.	Part 8.1: Please indicate the reasons for any decreases and/or increases greater than 10%.

Medical Scheme:
Ref No.:
Financial Year End:



9.2	If the solvency ratio in part 9.2.10 < 25%, then the reason box should be completed.	Part 9.2: Please indicate the reasons for not meeting the 25% statutory solvency.
9.2	Reason box should appear when the scheme has selected > 90 days in the 2nd reason box.	Part 9.2: When was/will the business plan be submitted to the Council for Medical Schemes (in terms of section 35 (11) and Regulation 30(4))?

Initials of Principal Officer: _____

ACCREDITING ADMINISTRATORS: EVALUATION FINDINGS

DANIE KOLVER
HEAD OF ACCREDITATION



Compliance by administrators and self administered schemes with accreditation standards - positive findings to date:

1. Sophisticated, integrated administration systems allow for real-time processing;
2. Successful alignment of administration systems with registered scheme rules in all respects;
3. Detailed and well drafted administration agreements complying with standards;
4. Obtaining and recording of principal member ID numbers;
5. Billing, collection and reconciliation of scheme contributions at individual member level;
6. Valid processing of claims within prescribed timeframes;



Compliance by administrators and self administered schemes
with accreditation standards - positive findings to date:

7. Processes for detecting and mitigation of irregularities and illegal acts;
8. Most have comprehensive disaster recovery and business continuity plans in place;
9. Adequate call centre facilities to deal with member enquiries; and
10. Overall - satisfactory compliance with regulatory requirements and administration standards.



Compliance by administrators and self administered schemes with accreditation standards - room for improvement

1. Compliance with ICD10 coding;
2. Less reliance on external brokers where members contact the scheme (administrator) directly;
3. Broker training in respect of ongoing service delivery to members and broker services in general:
 - particular attention to be drawn to duties of broker not to bind scheme with regard to underwriting criteria e.g application of waiting periods and late joiner penalties and ensuring all relevant information is disclosed by client;
4. Payment of remuneration to:
 - accredited brokers;
 - in terms of valid appointments;
 - Correctly determined as per prevailing legislation.
 - Guard against professional fee arrangements.
5. Correct/lawful application of underwriting rules – e.g. condition specific exclusions must be specific and must include only directly related conditions. Phrases such as “and other associated conditions” cause confusion and are open for interpretation;



Compliance by administrators and self administered schemes with accreditation standards - room for improvement

6. Make reasonable effort to obtain and record dependant ID numbers;
7. Consistent application of appropriate credit control measures, i.e. managing collection of outstanding contributions, member and provider debts;
8. Consistent and fair application of the PMB provisions – payment of claims at cost, correct application of co-payments, no PMBs paid from savings;
9. Refunding member savings accounts upon termination or moving to an option without savings within appropriate timeframes. (Circular 38/2011)
10. Recording prior medical scheme membership details to i.e prior cover period - assists in applying waiting periods, late joiner penalties, etc.
11. Quality checks to ensure that marketing material corresponds with registered rules
12. Certain PO's either fail to disclose to or provide incomplete information to their BOT's and fail to obtain BOT approval for critical decisions affecting the Scheme. (Examples of unnecessary litigation and wasteful expenditure on appeals processes).

