

Contact details

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

Application to add dependants

Complete this form if you want to add dependants to your Engen Medical Benefit Fund membership

Who we are

Engen Medical Benefit Fund (referred to as 'the Fund'), registration number 1572, is the medical scheme that you are applying to become a member of. This is a not-for-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 terms and conditions for membership (section 8).
3. Sign the application form.
4. You, as the main member must sign and date any change made to this form.
5. Your HR department must email it to application@engenmed.co.za.
6. Please attach a copy of each dependant's identity document to this application form. We also accept valid passports and birth certificates for children.
7. 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 Scheme for statistical purposes only. You are not compelled to provide this information.

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 a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made.
- We will send you, the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
- We will send you a set of updated membership cards.
- You can also find the latest version of the card on the Discovery App.

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 terms and conditions (Section 8 of this form) of the Fund. You can find a copy of the Rules at www.engenmed.co.za.

1. About the main member

Membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
ID or passport number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Member's surname	<input type="text"/>											
Member's name	<input type="text"/>											
Physical address (If your post is delivered to your street address, please complete these details under physical address)												
Unit/Suite number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Complex name	<input type="text"/>						
Street number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Street name	<input type="text"/>						
Suburb	<input type="text"/>											
City	<input type="text"/>								Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal address (Post collected from post box, suite or private bag)												
<input type="checkbox"/> PO Box	<input type="checkbox"/> Private Bag	Box number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Suite	<input type="checkbox"/> PostNet Suite	Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Suburb	<input type="text"/>											
City	<input type="text"/>								Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please choose a date you want cover to start for all dependant/s you are applying for. This date must be the same for all your dependant/s applying for cover.

Cover start date

D	0	D	1	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

2. Adding a spouse or partner (if applying for cover)

Only complete this section if you are adding a spouse or partner.

Title	<input type="text"/>	Initials	<input type="text"/>									
Surname	<input type="text"/>											
First name(s) (as per identity document)	<input type="text"/>											
Previous or maiden name	<input type="text"/>											
ID or passport number	<input type="text"/>											
Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of birth <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	
D	D	M	M	Y	Y	Y	Y					
Race	African <input type="checkbox"/>	Coloured <input type="checkbox"/>	Indian / Asian <input type="checkbox"/>	White <input type="checkbox"/>	Other <input type="checkbox"/>	Do not want to disclose <input type="checkbox"/>						
<i>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.</i>												
Marital status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>								
Date of marriage to main applicant (where applicable). Please attach a copy of an official certificate				<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y					
Telephone (H)	<input type="text"/>	<input type="text"/>	Telephone (W)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
Cellphone	<input type="text"/>	<input type="text"/>										
Personal email	<input type="text"/>											

Addition of spouse to an existing membership

If addition of spouse or partner to an existing membership is:

- As a result of a legal and registered marriage within the last three months, an official certificate must accompany this application form to avoid underwriting.
- For a spouse married for a period of more than three months, full underwriting will apply.

3. Adding an adult dependant or child (applying for cover)

Complete this section with their details if you are adding a child or adult dependant.

Dependant 1

Title	<input type="text"/>	Initials	<input type="text"/>								
Surname	<input type="text"/>										
First name(s) (as per identity document)	<input type="text"/>										
ID or passport number	<input type="text"/>										
Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of birth <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Race	African <input type="checkbox"/>	Coloured <input type="checkbox"/>	Indian/Asian <input type="checkbox"/>	White <input type="checkbox"/>	Other <input type="checkbox"/>	Do not want to disclose <input type="checkbox"/>					
<i>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.</i>											
Relationship to main member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.)											
<input type="text"/>											
If over 18 years provide cellphone number	<input type="text"/>	<input type="text"/>									
Is your dependant: married?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	financially dependent on you? Yes <input type="checkbox"/>								
disabled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	a student? Yes <input type="checkbox"/>								
Does your dependant earn an income? Yes <input type="checkbox"/>	No <input type="checkbox"/>	How much does your dependant earn each month? R	<input type="text"/>								

Dependant 2

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		

ID or passport number

Gender M F Date of birth

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 main member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.)

If over 18 years provide cellphone number

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

Dependant 3

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth

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 main member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.)

If over 18 years provide cellphone number

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

Dependant 4

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M F Date of birth

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 main member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.)

If over 18 years provide cellphone number

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

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

Name of employer	<input type="text"/>	Employer or billing number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employee number	<input type="text"/>	Date of employment	D	D	M	M	Y	Y	Y
Branch name	<input type="text"/>	Branch number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Monthly Salary	R	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The employer will reconfirm 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 dependant(s) in the same way as it does for the main member registered on this membership of Engen Medical Benefit Fund.

Authorised signature	<input type="text"/>	Date	D	D	M	M	Y	Y	Y	Y
----------------------	----------------------	------	---	---	---	---	---	---	---	---

Please do not sign an incomplete application form

Name/s	<input type="text"/>
Designation	<input type="text"/>

5. Previous medical scheme details

Please give us the details of all registered South African medical schemes 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 <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

Information on symptoms, conditions or disorders (must be completed for the main applicant, spouse/partner and all dependant/s and must include information on conditions even if covered or not on previous memberships)

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customized information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Fund benefits, to improve Funds financial modeling, to assist the Fund to better assess and mitigate its risk (which includes whether to impose a waiting period on your membership) and any other relevant uses.

Please note that the Council for Medical Schemes has oversight over any irregular use of your or your dependant/s health information.

Please also note that the Medical Schemes Act restricts the ability of the Fund to impose waiting periods. A condition specific waiting period cannot be imposed on you or any of your dependant/s relating to any condition that you disclose in this application except if you or your dependant/s received or were recommended any medical advice, diagnosis, care or treatment in respect of such a condition within a 12-month period ending on the date on which this application is considered to be fully and properly made.

Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Fund requiring that you undergo a medical examination, at the Fund's cost. Should that medical examination reveal a current health condition, waiting periods may apply in respect of such current condition.

Below we require you to advise us about whether you or any dependant/s specified in this application at any time experienced, have been treated/investigated 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 take note that if you or any of your dependant/s have any disorder, symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or conditions in response to questions 6.1 – 6.18 below.

Please also note that you must tell us in writing if any of the information you gave, in this 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. Please take note further that any indication of existing medical conditions on this application does not automatically enrol you/your dependant/s onto the Fund's Disease Management programmes. For more information with regards to the Fund disease management enrollment visit www.engenmed.co.za.

Please answer ALL questions by ticking "Yes" or "No". If you answered 'Yes', please provide full details in the sections provided.

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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.3 Gynaecological and obstetrics conditions

Yes No

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.5 Mental healthYes No

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like 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 autoimmune conditions, any congenital conditions and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.6 Metabolic or endocrine conditionsYes 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.7. Abdominal conditionsYes No

Example: hepatitis, cirrhosis, portal hypertension, liver disease, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, ulcerative colitis, Crohn's disease, diverticulitis, constipation, any autoimmune conditions, any congenital conditions

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.8 Brain and nerve conditionsYes 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), 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.9 Breathing and respiratory conditionsYes No

Example: asthma, ventilator, oxygen therapy, CPAP, 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

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, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.11 Kidney or urinary conditions including current or past dialysisYes No

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.12 Blood conditionsYes 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.13 Eye conditionsYes No

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, keratoconus (cross linkage), 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.14 Ear, nose and throat (ENT) and dentistry conditionsYes 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.15 Male urogenital conditionsYes No

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), undescended testes, phimosis, urinary incontinence, retention, infertility, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.17 Have any of your dependant/s received medical advice or treatment for symptoms not 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

6.18 Have you or any of your dependants 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 within the last 12 months	Medication used for this condition and dosage	Date of last treatment within the last 12 months

HIV and AIDS

If you, or one or more of your dependants, 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. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme. Engen Medical Benefit Fund may have waiting periods that apply in certain circumstances. This means there may be a set time period before Engen Medical Benefit Fund 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 dependants HIV status within 7 days of your membership being active, we may end your Engen Medical Benefit Fund membership.

7. Privacy Statement 2026

When you engage with Engen Medical Benefit Fund, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, children, and other dependants, collectively "your dependants", where applicable. To view and read our Privacy Statement, please follow this link: <https://www.engenmed.co.za/assets/medical-schemes/engen/legal/privacy-statement-and-rules.pdf>.

8. Engen Medical Benefit Fund Rules for managing membership

Rules for membership

The Rules of the Fund record your rights and responsibilities for your membership. 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 terms and conditions and you agree that you and, those for whom you apply, will be bound by these terms and conditions and the Fund Rules.

Who you may apply for

You may apply for your immediate dependants to be added to your membership – your spouse, your partner, your children and dependants 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 and care for that dependant. We might ask you to give us proof of their dependency.

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 act on behalf of the persons you are applying to register on your membership, and in any matter relating to their 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 during the application stage and in future dealings with us. It is important that you inform us of any medical condition, symptom or illness relating to those for whom you are applying, even if you do not consider it relevant to the application. We may ask for more information about those for whom you are applying, if they are 21 years of age or older.

Your legal address

We will send documents to you at your preferred. If it is necessary to send you any legal notices or summonses, our legal team will serve those 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 the 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 the 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 for your membership from your employer.

Tell the Fund or the Administrator immediately if your information changes

You or your employer must inform us in writing of any changes to the information provided. This includes information about the health of the persons you are applying for. We also 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 your membership, or the membership of any of your dependants, 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 the health of those you are applying for) when they occur.

Contributions

As the main member of the Fund, you are responsible for ensuring that your contributions and the contributions for your dependants 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.

You must ensure contributions are paid on time.

Your dependants may not have immediate access to benefits

The Fund might not pay for certain expenses immediately after we have activated the membership(s) of those persons you are applying for. Waiting periods may 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 in any way to the persons you are applying for in this application.

Dual membership of medical schemes

It is illegal to be a member of more than one medical scheme at the same time. Any person you are applying for must terminate any other cover held.

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 to the Fund.

Any money you owe to the Fund may be deducted from any future refund amounts that are due to be paid to you.

I declare to have read and understood the terms and conditions above.

Signature of new main member

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

I confirm the information is accurate and complete.