

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 Fund 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, child)

If over 18 years provide cellphone number

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) (as per identity document)

ID or passport number

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

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

If over 18 years provide cellphone number

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	<input type="text"/>	Employer or billing number	<input type="text"/>
Employee number	<input type="text"/>	Date of employment	<input type="text"/>
Branch name	<input type="text"/>	Branch number	<input type="text"/>
Monthly Salary	R <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	<input type="text"/>
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Please do not sign an incomplete application form

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

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	<input type="text"/>		
Branch name	<input type="text"/>	Branch code	<input type="text"/> - <input type="text"/> - <input type="text"/>
Account number	<input type="text"/>	Type of account	Cheque/Transmission/Transaction <input type="checkbox"/> Savings <input type="checkbox"/>
Account holder	<input type="text"/>		

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

If third party 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 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 and authorise Engen Medical Benefit Fund to contact the account holder provided above to verify payments made or received, if necessary.

Signature of main applicant	<input type="text"/>
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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	Are you still a member	End date if you have already registered	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"/>		

If all dependants were on the same medical scheme as completed above, please tick here to confirm this

If any of your dependants applying for cover belonged to different medical schemes, please provide the relevant information:

Dependant name	Scheme name	Start date	Are you still a member	End date if you have already registered	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"/>		

7. Your 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 7.1 – 7.18 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 enroll you/your dependant/s onto the Fund's Disease Management programmes. Disease. 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.

7.1 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, 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	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

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, 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	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

7.3 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.

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

7.4 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	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

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, post traumatic stress disorders, counselling, bulimia 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	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

7.6 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.

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

7.7 Abdominal conditionsYes No

Example: hepatitis, cirrhosis, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, portal hypertension, alcoholic 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).

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

7.8 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.

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

7.9 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.

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

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

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis, and internal insertion of surgical implants, amputation.

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

7.11 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 the bladder), bladder infections, other bladder or kidney problems.

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

7.12 Blood conditionsYes No

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

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

7.13 Eye conditionsYes No

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment.

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

7.14 Ear, nose and throat (ENT) and dentistry conditionsYes No

Examples: 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.

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

7.15 Male urogenital conditionsYes No

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

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

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

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

7.18 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken 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 HIV Care 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.

8. Privacy Statement

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>

9. Engen Medical Benefit Fund terms and conditions for managing your membership

Terms and conditions for membership

These terms and conditions record your rights and responsibilities for your membership of the Fund. They may change from time to time. You may ask us for the latest 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 registered on your membership will be bound by these terms and conditions. Where applicable, you also acknowledge and confirm that your employer may communicate with us about this application and your membership of the Fund.

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 dependants who are financially dependent on you as defined in these terms and conditions.

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 your financial responsibility. You may be called the principal 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 act for those the persons currently registered on the membership 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 at application stage and 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 21 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 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 Discovery Health (Pty) Ltd 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 Discovery Health (Pty) Ltd 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 to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers). 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 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 changes. 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 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 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.

About becoming a member

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

Certain 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 condition-specific waiting periods. 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 before we activate your membership of the Fund.

Repaying money owed to the Fund

We have 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 claim payment amounts that are due to be paid to you. If you are an Engen employee and in active employment, your Employer will contact you regarding salary deductions in respect of debt owed to the Fund.

Signature of new main member

Date

Please do not sign an incomplete application form.

Signature of current main member, if applicable

Date

**Please do not sign an incomplete application form.
I confirm the information is accurate and complete.**

10. Third Party Bank Details - Annexure A

Banking details for a third party

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds.

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (accountholder) ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
 - State that the account can be used
 - State the membership details (including the membership or policy numbers) for which the bank account will be used
 - Include the details of the signatory
 - Be dated and signed by an authorised person on behalf of the company
- A copy of the company's certificate of registration.
- A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
 - Show the trustees
 - Be dated and signed by an authorised person on behalf of the trust
 - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.