TFG MEDICAL AID SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

Application to add dependants in 2019 (with underwriting)

Complete this form if you want to add dependants to your TFG Medical Aid Scheme membership.

For TFG office use

Employee number	
Cost centre code	
Branch code	

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, 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 'we' 'us' and 'our' or 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 rules for membership (section 9).
3. Sign this application form.
4. Please make sure the main member signs and dates any changes.
5. Please return the completed and signed form to the Payroll Department, TFG Head Office, Parow.
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.

Once you send TFG Medical Aid Scheme and Discovery Health (Pty) Ltd your application, here is what will happen:

- Discovery Health (Pty) Ltd will capture and check your details.
- If any details are missing, or if we need more information for underwriting purposes, Discovery Health (Pty) Ltd will contact you.
- Discovery Health (Pty) Ltd will send you a letter, SMS or an email to let you know when the application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- After accepting your dependants' application to join the TFG Medical Aid Scheme, we will send you an SMS and an email letter confirming acceptance. The SMS and email will advise you of when your dependants' membership will start. Depending on their circumstances, it may also indicate any conditions applicable to their membership, such as waiting periods or late-joiner penalties.
- You have to sign this letter in the appropriate place and return it to Discovery Health (Pty) Ltd. When you do so, you confirm your dependants' membership start date and acceptance of any conditions applicable to their membership of TFG Medical Aid Scheme.
- You will then get a membership pack in the post.

If you do not hear from Discovery Health (Pty) Ltd seven days after sending us the application form, please call Discovery Health (Pty) Ltd on **0860 100 345.**

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.

1. About the main member

Membership number

Surname

First names

ID or passport number Country of issue

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

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

☐ PO Box ☐ Private bag Number

☐ Suite ☐ Postnet Suite Number

Suburb Postal code

TFGNB03

1. About the main member *(continued)*

Physical address

Suite or unit number | Complex name

Street number | Street name

Suburb | Postal code

Telephone (H) | (W)

Cellphone | Fax

Email address

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

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

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

When do you want your cover to start? 2 0 Y Y M M 0 1

Title | Initials | Surname

First names

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

Marital status: Married ☐ Single ☐ Widowed ☐

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

Previous or maiden name

ID or passport number | Country of issue

Telephone (H) | (W)

Cellphone | Fax

Email address

Gross monthly salary R

Please attach your spouse's payslip as proof of income. If your spouse is unemployed, please attach an affidavit to this effect.

Please also provide a utility bill that proves the spouse is residing with the main member.

Addition of spouse to an existing membership

If addition of spouse to an existing membership is:

- Due to legal and registered marriage within the last month, an official marriage certificate must accompany this application form;
- For a spouse married for more than a month, full underwriting will apply;
- As a result of a long standing relationship or in terms of common-law practice, the partnership declaration must be completed and signed.

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.

Signature of main member | Signature of partner

Date Y Y Y Y M M D D | Date Y Y Y Y M M D D

3. Adding your dependant/s (applying for cover)

Only complete this section if you are adding a child or adult dependant. Please choose a date you want cover to start for all dependants you are applying for. This date must be the same for all your dependants applying for cover.

Cover start date 2 0 Y Y M M 0 1

Dependant 1

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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 give legal proof)

TFGNB03

3. Adding your dependants (if applying for cover) *(continued)*

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐ A special dependent? Yes ☐ No ☐

If your dependant is a student, a disabled child or a special dependant, please send us the following:

- If student, proof of enrolment at an academic institution;
- If disabled, your medical proof of disability;
- If special dependant, proof of financial dependence, an affidavit from the main member confirming financial dependence as well as proof that the dependant resides at the same residence as the main member.

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

- Please provide proof of income.

Dependant 2

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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 give legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐ A special dependent? Yes ☐ No ☐

If your dependant is a student, a disabled child or a special dependant, please send us the following:

- If student, proof of enrolment at an academic institution;
- If disabled, your medical proof of disability;
- If special dependant, proof of financial dependence, an affidavit from the main member confirming financial dependence as well as proof that the dependant resides at the same residence as the main member.

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

- Please provide proof of income.

Dependant 3

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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 give legal proof)

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐ A special dependent? Yes ☐ No ☐

If your dependant is a student, a disabled child or a special dependant, please send us the following:

- If student, proof of enrolment at an academic institution;
- If disabled, your medical proof of disability;
- If special dependant, proof of financial dependence, an affidavit from the main member confirming financial dependence as well as proof that the dependant resides at the same residence as the main member.

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

- Please provide proof of income.

Dependant 4

Title | Initials | Surname

First names

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

ID or passport number | Country of issue

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 give legal proof)

3. Adding your dependants (if applying for cover) *(continued)*

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐ A special dependent? Yes ☐ No ☐

If your dependant is a student, a disabled child or a special dependant, please send us the following:

- If student, proof of enrolment at an academic institution;
- If disabled, your medical proof of disability;
- If special dependant, proof of financial dependence, an affidavit from the main member confirming financial dependence as well as proof that the dependant resides at the same residence as the main member.

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

- Please provide proof of income.

4. Your employer warranty

Please make sure your employer completes this warranty.

1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.
2. The Scheme may bill us for the amount due for this dependant in the same manner as for other employees with the Scheme.

Authorised signatory

Name

Designation

5. Choosing your dependant/s healthcare professional

Choosing your dependant/s healthcare professional

If you are on TFG Health, you need to choose a GP from the KeyCare Network for your dependant/s. Please fill in the details of the GP you have chosen for your dependant/s.

*If you live far away from where you work or you often need to work in different towns or provinces, your dependant/s may need a second GP.

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

6. Previous medical scheme details

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

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

7. Your spouse, partner or dependants' health questions

Treating healthcare professional's name

Practice number

Telephone

Email

7.A. Only the spouse or partner and any adult dependant applying for cover need to complete section 7.A.

Spouse or partner

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No",** have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes",** amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 1

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No",** have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes",** amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 2

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No",** have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes",** amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 3

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No",** have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes",** amount each day

If you stopped smoking, what was your reason for stopping?

Dependant 4

How tall are you? . metres How much do you weigh? kilograms

Your blood type Your allergies

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week?

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day

If **"No",** have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes",** amount each day

If you stopped smoking, what was your reason for stopping?

7. Your spouse, partner or dependants' health questions *(continued)*

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

Please take note that if you have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 7.18 below. 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.tfgmedicalaidscheme.co.za

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

Example: abnormal pap smear results, skin lesions, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result.

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

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

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

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

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

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

7.4 Are any of your dependants pregnant? **Yes** ☐ **No** ☐

Patient name		

7.5 Mental health **Yes** ☐ **No** ☐

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

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

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

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

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

7. Your spouse, partner or dependants' health questions *(continued)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Your spouse, partner or dependants' health questions *(continued)*

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

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

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

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

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

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

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

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

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

7.18 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	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

HIV and AIDS

You do not need to disclose the HIV status of your dependant/s on this form if you do not feel comfortable doing so. However, if one or more of your dependants are HIV positive, you or they must call us on **0860 123 077** within seven working days from the date we activate your or their TFG Medical Aid Scheme membership. We treat this information in the strictest confidence. If one or more of your dependants are HIV positive, it is in your and your dependants' best interest to register on the **HIV*Care*** Programme. A 12-month condition specific waiting period may apply to this condition.

8. TFG Medical Aid Scheme - Privacy Statement - The purpose of this Privacy Statement is to set out how We collect, use, share and otherwise Process Your Personal Information, in line with the Protection of Personal Information Act 4 of 2013.

Definitions

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

Competent Person means anyone who is legally competent to consent to any action or decision being taken on any matter concerning a member or dependant, for example a parent or legal guardian.

Discovery Group refers to Discovery Limited, registration number 1999/007789/06, including all subsidiaries of the group as defined in the Companies Act, 2008.

Personal Information refers to personal information about You. It can include information about Your title and name, health, financial status and/or banking information, marital status, gender, age, ethnic group, nationality, language, contact numbers or email addresses and postal and/or street addresses or any other form of personal information as defined in the Protection of Personal Information Act 4 of 2013, which TFGMAS or the Administrator may reasonably require to offer or render its services/products to You (to the extent that TFGMAS or the Administrator is permitted in law to do so and where You have not objected thereto).

Process(ing) refers to the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting Personal Information.

The Scheme or TFGMAS refers to TFG Medical Aid Scheme, registration number 1578, registered with the Council for Medical Schemes.

Us, We or Our refers to the Scheme and the Administrator jointly.

You, Yourself and Your refers to you, the TFGMAS member, and includes Your registered spouse and/or dependants (if any) on Your TFGMAS plan.

1. When You apply to become a member of TFGMAS and when You engage with Us from time to time, You choose to provide Us with Personal Information. We are committed to taking all reasonable steps to protect Your right to privacy and Your Personal Information that You provide to Us.
2. You have the right to object to the Processing of Your Personal Information and You have a choice whether or not to accept the terms and conditions contained in this Privacy Statement, however, it is important to note that We require your acceptance of these terms and conditions in order to activate and/or service your TFGMAS membership.
3. We will take all reasonable steps to keep Your Personal Information confidential. You may have given us this information Yourself, or We may have collected it from other sources ('Sources") with whom You have shared your Personal Information. You indemnify Us against any losses You may sustain as a result of Sources not protecting Your Personal Information.
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 the policy/benefit 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 giving consent for a person under 18 (a "Minor"), You confirm that You are a Competent Person in relation to said Minor.
6. You agree that We may Process Your Personal Information for the following purposes:
   - for the administration of Your TFGMAS health plan;
   - to provide You with managed care services on Your TFGMAS health plan;
   - to profile and analyse risk;
   - to share Your Personal Information with external health specialists to enable them to assess or evaluate certain clinical information in the event that You are subject to such a clinical assessment under your TFGMAS health plan; and
   - any other reasonably required purpose relating to Our business and Your chosen TFGMAS health plan or Your application to join TFGMAS.

Examples of the above purposes may include, but are not limited to:

i. Obtaining 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 health status;
ii. Communicating with You about any changes in Your TFGMAS health plan, including changes to Your contributions or changes to the benefits You are entitled to on the TFGMAS health plan You have chosen;
iii. Transferring Your Personal Information outside the borders of the Republic of South Africa in order to give effect to Your TFGMAS health plan, or if You provide an email address which is hosted outside the borders of the Republic of South Africa;
iv. We will ensure that anyone with whom we share Your Personal Information agrees to treat Your Personal Information with the same level of protection as We are obliged to.

7. We will only share Your Personal Information with a third party if:
   - You have given Your consent for the disclosure of Your Personal Information to that third party; or
   - We have a legal or contractual duty to give Your Personal Information to that third party; or
   - We need to share it with them for risk analysis or fraud detection, prevention or recovery purposes.
8. You agree that We may share Your Personal Information with a third party contracted to Us who requires Your Personal Information in order to provide a healthcare service to you in terms of Your TFGMAS health plan.
9. We may provide Your Personal Information to any other entity within the Discovery Group with which You have applied for a product, service or benefit and where such application includes permission for said entity within the Discovery Group to request Your Personal Information from Us.
10. We may share all Your Personal Information with third parties which whom We have contracted, such as academics and researchers, where research is required to evaluate Our service to You. We ensure that all Personal Information about You that is shared with such third parties will be made anonymous to the extent possible. If We publish the results of any academic research, You will not be identified by name.
11. By accepting this Privacy Statement, You authorise Us to obtain and share Personal Information about Your creditworthiness with any credit bureau or credit providers' industry association or industry body. This includes Personal Information about credit history, financial history, judgments, and default history. It also includes sharing of Personal Information for purposes of risk analysis and tracing.
12. You agree that We may communicate with You electronically about any changes to your TFGMAS health plan, including changes to Your contributions or changes to the benefits You are entitled to on the TFGMAS health plan You have chosen.
13. 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.
14. The Scheme has a duty to keep you updated about any offers relevant to You that are made available from time to time. You agree that the Scheme may communicate with you about these.
15. Please let the Administrator know if you wish to receive any direct telephonic marketing.
16. You have the right to know what Personal Information We hold about You. If You wish to receive copies of documents containing Your Personal Information, please complete an 'Access Request Form', attached to the PAIA manual, on www.tfgmedicalaidscheme.co.za. We are entitled to charge a reasonable fee for this service and We will let You know what it is at the time of Your request. We can refuse to disclose certain information to You or refuse to provide You with documents in terms of the Promotion of Access to Information Act.
17. You agree that We may keep Your Personal Information until You ask Us to delete and/or destroy it. You have the right to ask Us to update or amend Your Personal Information, unless the law requires Us to keep it.
18. Where the Scheme and Administrator are required by law to collect and keep Personal Information, We shall do so. At a minimum, We are required to collect and keep Personal Information in terms of the following laws, subject to repeals, amendments and other legislative changes which may come into effect:

8. TFG Medical Aid Scheme - Privacy Statement - The purpose of this Privacy Statement is to set out how We collect, use, share and otherwise Process Your Personal Information, in line with the Protection of Personal Information Act 4 of 2013. *(continued)*

- 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 applicable to the Administrator only:

- Financial Advisory and Intermediary Services Act, 2002
- Companies Act, 2008

19. If the Scheme or Administrator becomes involved in a proposed or actual amalgamation or merger, acquisition or any form of sale of any assets, We may share Your Personal Information with third parties in connection with the transaction. In the case of such an event, the new entity will have access to Your Personal Information. The terms of this Privacy Statement will continue to apply.
20. We have physical, technological and procedural security safeguards in place and will use Our best endeavours to protect Your Personal Information.
21. We may change this Privacy Statement from time to time. The current version is available on www.tfgmedicalaidscheme.co.za
22. If You believe that the Scheme or Administrator have used Your Personal Information contrary to this Privacy Statement, We request that You first follow Our internal complaints procedure to resolve the complaint. We explain the complaints and disputes process on the website www.tfgmedicalaidscheme.co.za. If You are not satisfied with the outcome of Your complaint, You have the right to lodge Your complaint with the Information Regulator, under the Protection of Personal Information Act 4 of 2013.
    Contact details for the Information Regulator are:
    The Information Regulator (South Africa)
    SALU Building
    316 Thabo Sehume Street
    PRETORIA
    Ms Mmamoroke Mphelo
    Tel: 012 406 4818
    Fax: 086 500 3351
    inforeg@justice.gov.za

Signature of main member

Please do not sign an incomplete application form

By signing this Privacy Statement, You acknowledge that You have read, understood and accepted all the terms and conditions contained in this Privacy Statement.

9. TFG Medical Aid Scheme ("TFGMAS") rules for membership

9.1 Who "we" are

TFGMAS, registration no 1578, registered with the Council for Medical Schemes.

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

9.2 Rules for membership

The rules of TFGMAS record your rights and responsibilities for your membership of TFGMAS. 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 will be bound by them.

9.3 Who you are applying for

You may apply to join TFGMAS on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the TFGMAS rules. For anyone to be treated as financially dependent for this application, you must have a legal responsibility to provide financially for that dependant. We might ask you to give us proof of financial or legal responsibility. You may be called the principal member or main member in our future communications to you.

9.4 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 apply for membership and to act for those you apply for in any matter relating to this application;
- you have received permission from your spouse and any dependant/s over 18 to act for them in any matter relating to this application.

9.5 Giving and getting information

You must give true, correct and complete information

To consider your application for membership, TFGMAS 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.

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.

TFGMAS and Discovery Health (Pty) Ltd may record telephone 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.

TFGMAS and Discovery Health (Pty) Ltd may get information about you from other relevant sources

To consider your application for membership, conduct underwriting to consider 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, 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 or that arose during your membership of TFGMAS, is true, correct and complete. You give your permission that we may get any information that is relevant to your application from your employer.

Tell TFGMAS or Discovery Health (Pty) Ltd immediately if your information changes

You or your employer must 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 backdated changes may not be accepted.

When TFGMAS may cancel your membership/s

TFGMAS may cancel any memberships immediately, if you and those you apply for:

- do not give us information that later turns out to be relevant to this application;
- give us any information that is not true, correct and complete;
- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

9.6 About becoming a member

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

TFGMAS may have waiting periods that apply in certain circumstances. This means there may be a set time period before the TFGMAS starts paying claims 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 TFGMAS by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time

As the main member of TFGMAS, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. TFGMAS has the right to amend monthly contributions and benefits from time to time.

9.7 Repaying money owed to TFGMAS

TFGMAS 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 TFGMAS.

By signing this form, you agree that any money you owe to TFGMAS may be deducted from any future claim payment amounts that are due to be paid to you.

Signature of main member

Date 2 0 Y Y M M D D

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