ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

Contact details
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Applying to become a member of the Anglovaal Group Medical Scheme in 2022 (with underwriting)

This application should be completed by employees who join the Scheme after 90 days of their employment date. All medical questions must be completed as the application will be underwritten.

Thank you for applying to join the Anglovaal Group Medical Scheme. This document is an application form for membership. It also contains some terms and conditions for membership. Please make sure you read and understand the terms.

Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

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 (section 10).
3. Sign sections 6, 9 and 10.
4. Please make sure the main applicant signs and dates any changes.
5. Once completed, email the completed and signed form to **application@discovery.co.za or fax it to 011 539 3000.**
6. Please attach a copy of each applicant'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 send us 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 activate your membership and send you or your employer a letter of confirmation when we are offering standard terms of acceptance (no waiting periods or late-joiner penalties). For any non-standard terms, we will issue a counter-offer letter which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). You may accept the offer by signing and returning this letter for us to activate your membership.
- 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 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. This date may differ from the date on which you sign the application form.
- 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).
- You will then get a pack in the post.

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

When you sign this application, you confirm that you have read and understood the terms and conditions (Section 10 of this form) and agree to them.

1. About yourself (main applicant)

When do you want your cover to start? D D M M Y Y Y Y

Title | Initials | Surname

First name/s (as per identity document)

Preferred name | Gender M F

AGMABM002

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

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

Occupation Tax number

ID or passport number Country of issue

Telephone (H) Work

Cellphone Fax

Email address

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

Suite Postnet Suite Number

PO Box Private bag Box number

Suburb Postal code

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

Physical address:

Suite or unit number Complex name

Street number Street name

Suburb Postal code

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

Title Initials Surname

First name(s)
(as per ID document)

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

Marital status Married Single Divorced Widowed

ID or passport number

Country of issue

Telephone (H) (W)

Cellphone Fax

Email

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

Partnership declaration

If you are not legally married and you cannot give us a marriage certificate, you have to complete the following section in full.
We declare we are in a long-term, committed relationship that is like a marriage and that we live together at the same residence. We understand that by signing this declaration, we agree to tell the Scheme about any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that if the information we give about our relationship or residency is false in any way, the Scheme reserves the right to end both our memberships. If both parties have not signed and dated the below section, we will halt the application process until we receive the section signed and dated by both parties.

How long have you and your partner been in a relationship that is like a marriage? D D M M Y Y Y Y

Signature of main applicant

Date D D M M Y Y Y Y

Signature of partner

Date D D M M Y Y Y Y

3. About your dependants (only complete if applying for cover)

Dependant 1

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, child)

ID or passport number | Country of issue

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

Married? Yes No | Financially dependent on you? Yes No

Disabled? Yes No | A full-time student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

Dependant 2

Title | Initials | Surname

First 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, child)

ID or passport number | Country of issue

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

Married? Yes No | Financially dependent on you? Yes No

Disabled? Yes No | A full-time student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

Dependant 3

Title | Initials | Surname

First 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, child)

ID or passport number | Country of issue

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

Married? Yes No | Financially dependent on you? Yes No

Disabled? Yes No | A full-time student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

4. Please choose your income band

Please mark which monthly salary band will apply to you

Below R4 600

R4601 - R9100

R9101 - R13 600

R13 601 - R18 100

R18101+

5. Your employment details

If your employer is paying your full contribution or a part of it and we need to debit their account, please complete this section:

Name of employer | Employer or billing number

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

1. Employer contact person | 2. Employer contact person

Telephone | Telephone

Email | Email

Branch name | Branch number

Department name | Department number

Please make sure your employer completes this warranty:

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.

The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised Signature

Name/s

Designation

AGMABM002

6. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you previously belonged to. Please give us proof in the form of a membership certificate.

Main applicant

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
		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 ☐	

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

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

Dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
		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 ☐	

7. Your banking details

7.1 Your contributions

Should you be paying your contributions in full or in part, please complete this section:

Please note: we cannot accept credit card account details

Bank name

Branch name   Branch code

Account number

Type of account ☐ Cheque ☐ Savings

Accountholder

Account holder contact

Account holder email address

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

ID Number

Signature of accountholder

Original hand signature required

7.2 Your claims refund

May we use the same account from which contributions are deducted in order to refund your claims? Yes ☐ No ☐

If you do not wish to use the same banking details for your contributions and claims refunds, please provide us with the details you wish to use:

Please note: we cannot accept credit card account details

Bank name

Branch name | Branch code

Account number

Type of account ☐ Cheque ☐ Savings

Accountholder

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

ID Number

By signing this application, you agree that once claims have been refunded into the selected bank account, Anglovaal Group Medical Scheme will not be responsible in any way for the amounts refunded.

8. Your health questions

Have you or **any dependant/s** in this application **ever** experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

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 Scheme benefits, to improve Scheme's financial modeling,to assist the Scheme to better assess and mitigate its risk and other beneficial uses. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a within a 12-month period ending on the date on which this application is considered to be fully and properly made.

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 9.18 below. Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit www.avgms.co.za.

8.1 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, or other skin conditions, abscess, any autoimmune conditions, any congenital conditions.

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

8.2 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	Medicine used for this condition and dosage	Date of last treatment taken
		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

8.3 Gynaecological and Obstetric conditions8.3 Gynaecological and Obstetric conditions **Yes** **No**

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

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

8.4 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	Medicine used for this condition and dosage	Date of last treatment taken
		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

8.5 Mental health8.5 Mental health **Yes** **No**

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

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

8.6 Metabolic or endocrine conditions **Yes** **No**

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

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

8.7. Abdominal conditions

Yes ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, Crohn's disease ulcerative colitis, diverticulitis, Irritable Bowel Syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ongoing abdominal pain, ascites (fluid in the abdomen), any autoimmune conditions, any congenital conditions.

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

8.8 Brain and nerve conditions

Yes ☐ **No** ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt used to drain fluid from the brain), Intellectual disability, CVA, bleeding on the brain, any autoimmune conditions, any congenital conditions, down's syndrome.

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

8.9 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	Medicine used for this condition and dosage	Date of last treatment taken
		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

8.10 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, injury, physical disability, any autoimmune conditions, any congenital conditions.

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

8.11 Kidney or urinary conditions including current or past dialysis

Yes ☐ **No** ☐

Example: kidney failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

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

8.12 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	Medicine used for this condition and dosage	Date of last treatment taken
		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

8.13 Eye conditions

Yes ☐ **No** ☐

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

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

8.14 Ear, nose and throat (ENT) and dentistry conditions

Yes ☐ **No** ☐

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

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

8.15 Male urogenital conditions **Yes** **No**

Example: prostate disorders, urogenital defects, varicocele, undescended testes, phimosis, urinary incontinence, infertility any autoimmune conditions, any congenital conditions.

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

8.16 Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months? **Yes** **No**

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

8.17 Have any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical professional, in the last 12 months before this application? **Yes** **No**

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

8.18 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	Medical diagnosis	Date first diagnosed/ symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		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 your HIV status nor that of your dependant/s on this form if you do not feel comfortable doing so. However, should you, or one or more of your dependants, be HIV positive, you or they must call us on 0800 226 5633 within seven working days from the date that your Anglovaal Group Medical Scheme membership is activated. We treat this information in the strictest confidence. If you, or one or more of your dependants, are HIV positive, it is in your/their interest to register on our HIVCare Programme. A 12-month condition-specific waiting period may however apply. When you call in to register on the HIVCare Programme, kindly confirm these details.

9. Anglovaal Group Medical Scheme – Privacy Statement

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

Definitions
The Scheme refers to the Anglovaal Group Medical Scheme, registration number 1571, 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 Scheme and a subsidiary of the Discovery Limited (registration number 1999/007789/06).

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.

Process(ing) (of) information means the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information.
We or our or us refers to the Scheme.

You or your refer to the member and your registered dependants on your medical scheme plan.
Your personal information refers to all personal information the Scheme or the Administrator has processed relating to you or persons who are related to you or under your authority (as may become relevant depending on the context). Your personal information includes:

- financial information;
- information about your health, race or ethnic origin, biometrics;
- your gender or sex;
- your age;
- unique identifiers such as your identity number or contact numbers; and
- addresses.

1. When you engage with the Scheme and Administrator, you trust us with personal information about yourself, your family, and your dependants. We are committed to protecting your right to privacy.
2. The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in a manner that is compliant, ethical, and adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time.
3. We have a duty to take all reasonably practicable steps to ensure that your personal information as processed by us is complete, accurate, not misleading, and updated on a regular basis. To enable this, we will always endeavour to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources, such as your employer.
4. You have the right to object to the processing of your personal information and have a choice whether or not to accept these terms and conditions. However, it is important to note that the Scheme and Administrator require your acceptance of these terms and conditions and consent to process your personal information for purposes of your medical scheme membership, otherwise we cannot activate and service your medical scheme membership.
5. The Scheme 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).
6. You understand that when you include your spouse and/or dependants on your application, we will process their personal information for the activation of their benefits and to pursue their legitimate interests. By submitting your dependants' personal information, you confirm that you are duly authorised to share such information with us. We will process their information for the purposes set out in this Privacy Statement.
7. Each party accepts responsibility to the extent that the processing activities of personal information fall under the control of that party and agrees to indemnify the other party/ies against any loss or damage, direct or indirect, that a member may suffer because of any unauthorised use of the member's personal information or if a breach of the member's personal information should occur, but only if the processing of that personal information is controlled by that party.
8. 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.
9. You agree that the Scheme and Administrator may process your personal information for, inter alia, the following purposes:
   9.1. the processing and activation of your application for membership and for the administration of your health plan;
   9.2. the provision of managed care services to you on your health plan;
   9.3. the provision of relevant information to a contracted third party who requires this information in order to provide a healthcare service to you on your health plan;
   9.4. to analyse risks, trends and profiles;
   9.5. to share your personal information with external health providers for the purposes of evaluating certain clinical information, in the event that you require medical treatment;
   9.6. to share your information with relevant regulatory bodies as required by operation of law.
   Examples of this include:
      9.6.1. Obtaining and sharing your personal information from and with other relevant sources, including medical practitioners and contracted service providers; health information exchanges; 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 on-going basis) verify with the relevant sources that your personal information is true, correct and complete;
      9.6.2. 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 to considerations of confidentiality in respect of your state of health;
      9.6.3. Communicating with you about any changes in your health plan, including changes to your contributions or changes to the benefits you are entitled to on your health plan.
10. If a third party asks the Scheme and Administrator for any of your personal information, we will share it with them only if:

10.1. you have already given your consent for the disclosure of this information to that third party; or
10.2. we have a legal or contractual duty to give the information to that third party; or
10.3. we need to share it with them for risk analytical or fraud detection, prevention or recovery purposes; or
10.4. the information is de-identified to such an extent that it cannot be re-identified again.

11. 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 if any legislative reportable matters are identified.
12. The Scheme and the Administrator may provide your personal information to any other entity within the Discovery Ltd 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, in both cases only where you have given your consent to such other entity to obtain information from the Scheme or the Administrator. This information will be provided for the administration of your or your dependant/s products or benefits with other entities within Discovery Ltd, and for fraud detection, prevention or recovery purposes.
13. You may opt out of direct Electronic Marketing by:
    13.1. Logging into your profile on www.discovery.co.za or the Discovery App; and
    13.2. Following the unsubscribe prompts on the electronic marketing communication received.
    We will store your personal information for the purpose of actioning this request and action it as soon as reasonably possible.
14. The Scheme and Administrator may share and combine your personal information for any one or more of the following purposes:
    - market, statistical, and academic research; and
    - to customise our benefits and services to meet your needs.
    Information about you may be shared with third parties such as academics and researchers, including those outside South Africa. We 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.
15. By accepting this privacy statement, you authorise the Scheme and Administrator to obtain and share information for purposes of risk analysis, tracing, and any related purposes.
16. The Scheme and Administrator have the right to communicate with you electronically about any changes to your health plan, including changes to your contributions or changes to the benefits to which you are entitled on your health plan.
17. 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.
18. The Scheme and Administrator have a duty to keep you updated about any matters relevant to you from time to time. The Scheme and Administrator may communicate with you about these.
19. You have the right to know what personal information the Scheme and Administrator holds about you. If you wish to receive this information please complete an 'Access Request Form', attached to the PAIA manual, on www.avgms.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.
20. You agree that the Scheme and Administrator may keep your personal information until you ask us to delete or destroy it, subject to our lega right to retain it. You have the right to ask us to update, correct or delete your personal information, unless the law requires us to keep it for th pursuit of our legitimate business purpose. Where we cannot delete your personal information, we will take all practical steps to de-identify it.
21. If you wish to ask us to update, correct or delete your personal information please complete the Request for Deletion or Correction of Informat Form available at https://www.discovery.co.za/corporate/privacy /.
22. Where the Scheme and Administrator are required by law to collect and keep personal information, we shall do so. We are required to collec 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
23. You agree that the Scheme 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 you information in a manner that complies with the data protection requirements of that country and at least with the same level of protection a we are obliged to do in South Africa. If the Scheme 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.
24. The Scheme or Administrator may change this Privacy Statement at any time. The most updated version will always be available on www.avgms.co.za.
25. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator. However, we encourage you to first follow our internal complaints process to resolve the complaint or contact the Information Officer at privacy@discovery.co.za. If, thereafter, you feel that we have not resolved your complaint adequately kindly contact the Information Regulator at: JD House |27 Stiemens Street | Braamfontein |Johannesburg |PO Box 31533

Signature of main applicant

Please do not sign an incomplete application form

10. Anglovaal Group Medical Scheme Terms and Conditions

10.1. Who "we" are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, registered with the Council of Medical Schemes, Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organization for The Anglovaal Group Medical Scheme , and an authorised financial services provider.

10.2. Rules for membership

Rules for membership are the rights and responsibilities for your membership of the Anglovaal Group Medical Scheme. They may change from time to time. You may ask us for a copy at any time. When you sign this application, you confirm that you have read and understood the rules and you agree that you and those you apply for membership for will be bound by them. Please speak to us if there is anything you do not understand. Where applicable, you also acknowledge and confirm that your employer contact person may communicate with us on this application and your membership of the Anglovaal Group Medical Scheme. You give permission that we can share your medical information and other relevant personal information about you and your dependants with your employer contact. The information will be shared so that he or she can help us, if necessary, while we process your membership application. Please speak to us if there is anything you do not understand.

10.3. Who you are applying for

You may apply to join the Anglovaal Group Medical Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you. To be treated as financially dependent for this application, a dependant must earn an income of less than what is stated in the Anglovaal Group Medical Scheme rules, or you must have a legal responsibility to provide for them financially.

We might ask you to provide proof of financial responsibility. You will be called the principal member or main member in our future communications to you.

10.4. Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

10.4.1. You have the right to apply for membership and to act for those you apply for in any matter relating to this application.

10.4.2. You have received permission from your spouse and any dependants over 18 to act for them in any matter relating to this application.

10.5. Getting and giving information

You must give true, correct and complete information

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

Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd may record calls

We may record telephone conversations with you and with those you apply for.

The recordings and all information we get during the recordings will be processed and kept as required by law.

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.

Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd may get information from other relevant sources

To consider an application for membership or a claim for medical expenses, you agree that we can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to that arose during your membership of the Anglovaal Group Medical Scheme, is true, correct and complete. You give your permission that we may get any information that is relevant to your application and for ongoing servicing of your membership from your employer.

Tell Discovery Health (Pty) Ltd and Anglovaal Group Medical Scheme about changes right away

You have to tell us in writing if any of the information you gave in your application for membership changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Anglovaal Group Medical Scheme may cancel your membership

The Anglovaal Group Medical Scheme may cancel any memberships immediately and keep any contributions paid, if you and those you apply for:

10.5.1. Do not give us information that later turns out to be relevant to this application.

10.5.2. Give us any information that is not true, correct and complete.

10.5.3. Do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

10.6. About becoming a member

Anglovaal Group Medical Scheme might not pay for certain expenses immediately The Anglovaal Group Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Anglovaal Group Medical Scheme starts paying for any general or specific medical conditions. Please speak to us to find out if waiting periods apply to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must make sure contributions are paid on time

As the main member of the Anglovaal Group Medical Scheme, you are responsible for making sure your contributions and the contributions of those you apply for are paid on time every month.

10.7. Repaying money owed to the Scheme

Anglovaal Group Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you if there is any amount that you owe to the Scheme.

You must repay any medical savings owing if you leave the Anglovaal Group Medical Scheme

When you become a member, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the Medical Savings Account. If you leave the Anglovaal Group Medical Scheme before the year is up, you must repay the portion of the Medical Savings Account you have used that is more than you have paid back to the Anglovaal Group Medical Scheme over the year. By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.

Signature of main applicant

Date D D M M Y Y Y Y

The main applicant must sign and date any changes.
Please do not sign an incomplete application form
I confirm the information is accurate and complete

Signature of previous main member*

*If previous main member's signature cannot be obtained, please state reason.

11. Debit order mandate

This signed authority and mandate refers to the application on the signed date (''the Agreement'')

I, the undersigned:

- warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct;
- authorise Anglovaal Group Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Anglovaal Group Medical Scheme from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application on condition that the sum of such payment instructions will never exceed my obligations as framed in the which shall commence on the date that cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Anglovaal Group Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this Authority and Mandate.
- confirm that that the payment instructions mentioned above must be issued on the first working day of the month. If the membership is not activated in time for the debit order collection and there is an amount outstanding Anglovaal Group Medical Scheme can collect that amount in the interim, upon activation. If I change the date of the debit order after activation, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
- authorise Anglovaal Group Medical Scheme to track my bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my bank account to meet my obligations under or in terms of this Agreement
- acknowledge that my bank will treat each payment instruction to pay premiums or amounts due under this Agreement to Anglovaal Group Medical Scheme as if each payment instruction came from me personally as the account holder.
- undertake to advise Anglovaal Group Medical Scheme in writing of any changes to my account details and acknowledge that Anglovaal Group Medical Scheme will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify Anglovaal Group Medical Scheme of a change in banking details or if the bank account has insufficient funds to meet my obligations under or in terms of the Agreement. and understand that the withdrawals hereby authorized will be processed through a computerized system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and
- know must show the reference number of the membership inserted in the Agreement so as to enable me to identify this membership;
- acknowledge that although this Authority and Mandate may be terminated by me, such termination does not necessarily terminate this Agreement . In the event of such termination I am not entitled to any refund of any premiums or amounts due that was withdrawn by Anglovaal Group Medical Scheme whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Anglovaal Group Medical Scheme in terms of the Agreement
- acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.

- Acknowledgment that this Authority may be assigned to a third party if this agreement is also assigned to a third party. Reference **number**

  This Agreement reference number: System generated reference number

  Abbreviated name

  Abbreviated name: DISC PREM

  Deduction amount – as per signed contract

  Payment start date – as per signed contract

Reference number

This Agreement reference number is ANGLO CONT/ANGLOCLAWB

Signature of main applicant

On D D M M Y Y Y Y

Please sign this section, if the scheme is collecting contributions from your bank account.

AGMABM002

12. Third party Bank details

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

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

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

JOINT ACCOUNT

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

COMPANY ACCOUNT

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

TRUST ACCOUNT

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

If you are completing the request on behalf of the main member, please include proof that you have obtained the necessary authority (example, Letter of Authority or Letter of Executorship)