Retail Medical Scheme

Administered by Discovery Health

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

Retail Medical Scheme membership form

Who we are

Retail Medical Scheme, (the Scheme) registration number 1176, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, (the administrator) registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Retail Medical Scheme and takes care of the administration of your membership.

How to complete this form

1. Please use one letter per block, complete with black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. Submit the completed and signed form to your People Team Department.
4. Please attach a copy of your and any dependant that must also be registered identity document to this application form. We also accept valid SA driver's licences, passports and birth certificates for children.
5. 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.
6. You must attach a membership certificate from your current medical scheme to this form. If you do not provide it, we will not be able to process this application.

1. About yourself (main applicant)

Your cover will start on Y Y Y Y M M D D

Date of employment Y Y Y Y M M D D Employee number

Title Initials

Surname

First name(s)
(as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

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.

Marital status Married Single Divorced Widowed

Previous or maiden name

Telephone (H) Telephone (W)

Cellphone

Physical address

Unit/Suite number Complex name

Street number Street name

Suburb

City Postal code

Postal address

PO Box | Private bag | Box number

Suite | Postnet suite | Number

Suburb | Postal code

Preferred means of communicating Email | SMS | Email type (H) | (W)

Email

Please do not provide us with a Shoprite branch email (the type that has numbers in the address)

Tax number

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

Title | Initials

Surname

First name(s) (as per identity document)

Previous or maiden name

ID or passport number

Gender M | F | Date of birth D D M M Y Y Y Y

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.

Marital status Married | Single | Divorced | Widowed

Telephone (H) | Telephone (W)

Cellphone

Email

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

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

Dependant 1

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M | F | Date of birth D D M M Y Y Y Y

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.

Relationship to member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child)

If your dependant is 21 years and older, are they:

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** .

Dependant 2

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

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.

Relationship to member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child)

If your dependant is 21 years and older, are they:

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** .

Dependant 3

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth D D M M Y Y Y Y

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.

Relationship to member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child)

If your dependant is 21 years and older, are they:

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** .

4. Please select your medical benefit option

Please select your benefit option by ticking the applicable box **Essential** **Essential Plus**

5. Previous medical scheme details

Please give us the details of all registered South African medical schemes of the dependant/s you want to add, 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.

If any of your dependants applying for cover belonged to different medical schemes, please complete below:

Dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

6. Your health questions

Have any of your dependant/s in this application ever experienced, been treated/investigated 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 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 6.18 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.

6.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast **Yes** ☐ **No** ☐

Example: 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, 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

6.2 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, varicose veins.

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

6.3 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

6.4 Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or difficulty falling 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

6.5 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

6.6 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

6.7 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, ascites (fluid in the abdomen), any autoimmune conditions, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, colo-rectal symptoms/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

6.8 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

6.9 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, ventilator, oxygen therapy, CPAP, 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

6.10 Musculoskeletal (back, bone, injury 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, physical disability, prosthesis and internal insertion of surgical implants, 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

6.11 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), 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

6.12 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, varicose veins.

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

6.13 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, intra-ocular pressure, visual disturbances, night blindness, 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

6.14 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

6.15 Male urogenital conditions Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), 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

6.16 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

6.17 Have you or 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

6.18 Have you or any of your dependants ever been diagnosed with or received treatment for, any condition/ symptoms or any allergic reactions or side-effects, 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

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 101 252** within seven working days from the date we activate your Retail Medical Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIV*Care* Programme. Retail Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Retail Medical Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. If you do not let us know about you or your dependant's HIV status within 7 days of your membership being active, we may end your Retail Medical Scheme membership.

7. Banking details for claim refunds

Please provide us with your bank details for the refund of claims. You can only use a South African bank account.

Bank Name

Branch name

Branch code - -

Account number

Type of account Cheque Savings

Name of account holder

Signature of main applicant

Date D D M M Y Y Y Y

Signature of account holder

Date D D M M Y Y Y Y

Third party bank details

If third party bank details, please insert the third party ID number

If the third party bank account is a: joint account company account trust account

Please provide proof of bank account.
Refer to Annexure A at the back of the application form for the proof of bank account required.

By signing the above, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will no longer be responsible in any way for the amounts refunded.

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

Definitions

The Scheme refers to Retail Medical Scheme, registration number 1176, registered with the Council for Medical Schemes.

The Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed care organisation for Retail Medical Scheme.

We, us, our refer collectively to the Scheme and the Administrator.

You and your refer to:

- the member and the dependants on the Scheme which may include your spouse, children and other dependants, collectively “your dependants”

Your personal information includes information about race, gender, sex, pregnancy, biometrics, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and date of birth of the individual amongst other things.

Process(ing) (of) information means the lawful and reasonable automated or manual activity of collecting, recording, organising, using, 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, legal guardian or a legal representative appointed by a court to manage the finances, property, or estate of another person unable to do so because of mental or physical incapacity.

How we will process and disclose your personal information and communicate with you

1. The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in a manner that is compliant, ethical, adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time.
2. This Privacy Statement applies to you if you engage with us physically through our offices, or virtually through our website (**www.retailmedicalscheme.co.za**) email, mobile applications such as the Discovery App, social media platforms, over the phone, or otherwise as may be the case from time to time.
3. When you engage with us, you entrust us with personal information about you.
4. We are committed to protecting your right to privacy. We will keep your personal information confidential. We take protecting your personal information seriously and are continuously developing and updating our security systems, processes and data governance policies.

5. 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 endeavour 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. Thus, your personal information comprises information you may have given to us yourself or we may have collected from other sources.
6. 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. However, it is important to note that we require your acceptance to activate and service your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your medical scheme membership.
7. You understand and/or acknowledge that when you include your dependants on your application, we will process their personal information for the activation of the benefit and to pursue their legitimate interest. By submitting your dependants' relevant personal information, you hereby confirm that you are duly authorised to share such information with us.
8. If you are giving consent for a person under 18 (a minor) you confirm that you are their parent or legal guardian and that you give consent for us to process their personal information for the purposes covered in this Privacy Statement.
9. If you share your personal information with any third parties, we will not be responsible for how they use this information nor be responsible for any loss suffered by you.
10. You understand, accept and consent that we may process your personal information for the following purposes:
    10.1. to verify the accuracy, correctness and completeness of any information provided to us in the course of processing an application for membership or providing services related to the membership;
    10.2. for the administration of your benefit option;
    10.3. for the provision of managed care services to you on your benefit option;
    10.4. for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you on your benefit option;
    10.5. to profile and analyse risk;
    10.6. to share your personal information with external healthcare providers for them to assess or evaluate certain clinical information, when you are subject to such a clinical assessment;
    10.7. to investigate and/or remedy fraud, waste and and abuse.
11. By signing this application form, you expressly consent that we can obtain and share information about your creditworthiness, or the creditworthiness of any payer of your contribution, with any credit bureau or credit providers' industry association or industry body. This includes information about credit history, financial history, judgments, default history and sharing of information for purposes of risk analysis, tracing and any related purposes.
12. Examples of when and how we will obtain and share your personal information include:
    12.1. Obtaining your personal information from other relevant sources, including medical practitioners, contracted service providers, credit bureaus, entities that are part of Discovery Limited 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 consider 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;
    12.2. If you have joined as a member of an employer group, getting from and sharing with your employer information that is relevant to your application;
    12.3. Communicating with you about any changes to your benefit option, including your contributions or changes and enhancements to the benefits you are entitled to on the benefit option you have chosen;
    12.4. Transferring your personal information outside the borders of the Republic of South Africa where appropriate, or if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research.
    12.5. Sharing your personal information to be processed by healthcare providers via a health information exchange to improve members' treatment and healthcare outcomes.
13. If a third party asks us for any of your personal information, we will share it with them only if:
    13.1. you have already given your consent for the disclosure of this information to that third party; or
    13.2. we have a legal or contractual duty to give the information to that third party.
    13.3. I consent to my spouse and/or adult dependant, that is part of this application process, acting on my behalf and providing personal information, including health information, to Discovery Health for the purpose of my application to join Retail Medical Scheme.
    13.4. we may be able to retrieve certain previous medical information we have for you and your dependants (if applicable) from previous memberships, however, it is still the applicant's obligation to disclose any and all relevant information as required above.
14. We will provide your personal information to any Discovery Limited entity for the following purposes only:
    14.1. to allow for the administration of your profile/membership/benefit option with the entity with whom you or your dependant/s already have a relationship; or
    14.2. where you or your dependant/s have applied for a product, service or benefit from such an entity for the purposes of underwriting.
15. We may process your personal and/or depersonalised information for the following purposes:
    15.1. for research and analysis; or
    15.2. to support the early identification of medical conditions and/or other lifestyle risks and to encourage you to change your lifestyle to lessen the impact of such conditions; or
    15.3. to provide personalised advice to you about risks to your health, how you may become healthier (such as by seeing a healthcare practitioner, having additional tests done or activating benefits) and the rewards and incentives which you may receive as a result of undertaking these activities. We will provide this advice to you based on market and behavioural research and analysis carried out using your personal, special and or depersonalised information. We may communicate this advice to you using the Discovery App or other communication channels.
16. Your personal information may be shared with third parties such as academics and researchers, including those outside South Africa. We ensure that the academics and researchers will keep your personal information confidential and all data will be made anonymous to the extent possible and where appropriate. No personal information will be made available to an academic or research party unless that party has agreed to abide by strict confidentiality protocols that we require. If we and/or the academic and researcher publish the results of this research, you will not be identifiable:
17. You agree that we may transfer your personal information outside South Africa only:

17.1. if you give us an email address that is hosted outside South Africa; or
17.2. to administer certain services, for example, cloud services.

18. When we share your information, we will ensure that, the company, person or regulatory body (in or outside of South Africa) to whom we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to.
19. You consent and agree that:
    19.1. 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;
    19.2. we may communicate such personal information to local regulatory bodies as well as to other relevant governance structure of Discovery Limited or any of its relevant entities if any Legislative reportable matters are identified.
20. 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 any product or service. You may query the decision made about you.
21. We have the right to communicate with you electronically about any changes on your benefit option, including your contributions or changes and improvements to the benefits you are entitled to on the benefit option you have chosen
22. Where we are required by law to collect and keep personal information, we shall do so. At a minimum, this includes the following:
    22.1. Legislation applicable to us:
    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
    22.2. Legislation specific to Access to Information Act, 2002
    Financial Advisory and Intermediary Services Act, 2002
23. The Scheme may change this Privacy Statement at any time. It is your responsibility to check our website regularly to ensure that you are aware of these changes. By continuing to be a member you agree that the latest version will apply to you. The current version is available on **www.retailmedicalscheme.co.za**.
24. You have the right to know what personal information we hold about you. If you wish to receive this information please complete a 'PAIA Form to Request Access to Records' 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 in respect of this request. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
25. If you believe that we have used your personal information in a way that is contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator, under POPIA, but we encourage you to first follow our internal escalation and/or disputes process to resolve the matter. We explain the escalation and/or disputes process on the website **www.retailmedicalscheme.co.za** or contact the Scheme's Information Officer at **privacy@discovery.co.za**.
    If, thereafter, you feel that we have not resolved your complaint adequately kindly contact the Information Regulator at: The Information Regulator (South Africa) | JD House | 27 Stiemens Street | Braamfontein | PO Box 31533 | Braamfontein | 2017 | Tel: **+27 (0) 10 023 5200** | **POPIAComplaints@inforegulator.org.za**.

Signature of main member

Date D D M M Y Y Y Y

Please sign that you have read and understand this statement

9. Terms and conditions

Rules for membership

The Rules of Retail Medical Scheme gives you details about the rights and responsibilities for your membership of the Scheme. You may ask us for a copy of the Rules at any time. These Rules 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 and those you apply for will be bound by these and the Scheme Rules.

Who you are applying for

You may apply to join Retail Medical Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Retail Medical Scheme Rules. For anyone to be treated as financially dependent for this application, you must have a legal responsibility to provide financially for that dependant. We might ask you to give us proof of financial responsibility. You may be called the principal member or main member in our future communications to you.

Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

- you have the right to apply for membership and to act for those you apply for in any matter relating to this application;
- you have received permission from your spouse and any dependant/s over 18 to act for them in any matter relating to this application.

Giving and getting information

You must give true, correct and complete information

To consider your application for membership, Retail Medical Scheme must learn more about you and those you apply for. Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for information and this will be treated as if Retail Medical Scheme had asked you in your role as main member.

Your legal address

We will send documents to you at the valid email address. 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 the 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, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers). 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 the 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

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

The Scheme may have waiting periods that apply 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 Department or us to find out if waiting periods apply to your membership and the memberships of those you apply for.

Resign from your current medical scheme when we accept your membership

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

The 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 Retail Medical 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 an account called 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 applicant

Date D D M M Y Y Y Y

Please do not sign an incomplete application form

10. Annexure A : Third party bank account details

Please attach the relevant proof of bank account if you are providing a third party bank account for claims refund.

THIRD PARTY ACCOUNT (e.g. spouse, aunt, uncle, friend, father, son)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, Passport or Driver's Licence
- A copy of the main member's ID, Passport or Driver's Licence

JOINT ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the joint owners

COMPANY ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of the signatories who have authority to sign on behalf of the company
- A letter of authority stating that the account can be used, including the details of the signatory and stating the membership details for which the bank account will be used. The letter must be dated, signed by an authorised person on behalf of the company, and it must contain the membership number
- A copy of the company's certificate of registration
- A copy of the main member's ID, Passport or Driver's Licence

TRUST ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the trustees of the account
- A copy of the Trust's certificate of registration
- A copy of the Trust resolution. The resolution must be dated, and signed by an authorised person on behalf of the Trust

11. For office use only

Membership commencement date Y Y Y Y M M D D

Group number (billing category)

Underwriting? Yes ☐ No ☐ Late joiner penalty Yes ☐ No ☐

Additional details or comments

12. Approval by the Scheme

This application form has been duly approved.

Name

Signature

Date Y Y Y Y M M D D