ENGEN | Medical Benefit Fund

Administered by Discovery Health

Contact details
Tel: 0800 001 615 • PO Box 652509, Benmore, 2010 • www.engenmed.co.za

Applying to become a member of Engen Medical Benefit Fund (with underwriting)

Thank you for applying to join Engen Medical Benefit Fund. This document is an application for membership form. It also contains the conditions of application. Please make sure you read and understand the Rules of Engen Medical Benefit Fund which can be found at www.engenmed.co.za

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is the Fund that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.

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

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the rules of membership (Section 9).
3. Please make sure the main applicant signs section 5, 8, and 9 as well as signs and dates any changes.
   Once completed, please fax the completed and signed form to 011 539 3000 or email it to **application@engenmed.co.za**
4. Please attach a copy of each applicant's (including your dependants) identity document to this application form. We also accept valid passports and birth certificates for children.
5. To follow up on this application, please call 0860 100 345 or email **newbusiness_queries@engenmed.co.za**

Once you submit your application form, here is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will send you or your employer a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made.
- You will then receive a welcome pack through the post.

If you do not hear from us seven days after sending your application form, please contact us on 0860 100 345 or your local HR office.

When you sign this application, you confirm that you have read and understood the conditions of application and Rules of Engen Medical Benefit Fund.

1. About yourself (main applicant)

Cover start date 2 0 Y Y M M D D

Title | Initials | Surname

First name/s

Preferred name | Sex | Date of birth Y Y Y Y M M D D

Previous or maiden name

Your current salary

Preferred method of communication: Email ☐ Post ☐ By choosing email, you will receive your communication quicker and there is less of an impact on the environment.

ID or passport number | Country of issue

Telephone (H) | (W)

Cellphone | Fax

Personal email

Postal address (post collected from post box, suite or private bag)

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb | Postal code

If your post is delivered to your street address, please complete these details under physical address.

Physical address

Suite or unit number | Complex name

Street number | Street name

Suburb | Postal code

Occupation | Tax number

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

Title | Initials | Surname

First name/s (as per identity document)

Preferred name | Sex | 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

Tax number

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

Dependant 1

Title | Initials | Surname

First name/s

Preferred name | Sex | Date of birth (Y Y Y Y M M D D)

Relationship to main member (for example, mother, child)

ID or passport number | Country of issue

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

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐ A full-time 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

Preferred name | Sex | Date of birth (Y Y Y Y M M D D)

Relationship to main member (for example, mother, child)

ID or passport number | Country of issue

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

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐ A full-time 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

Preferred name | Sex | Date of birth (Y Y Y Y M M D D)

Relationship to main member (for example, mother, child)

ID or passport number | Country of issue

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

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐ A full-time student? Yes ☐ No ☐

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

4. Your employer warranty (this section must be signed by the HR or payroll contact)

Name of employer | Employer or billing number

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

Branch name | Branch number

Monthly salary

The employer will reconfim the income stated above

Please make sure your employer completes this warranty. If this application form is sent without an employer warranty, we cannot process the application.

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. Engen Medical Benefit Fund may bill us for the amount due for this member in the same way as it does for our other employees who are members of Engen Medical Benefit Fund.

Authorised signature: Original hand signature required

Please do not sign an incomplete application form.

Employer stamp

Name/s

Designation

5. Your banking details

Please give us the details you would like to use for your claim refunds.

Please note: We cannot accept credit card account details. You may only use a South African bank account.

Bank name

Branch name | Branch code – – –

Account number

Type of account: Cheque ☐ Savings ☐

Account holder

By signing below, you agree that once claims have been refunded into the bank account you have chosen, Engen Medical Benefit Fund will not be responsible in any way for the amounts refunded, if these details are incorrect.

Signature of main applicant: Original hand signature required

Please do not sign an incomplete application form.

6. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you 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.

Main applicant

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

If all dependant/s were on the same medical schemes as completed above, please tick here to confirm this. ☐

If any of your dependant/s applying for cover belonged to different medical schemes, please complete them below:

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

7. Your health questions

Treating healthcare professional's name

Practice number

Telephone

Email

In the preceding 12 months, have you or **any dependant/s** in this application experienced, or received treatment for, or are you 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.

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 7.18 below.

7.1 Tumours and growths **Yes** ☐ **No** ☐

Example: abnormal pap smear results, skin lesions, 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.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.2 Heart and circulatory 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, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.3 Gynaecological and obstetrics conditions **Yes** ☐ **No** ☐

Example: abnormal Pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.4 Are you or any of your dependant/s pregnant? **Yes** ☐ **No** ☐

Patient name	

7.5 Mental health **Yes** ☐ **No** ☐

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

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7. Your health questions *(continued)*

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

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

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.7 Abdominal conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, stomach ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

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

Example: stroke, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, vetriculo-peritoneal shunt (VP shunt), mental retardation, CVA, bleeding on the brain.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

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

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

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

Example: arthritis (any form), ongoing neck and/or back pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, neurogenic bladder, gout, fractures, physical disability.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.11 Kidney or urinary conditions including current or past dialysis **Yes** ☐ **No** ☐

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, bladder infections, other bladder or kidney problems.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7. Your health questions *(continued)*

7.12 Blood conditions **Yes** ☐ **No** ☐

Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.13 Eye conditions **Yes** ☐ **No** ☐

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

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

Examples: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.15 Male urogenital conditions **Yes** ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.16 Are you or any of your dependant/s expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months? **Yes** ☐ **No** ☐

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7.17 Have you or any of your dependant/s 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	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

7. Your health questions *(continued)*

7.18 Have you or any of your dependant/s 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	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

HIV or AIDS

You do not need to disclose the HIV status of your dependant/s or yours on this form if you do not feel comfortable doing so. However, if you or one or more of your dependant/s are HIV positive, you or they must call us on **0800 001 615** within seven working days from the date we activate your Engen Medical Benefit Fund membership. We treat this information in the strictest confidence. A 12-month condition specific waiting period may apply to this condition if you do not let us know about your HIV status within 7 days of your membership being active.

8. Engen Medical Benefit Fund – Privacy Statement
How we will process and disclose your personal information and communicate with you

Definitions

The Fund refers to Engen Medical Benefit Fund, registration number 1572, registered with the Council for Medical Schemes.

Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed care organisation for the Fund and a subsidiary of the Discovery Group.

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 refers to the member and your registered dependants, who are members of the Fund.

Your personal information refers to personal information about you, your spouse, your dependants, your beneficiaries, and your employees (as relevant). It includes information about health, financial status, gender, age, contact numbers and addresses.

Process(ing) (of) information means any automated or manual activity of collecting, verifying, recording, organising, analysing, storing, updating, distributing and removing or deleting personal information.

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 Fund and Administrator, you trust us with personal information about yourself, your family, and in some cases, your employees. We are committed to protecting your right to privacy.

   The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in line with the Protection of Personal Information Act ("POPIA").
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. However, it is important to note that the Fund and Administrator require your acceptance of these terms and conditions, otherwise we cannot service your membership of the fund.
3. The Fund and Administrator will keep your personal information confidential. You may have given us this information yourself, or we may have collected it from other sources. If you share your personal information with any third parties, we will not be responsible for any loss suffered by you or your employer (where applicable).
4. You warrant that when you give the Fund and Administrator personal information about your dependants, you have received their permission to share their personal information with us for the purposes set out in this Privacy Statement and any other related purposes.
5. If you are an employer, you agree to indemnify the Fund and Administrator against any loss or damage, direct or indirect, that an employee suffers because of any unauthorised use of your employees' 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 their consent for them.
7. You agree that the Fund and Administrator may process your personal information for the following purposes:
   - for the administration of your Care Plan;
   - for the provision of managed care services to you on your Care Plan;
   - for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you on your Care Plan;
   - to analyse risks, trends and profiles;
   - to share your personal information with external health care providers for the purposes of evaluating certain clinical information, when you require medical treatment.

   Examples of this include:
   i. Getting your personal information from other relevant sources, including healthcare providers, contracted service providers, financial advisers, credit bureaus, 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;
   ii. If you have joined as a member of an employer group, getting information from, and sharing information with, your employer that is relevant to your application for membership with due regard for considerations of confidentiality in respect of your state of health;
   iii. Communicating with you about any changes in your Care Plan, including changes to your contributions or changes to the benefits you are entitled to on your Care Plan;
8. If a third party asks the Fund and Administrator for any of your personal information, we will share it with them only if:
   - you have already given your consent for the disclosure of this information to that third party; or
   - we have a legal or contractual duty to give the information to that third party, or
   - we need to share it with them for risk analytical or fraud detection, prevention or recovery purposes
9. The Fund and the Administrator may provide your personal information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship; or where you or your dependant/s have applied for a product, service or benefit from such entity. This information will be provided for the administration of your or your dependant/s products or benefits with other entities within the Discovery Group, and for fraud detection, prevention or recovery purposes.
10. The Fund and Administrator may share and combine all your personal information for any one or more of the following purposes:
    - market, statistical and academic research; and
    - to customise our benefits and services to meet your needs.

    Information about you may be shared with third parties such as academics and researchers, including those outside South Africa. We will ensure that all data about you that is shared with such third parties will be made anonymous to the extent possible and where appropriate. Note also that personal information will be made available to such third party only if that third party has agreed to abide by strict confidentiality protocols that we require. 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 will do so only with your permission.
11. By accepting this privacy statement, you authorise the Fund and Administrator to obtain and share information about your creditworthiness with any credit bureau or credit providers' industry association or industry body. This includes information about credit history, financial history, judgments, and default history. It also includes sharing of information for purposes of risk analysis, tracing and any related purposes.
12. The Fund and Administrator have the right to communicate with you electronically about any changes to your Care Plan, including changes to your contributions or changes to the benefits you are entitled to on your Care Plan.
13. The Fund and Administrator have a duty to keep you updated about any offers and new products that are made available from time to time. The Fund, Administrator, any entity within the Discovery Group, and contracted third-party service providers, may communicate with you about these.

8. Engen Medical Benefit Fund – Privacy Statement
How we will process and disclose your personal information and communicate with you (*continued*)

14. Please let the Administrator know if you do not wish to receive any direct telephonic marketing.
15. You have the right to know what personal information the Fund and Administrator holds about you. If you wish to receive this information please complete an 'Access Request Form', attached to the PAIA manual, on the Fund's website 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.
16. You agree that the Fund and Administrator may keep your personal information until you ask us to delete or destroy it. You have the right to ask us to update, correct or delete your personal information, unless the law requires us to keep it. Where we cannot delete your personal information, we will take all practical steps to de-personalise it.
17. Where the Fund 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
18. You agree that the Fund and Administrator may transfer your personal information outside South Africa:
    - If you give us an email address that is hosted outside South Africa; or
    - for processing, storage or academic research, or
    - to administer certain services, for example, cloud services.

    When we share your information with a person (or company) outside South Africa, we will require of, such person (or company) to treat your information in a manner that complies with the requirements of that country and at least with the same level of protection as we are obliged to do in South Africa. Unless you specifically give us consent to share your personal information with such person (or company).
19. If the Fund or Administrator becomes involved in a proposed or actual amalgamation or merger, acquisition or any form of sale of any assets, we have the right to share your personal information with third parties in connection with the transaction. In the case of such an event, the new entity will have access to your personal information. The terms of this Privacy Statement will continue to apply.
20. The Fund or Administrator may change this Privacy Statement at any time. The current version will be available on the Fund website.
21. If you believe that the Fund or Administrator have used your personal information contrary to this Privacy Statement, we encourage you to first follow our internal complaints process to resolve the complaint. We explain the complaints and disputes process on the website (www.engenmed.co.za). If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

    Contact details for the Information Regulator are:

    The Information Regulator (South Africa)
    SALU Building
    316 Thabo Sehume Street
    PRETORIA
    Ms Mmamoroke Mphelo
    Tel: 012 406 4818
    Fax: 086 500 3351
    inforeg@justice.gov.za

Signature of main applicant

Original hand signature required

Please do not sign an incomplete application form.

9. Engen Medical Benefit Fund rules for managing membership

Who "we" are

Engen Medical Benefit Fund, registration 1572, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for the Engen Medical Benefit Fund (the Fund), and an authorised financial services provider

Rules for membership

The rules of the Fund records your rights and responsibilities for your membership of the Fund. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the Rules and you agree that you and, those for whom you apply, will be bound by them.

Who you may apply for

You may apply to join the Fund on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Fund rules.

For anyone to be treated as financially dependent, you must have a responsibility to provide financially for that dependant. We might ask you to give us proof of financial or 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 administer the membership and to act for those on your membership in any matter relating to membership;
- you have received permission from your spouse and any dependant/s over 18 to act for them.

Giving and getting information

You must give true, correct and complete information

Information about you and those on your membership must be true, correct and complete. This includes the details given at during application stage in future dealings with us. It is important that you inform us of any medical condition, symptom or illness relating to you or those for whom you are applying, even if you do not consider it relevant to your application. We may ask for more information about those for whom you are applying if they are 18 years of age or older.

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 Fund and Administrator may record telephone calls

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

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

To consider your claim for medical expenses, you agree that we can get information about you and those on your membership 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 and in respect of any matter pertaining to or that arose during your membership of the Fund, is true, correct and complete. You give your permission that we may get any information that is relevant to this application from your employer.

Tell the Fund or Administrator immediately if your information changes

You or your employer must inform us in writing if any of the information provided. This includes information about your health and the health of those on your membership. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Fund may cancel your membership/s

The Fund may cancel any memberships immediately, if you and those on your membership:

- do not give us information that later turns out to be relevant to your membership;
- 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) when they occur.

About becoming a member

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

The Fund may have waiting periods that apply in certain circumstances. This means there may be a set time period during which the Fund will not pay for claims related to any general or specific medical conditions. The Fund and Administrator will let you know if this applies to you or any of those on your membership

Dual membership of medical schemes

It is illegal to be a member of more than one medical scheme at the same time. You and those on your membership must terminate any other cover held.

You must ensure contributions are paid on time

Contributions

As the main member of the Fund, 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. The Fund has the right to amend monthly contributions and benefits from time to time.

Repaying money owed to the Fund

The Fund has the right at any time to collect from you any amount that you owe to the Fund. We will notify you if there is any amount that you owe.

Any money you owe to the Fund may be deducted from any future claim payment amounts that are due to be paid to you and that your employer will contact you regarding possible salary deductions in respect of debt owed to the Fund.

Signature of main applicant | Original hand signature required

Date | 2 | 0 | Y | Y | M | M | D | D |

Please do not sign an incomplete application form.

This form must be signed only once it has been completed in full and the main applicant must sign and date any changes thereto.