ENGEN Medical Benefit Fund

Administered by Discovery Health

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

Application to add dependants 2022

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 Fund 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. The main member must sign and date any change made to this form.
5. Your HR department must fax the completed and signed form to 011 539 3000, or 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 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.
- We will send you or your employer, 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 Engen Medical Benefit Fund. You can find a copy of the Rules at www.engenmed.co.za

1. About the main member

Membership number

Surname

First name/s

ID or passport Number | Country of issue

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 D 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 | Initials | Surname

First name(s) (as per identity document)

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

EMBAAD001

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

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

Previous or maiden name

ID or passport number Country of Issue

Telephone (H) (W)

Cellphone Fax

Email address

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 Initials Surname

First names

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

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

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.)

ID or passport Number Country of issue

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 2

Title Initials Surname

First names

Preferred name Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

Date of birth D D M M Y Y Y

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.)

ID or passport Number | Country of issue

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 names

Preferred name | Gender M F

Race African Coloured Indian/Asian White Other

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

Do not want to disclose

Date of birth D D M M Y Y Y Y

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.)

ID or passport Number | Country of issue

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 names

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

Race African Coloured Indian/Asian White Other

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

Do not want disclose

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.)

ID or passport Number | Country of issue

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

Employer or billing number

Employee number

Date of employment D D M M Y Y Y Y

Branch name

Branch number

Monthly Salary **R** .

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

Authorised signature

Please do not sign an incomplete application form

Name/s

Designation

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
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	
		D D M M Y Y Y Y	D D M M Y Y Y Y	Yes No	

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

In the preceding 12 months, have any of your dependant/s in this application experienced, or received treatment for, or are they currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

Please take note that if you have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 6.18 below. Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Fund's Disease Management programmes. For more information about enrollment on these Programmes, visit www.engenmed.co.za

6.1 Tumours, growths and disorders of the skin

Yes ☐ **No** ☐

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

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

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.

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

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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

6.4 Are you or any of your dependants pregnant or undergoing treatment/investigation for pregnancy?

Yes ☐ **No** ☐

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

6.5 Mental health Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like narcolepsy), eating disorders, Alzheimer's disease, 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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

6.6 Metabolic or endocrine conditions Yes ☐ No ☐

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

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

6.7. Abdominal conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, 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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

6.8 Brain and nerve conditions Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt), 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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

6.9 Breathing and respiratory conditions Yes ☐ No ☐

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

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

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

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

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

6.11 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, neurogenic bladder, bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

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

6.12 Blood conditions **Yes** ☐ **No** ☐

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

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

6.13 Eye conditions **Yes** ☐ **No** ☐

Example: cataract, 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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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

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

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

6.15 Male urogenital conditions Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, 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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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	Medication used for this condition and dosage	Date of last treatment
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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

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

HIV and 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 and any related conditions if you do not let us know about your HIV status within 7 days of your membership being active.

7. 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 (EMBF), 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 on your membership.

Your personal information refers to all personal information the Scheme or the Administrator has on you, or data subjects which are related to you or under your authority ("other data subjects") (as relevant). It includes:

- financial information;
- information about your health, race or ethnic origin, biometrics, criminal behaviour or religion;
- your gender;
- your age;
- unique identifiers such as your identity number or 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.
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 the Fund and Administrator require your acceptance of these terms and conditions, otherwise we cannot activate and service your medical Fund membership.
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 understand that when you include your spouse and/or dependents on your application, we will process their personal information for the activation of their membership and to pursue their legitimate interest. We will furthermore process their information for the purposes set out in this Privacy Statement.
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 unauthorized 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 benefit option;
   - for the provision of managed care services to you on your benefit option;
   - for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you on your benefit option;
   - to analyse risks, trends and profiles;
   - to share your personal information with external healthcare providers for the purposes of evaluating certain clinical information, in the event that you require medical treatment.

   Examples of this include:

   7.1. Sharing your personal information with your chosen financial adviser during the membership application process to enable the Administrator to process your membership application;

   7.2. Obtaining and sharing your personal information with other relevant sources, including medical practitioners, contracted service providers, health information exchanges, 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;

   7.3. 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;

   7.4. Communicating with you about any changes to your benefit option, including changes to your contributions or the benefits you are entitled to on the benefit option you have chosen.
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. You consent and agree that:
   - we may process your information, including personal information, to adhere to South African Legislative reporting obligations and to perform transaction monitoring activities;
   - we may communicate such personal information to local Regulatory Bodies as well as to other entities in the Discovery Group if any Legislative reportable matters are identified.
10. 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
11. 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.

12. Information about you may be shared with third parties such as academics and researchers, including those outside South Africa. We 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.
13. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always try to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources.
14. 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.
15. The Fund and Administrator have the right to communicate with you electronically about any changes to your benefit option, including changes to your contributions or changes to the benefits you are entitled to on the benefit option you have chosen.
16. We may process your information using automated means (without human intervention in the decision making process) to make a decision about you or your application for any product or service. You may query the decision made about you.
17. 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 Scheme, Administrator, any entity within the Discovery Group, and contracted third-party service providers, may communicate with you about these.
    Please let the Administrator know if you do not wish to receive any direct telephonic marketing.
18. You have the right to know what personal information the Fundand Administrator holds about you. If you wish to receive this information please complete an 'Access Request Form', attached to the PAIA manual, on www.lahealth.co.za, and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information.
    We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
19. You also confirm that we may share, both within the Discovery Group and with our service providers, and combine all your personal information, including your unique identifiers, for any one or more of the following purposes directly or through a third party:
    19.1. Market, statistical and academic research, including cross-company analytics;
    19.2. To customise and enhance our benefits and services to meet your needs; and
    19.3. To market our services to you.
20. You may opt out of Electronic Marketing by:
    20.1. Logging into your profile on www.discovery.co.za or the Discovery App;
    20.2. Following the unsubscribe prompts on the electronic marketing communication received;
    20.3. By informing your appointed financial adviser.
21. We will store your personal information for the purpose of processing this request and action it as soon as reasonably possible.
22. 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.
23. 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
24. 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).
25. 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.
26. The Fund or Administrator may change this Privacy Statement at any time. The current version is available on www.engenmed.co.za.
27. If you believe that the Fund or Administrator have used your personal information contrary to this Privacy Statement, we encourage you to first follow the Fund or Administrator's internal complaints process to resolve the complaint. We explain the complaints and disputes process on the website at 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:
The Information Regulator (South Africa)
JD House |27 Stiemens Street | Braamfontein |Johannesburg
PO Box 31533 |Braamfontein |Johannesburg |2001
PAIAComplaints@inforegulator.org.za and POPIAComplaints@inforegulator.org.za

8. Engen Medical Benefit Fund rules for managing membership

Rules for membership

The rules of Fund record 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 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 to join the Fund for your dependants to be added to your membership – your spouse, your partner 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 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 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 from 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 changes. This includes information about the health of the persons you are applying for in this application. 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

Fund may cancel your memberships 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.

About becoming a member

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 to 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 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 claim payment amounts that are due to be paid to you. Your employer assists the Fund and will contact you regarding possible salary deductions in respect of debt owed to the Fund.

I declare to have read and understood the terms and conditions above. Please do not sign an incomplete member form.

Signature of new main member

Date D D M M Y Y Y Y

I confirm the information is accurate and complete.