Retail Medical Scheme

Administered by Discovery Health

Contact details
Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

Application for addition of dependant/s

Who we are

Retail Medical Scheme ("the Scheme"), registration number 1176, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator'),(registration number 1997/013480/07), is a separate company and an authorised financial services provider, that takes care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Submit the signed and completed document to your People Team.
3. Please attach a copy of the ID documents of your dependant(s). We also accept SA driver's licences, passports and SA birth certificates for children.
4. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
5. We will send you or your employer the counter offer letter and any outstanding underwriting requirements when we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
6. To avoid administrative delays, please ensure this application is completed in full by you and your employer.

1. About yourself (main member)

Surname | Membership number

First names | Date of birth (D D M M Y Y Y Y)

Telephone (H) | (W)

Cellphone | Fax

Personal email | Employee number

2. About your spouse or partner (if applying for cover)

When do you want your cover to start? (Y Y Y Y M M D D)

Title | Initials | Surname

First name(s)
(as per ID document)

Preferred name | Gender M F

Race | African | Coloured | Indian/Asian | White | Other | Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Date of birth (Y Y Y Y M M D D)

Previous or maiden name

ID or passport number

Country of issue

Telephone (H) | (W)

Cellphone | Fax

Personal email

Date of marriage to main applicant (where applicable). Please attach a copy of an official certificate Y Y Y Y M M D D

If the application is for a partner, please provide information of any contractual obligations

Does the dependant live with you? Yes No

Confirm period Y Y Y Y M M D D to Y Y Y Y M M D D

If not, please state reason

3. About your dependant/s (if applying for cover)

When do you want your cover to start? Y Y Y Y M M D D

Dependant 1

Title Initials Surname

First name(s)
(as per identity document)

Preferred name Gender M F

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Date of birth D D M M Y Y Y Y ID or passport number

Country of issue

Relationship to member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

Is your dependant: Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A student? Yes No

Does your dependant earn an income? Yes No How much does your dependant earn each month? **R**

In case of permanent disability, please provide a doctor's motivation letter.

Brief description and estimated duration of disability

Is the dependant a resident of an institution? Yes No

If "**yes**", please state the name of the institution

and who is responsible for the medical expenses and the extent thereof.

Does the dependant live with you Yes No Confirm period Y Y Y Y M M D D to Y Y Y Y M M D D

If not, please state reason

Dependant 2

Title | Initials | Surname

First name(s)
(as per identity document)

Preferred name | Gender M F

Race | African | Coloured | Indian/Asian | White | Other | Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Date of birth (Y Y Y Y M M D D) | ID or passport number

Country of issue

Relationship to member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

Is your dependant: Married? Yes No | Financially dependent on you? Yes No

Disabled? Yes No | A student? Yes No

Does your dependant earn an income? Yes No | How much does your dependant earn each month? **R**

In case of permanent disability, please provide a doctor's motivation letter.

Brief description and estimated duration of disability

Is the dependant a resident of an institution? Yes No

If "**yes**", please state the name of the institution

and who is responsible for the medical expenses and the extent thereof.

Does the dependant live with you? Yes No | Confirm period (Y Y Y Y M M D D) to (Y Y Y Y M M D D)

If not, please state reason

Dependant 3

Title | Initials | Surname

First name(s)
(as per identity document)

Preferred name | Gender M F

Race | African | Coloured | Indian/Asian | White | Other | Do not want to disclose

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Date of birth (D D M M Y Y Y Y) | ID or passport number

Country of issue

Relationship to member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

Is your dependant: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

Does your dependent earn an income? Yes ☐ No ☐ How much does your dependant earn each month? **R**

In case of permanent disability, please provide a doctor's motivation letter.

Brief description and estimated duration of disability

Is the dependant a resident of an institution? Yes ☐ No ☐

If "**yes**", please state the name of the institution

and who is responsible for the medical expenses and the extent thereof.

Does the dependant live with you Yes ☐ No ☐ confirm period Y Y Y Y M M D D to Y Y Y Y M M D D

If not, please state reason

Dependant 4

Title Initials Surname

First name(s)
(as per identity document)

Preferred name Gender M ☐ F ☐ Date of birth Y Y Y Y M M D D

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want disclose ☐

You are not compelled to provide the information required on race. The Scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

Country of issue

Relationship to member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

Is your dependant: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? **R**

In case of permanent disability, please provide a doctor's motivation letter.

Brief description and estimated duration of disability

Is the dependant a resident of an institution? Yes ☐ No ☐

If "**yes**", please state the name of the institution

and who is responsible for the medical expenses and the extent thereof.

Does the dependant live with you? Yes [ ] No [ ] confirm period Y Y Y Y M M D D to Y Y Y Y M M D D

If not, please state reason

4. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you and your dependant/s previously belonged to. We will use this information to determine if we need to apply any waiting periods, late joiner penalty fees, or both. Please give us proof in the form of a membership certificate.

Person applying for membership	Scheme name	Start date	End date if already	Are they still	Reason for leaving
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes [ ] No [ ]	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes [ ] No [ ]	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes [ ] No [ ]	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes [ ] No [ ]	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes [ ] No [ ]	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes [ ] No [ ]	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes [ ] No [ ]	

5. Your spouse, partner or dependant/s health questions

Treating healthcare professional's name

Practice Number Telephone Number -

Email

Have any of your dependant/s in this application ever experienced, been treated for, or are they currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities (disease or physical abnormality present from birth).

Please take note that if you have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 5.18 below. Indications of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programmes. For more information on how to enroll on any of the disease management programmes offered by the Scheme visit www.retailmedicalscheme.co.za

We use this information only for lawful purposes, for example, to process your application and to administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customised information relevant to your health status, to develop disease management programmes for specific conditions, to review and enhance benefits, to improve the Scheme's financial modeling and to assist the Scheme to assess and mitigate risk. A condition specific waiting period will only be imposed on your membership if you or your dependant\s received or were recommended any medical advice, diagnosis, care or treatment within the preceding 12-month period ending on the date on which this application is considered to be fully and properly made.

5.1 Tumours growth and disorders of the skin Yes [ ] No [ ]

Example: abnormal pap smear results, skin lesions,eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result, abscess, any autoimmune conditions, any congenital conditions or other skin conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.2 Heart and circulation conditions **Yes** ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, deep vein thrombosis, pulmonary embolus.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.3 Gynaecological and Obstetric conditions **Yes** ☐ **No** ☐

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.4 Are any of your dependants pregnant? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.5 Mental health **Yes** ☐ **No** ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling, any other psychological conditions, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.6 Metabolic or endocrine conditions **Yes** ☐ **No** ☐

Example: diabetes mellitus (high blood sugar), diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.7 Abdominal conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ongoing abdominal pain, ascites (fluid in the abdomen), any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.8 Brain and nerve conditions **Yes** ☐ **No** ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt used to drain fluid from the brain), intellectual disability, CVA, bleeding on the brain, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.9 Breathing and respiratory conditions **Yes** ☐ **No** ☐

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease/chronic cough > 3months, any autoimmune conditions, any congenital conditions .

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.10 Musculoskeletal (back, bone and muscle pain) **Yes** **No**

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, injury, physical disability, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.11 Kidney or urinary conditions including current or past dialysis **Yes** **No**

Example: kidney failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), neurogenic bladder, bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.12 Blood conditions **Yes** **No**

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis, and other bleeding disorders, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.13 Eye conditions **Yes** **No**

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.14 Ear, nose and throat (ENT) and dentistry conditions **Yes** ☐ **No** ☐

Example: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.15 Male urogenital conditions **Yes** ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, undescended testes, phimosis, urinary incontinence, infertility, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.16 Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.17 Have any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

5.18 Have any of your dependants been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/ Symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

HIV and AIDS

You do not need to disclose the HIV status of your dependant/s on this form if you do not feel comfortable doing so. However, if one or more of your dependant/s are HIV positive, you or they must call us on 0860 101 252 within seven working days from the date we activate their Retail Medical Scheme membership. We treat this information in the strictest confidence. If one or more of your dependant/s are HIV positive, it is in your and your dependant/s best interest to register on the HIVCare Programme. A 12-month condition specific waiting period may apply to this condition. Should you or they only find out at a later stage that you or they are HIV-positive, please let us know as soon as possible.

6. Privacy Statement – how we will process and disclose your Personal Information and communicate with you

Definitions

Discovery Group refers to Discovery Limited, registration number 1999/007789/06, including all subsidiaries of the Group. Subsidiaries in the Group are authorised financial services providers.
You and your refer to you as the main member and your registered dependants who are registered on the Scheme.
Your personal information refers to all personal information the Scheme and the Administrator has on you, or your dependants that are registered on the membership. It includes:

- financial information;
- information about health, race or ethnic origin, biometrics, criminal behaviour or religion;
- gender;
- age;
- unique identifiers such as identity numbers or contact numbers; and
- addresses.

Process(ing) (of) information means the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information to ensure that such processing is adequate, relevant and not excessive given the purpose for which it is processed.
Competent person means anyone who is legally competent to consent to any action or decision being taken for any matter concerning a member or dependant for example a parent or legal guardian.

1. When you engage with the Scheme and Administrator, you entrust us with personal information. We warrant that we will protect your right to privacy and your personal information.
   The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information.
2. You have the right to object to the processing of your personal information and have a choice whether or not to accept these terms and conditions, but the Scheme and Administrator would require your personal information to process your application.
3. The Scheme and Administrator will keep your personal information confidential. You may have given us this information yourself, or we may have collected it from other source and subject to the provisions of this agreement.
4. You understand when you include your spouse and/or dependents on your application, we will process their personal information for the activation of the policy/benefit and to pursue their legitimate interest. We will furthermore process their information for the purposes set out in this Privacy Statement.
5. The Scheme and the Administrator agree to indemnify you against any loss or damage, direct or indirect, that you or your dependants may suffer because of any unauthorised use of your personal information.
6. If you are giving consent for a person under 18 (a minor) you confirm that you are a competent person and that you have authority to give consent on their behalf.
7. You agree that the Scheme and the Administrator may process your personal information for the following purposes:
   7.1. for the administration of your benefit option;
   7.2. for the provision of managed healthcare services to you as a member of the Scheme;
   7.3. for the provision of relevant information to a contracted third party who requires this information for the sole purpose of providing a healthcare service to you as a member of the Scheme;
   7.4. to analyse risks, trends and profiles;
   7.5. to share your personal information with external healthcare providers for the purpose of assessing certain clinical information, when you require medical treatment.
   Personal information may be used or processed as follows:
   7.6. Obtaining and sharing your personal information with other relevant sources, including medical practitioners, contracted service providers, health information exchanges entities that are part of Discovery Group, or industry regulatory bodies (“relevant sources”), and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to assess and value a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete;
   7.7. If you are a member of an employer group, getting information from your employer that is relevant to your application for membership, with due regard for considerations of confidentiality in respect of your state of health;
   7.8. Communicating with you about any changes in your benefit option, including changes to your contributions or changes to the benefits you are entitled to on the benefit option you have chosen;
8. If a third party asks the Scheme and Administrator for any of your personal information, we will share it with them only if:
   8.1. you have already given your consent for the disclosure of this information to that third party; or
   8.2. we have a legal or statutory duty to give the information to that third party, or
   8.3. we need to share it with them for risk analytical or fraud detection or fraud prevention purposes, in which case the information will be de-identified;

You consent and agree that:

8.4. we may process your information, including personal and special personal information, to adhere to South African Legislative reporting obligations and to perform transaction monitoring activities;

8.5. we may communicate such personal information to local Regulatory Bodies as well as to other entities in the Discovery Group if any Legislative reportable matters are identified.

9. The Scheme and the Administrator may provide your personal information to any other entity within the Discovery Group with whom you already have a relationship, on your approval from them. This information will be provided for the administration of your benefits with other entities within the Discovery Group, and for fraud detection and prevention purposes.
10. The Scheme and Administrator may process your personal information for any one or more of the following purposes:
    10.1. market, statistical and academic research; and
    10.2. to customise benefits and services to meet your needs.
    Information about you may be shared with third parties such as academics and researchers, who may be located outside of South Africa, but this will be done subject to compliance with POPI. We warrant that your personal information that is shared with such third parties will be de-identified in such an instance. Note also that personal information will be made available to such third party only if that third party complies with the provisions of POPI. If we publish the results of any academic research, you will not be identified by name.
    If we want to share your personal information for any other reason, we may only do so with your informed and specific consent.
11. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always try to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources.
12. By accepting this privacy statement, you authorise the Scheme and Administrator to obtain information about your creditworthiness with any credit bureau or credit providers, providers' industry association or industry body. This includes sharing of information for purposes of tracing and any debt management-related purposes.
13. The Scheme and Administrator have the right to communicate with you electronically about any changes to your benefit option, including changes to your contributions or changes to the benefits you are entitled to on the benefit option you have chosen.
14. We may process your information using automated means (without human intervention in the decision making process) to make a decision about you or your application for membership. You may query the decision made about you.
15. The Scheme and Administrator have a duty to keep you updated about any offers and new products that are made available from time to time. The Scheme, Administrator, any entity within the Discovery Group, and contracted third-party service providers, may communicate with you about these.
16. The Scheme and Administrator will not engage in direct telephonic marketing with you unless you have specifically provided consent for them to do so.
17. You confirm that we may share, both within the Discovery Group and with our service providers, and combine all your personal information, including your unique identifiers, for any one or more of the following purposes directly or through a third party:
    17.1. Market, statistical and academic research, including cross-company analytics;
    17.2. To customise and enhance our benefits and services to meet your needs; and
    17.3. To market our services to you.
18. You may opt out of Electronic Marketing by:
    18.1. Logging into your profile on www.retailmedicalscheme.co.za or the Discovery App;
    18.2. Following the unsubscribe prompts on the electronic marketing communication received.
19. We will store your personal information for the purpose of processing this request and action it as soon as reasonably possible.
20. You have the right to know what personal information the Scheme and Administrator holds about you. If you wish to receive this information please complete an 'Access Request Form', attached to the PAIA manual, on www.retailmedicalscheme.co.za and specify the information you would like.We will take all reasonable steps to confirm your identity before providing details of your personal information.
    We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
21. The Scheme and Administrator will retain your personal information until they are required to delete or destroy it in accordance with the provisions of POPI. You have the right to ask us to update, correct or delete your personal information unless the law requires us to retain it. We have a corresponding right to ensure that your personal information is kept relevant and updated in accordance with the provisions of POPI. Where we may not delete or destroy your personal information due to legislative constraints, we will take the necessary steps to de-identify it.
22. Where the Scheme and Administrator are required by law to collect and keep personal information, we shall do so. We are required to collect and keep personal information in terms of the following laws:
    - Medical Schemes Act, 1998
    - The Consumer Protection Act, 2008
    - The Protection of Personal Information Act, 2013
    - Electronic Communications and Transactions Act, 2002
    - Promotion of Access to Information Act, 2002

    Legislation specific to Discovery Health (Pty) Ltd only:
    - Financial Advisory and Intermediary Services Act, 2002
    - Companies Act, 2008
23. You agree that the Scheme and Administrator may transfer your personal information outside South Africa and the Scheme and Administrator will do so in accordance with the provisions of POPI:
    - if you give us an email address that is hosted outside South Africa; or
    - for academic research (in which case the information will be de-identified), or
    - to administer certain services, for example, cloud services.

    When we share your information with a person (or company) outside South Africa, we will ensure that such a person (or company) process your information in a manner that complies with the privacy legislation of that country and at least with the same level of protection as we are obliged to comply with in South Africa.
24. If the Scheme or Administrator becomes involved in a proposed or actual amalgamation or merger, acquisition or change in ownership, we

have the right to share your personal information with third parties in connection with the transaction. In such an event, the new entity will have access to your personal information. The terms of this Privacy Statement will continue to apply.

25. The Scheme or Administrator may change this Privacy Statement at any time, in which case it will notify members of any of such changes. The current version is available on www.retailmedicalscheme.co.za

26. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, we encourage (but not oblige) you to first follow our internal complaints procedure to resolve the complaint. We explain the complaints and disputes process on www.retailmedicalscheme.co.za. If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator, under POPI.

    Contact details for the Information Regulator are:
    The Information Regulator (South Africa)
    JD House
    27 Stiemens Street,
    Braamfontein, Johannesburg, 2001
    POPIAComplaints@inforegulator.org.za or PAIAComplaints@inforegulator.org.za

Signature of main member

Please sign that you have read and understand this statement

7. Terms and Conditions applicable to Retail Medical Scheme

Scheme terms and conditions for membership

The Rules of the Scheme give you details about the rights and responsibilities for your membership. You may ask us for a copy of the terms and conditions at any time. These terms and conditions may change from time to time.

When you sign this application, you confirm that you have read and understood the terms and conditions and you agree that you will be bound by them.

Your legal address

We will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Scheme and the Administrator may record telephone calls

We may record telephone conversations with you and with those you apply for. The recordings, and all information we get during the recordings, will be processed and kept as required by law.

The Scheme and Administrator may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that we can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of Retail Medical Scheme, is true, correct and complete. You give your permission that we may get any information that is relevant to your application from your employer.

Tell the Scheme or Administrator immediately if your information changes

You or your employer must tell us in writing if any of the information you gave in your application for membership changes between the day you sign this document, and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as backdated changes may not be accepted.

When the Scheme may cancel your membership/s

The Scheme may cancel any memberships immediately, if you and those you apply for:

- do not give us information that later turns out to be relevant to this application;
- give us any information that is not true, correct and complete;
- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document, and the day cover starts.

About becoming a member

Retail Medical Scheme might not pay for certain expenses immediately after you become a member

Certain waiting periods may apply to your membership in certain circumstances. This means there may be a set time period before the Scheme starts paying claims for any general or specific medical conditions. Please speak to your People Team or us to find out if waiting periods apply to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted as members of the Scheme.

You must ensure contributions are paid on time

As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits.

Repaying money owed to the Scheme

Retail Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you if there is any amount that you owe to the Scheme. By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.

You must repay any medical savings owing if you leave the Scheme.

When you become a member, and if you chose to belong to the Essential Plus Option, you may have money available in advance to use for medical expenses during the year. This money is made available in the 'Medical Savings Account'. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used, that is more than you have paid back to the Scheme during the specific year.

By signing this form, you agree to the terms as stipulated, and in particular that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.

Signature of main member

Date Y Y Y Y M M D D

The main member must sign and date any changes

Please do not sign an incomplete application form

8. For office use only

Membership commencement date Y Y Y Y M M D D

Underwriting? Yes No

Late joiner penalty Yes No Group number (billing category)

Comments:

9. Retail Medical Scheme approval

This application form has been duly approved.

Name

Signature

Date Y Y Y Y M M D D