



MEDICAL AID SCHEME



Contact details

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

Applying to become a member of TFG Medical Aid Scheme in 2022 (with underwriting)

For TFG office use

Employee number, Cost centre code, Branch code

Thank you for deciding to apply to join TFG Medical Aid Scheme. This document is an application form for membership. It also contains terms and conditions for membership. Please make sure you read and understand these rules.

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 '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

Please go through these steps:

- 1. Please use one letter per block, complete in black ink and print clearly. 2. Read and understand the terms and conditions for membership (section 10). 3. Sign sections 6, 9 and 10. 4. Please make sure the main applicant signs and dates any changes. 5. Please return the completed and signed form to the Payroll Department, TFG Head Office, Parow. 6. 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. 7. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

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.
• 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 or your employer contact person.

If you have any questions, please let us know. Once we have assessed your application, we will let you know what will happen next.

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

1. About Yourself (main applicant)

Cover start date, Title, First name/s, 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
---	---	---	---	---	---	---	---

 Previous or maiden name

Preferred communication: Email Post

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

Preferred language: English Afrikaans

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 identity 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
---	---	---	---	---	---	---	---

 Previous or maiden name

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Tax number

Email

Partnership declaration

If you are not legally married and unable to produce a marriage certificate, you must complete the section below in full. We hereby declare that we are in a long-term, committed relationship that is like a marriage and that we reside together at the same residence. We understand that by signing this declaration we agree to inform the Scheme of 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 process until we receive the section signed and dated by both parties.

Signature of main applicant

Original hand signature required

Date

Signature of partner

Original hand signature required

Date

3. About your dependant/s (if applying for cover)

Dependant 1

Title Initials Surname

First name/s (as per identity 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

ID or passport number Country of issue

Please answer all questions.

Is your dependant:

Your child? Yes No *A student Yes No

*Disabled? Yes No *A special dependant? Yes No

What is your dependant's marital status?

If your dependant is none of the above, please explain his or her relationship to you (for example: nephew, niece):

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

ID or passport number Country of issue

Please answer all questions.

Is your dependant:

Your child? Yes No *A student? Yes No

*Disabled? Yes No *A special dependant? Yes No

What is your dependant's marital status?

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

5. Employment details (to be completed by TFG Payroll only)

Name of employer Employer number

Employee number Date of employment

Branch number

Branch name

Cost centre number Date of promotion (if applicable)

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. TFG Medical Aid Scheme may bill us for the amount due for this member in the same way as it does for our other employees with TFG Medical Aid Scheme.

Authorised signatory

Original hand signature required

Name

Designation

If you have more than three dependants, please complete an application to add dependants to TFG Medical Aid Scheme.

6. Your claims refund banking details

Please give us the details you would like us to use to refund your claims. Please note: We cannot accept credit card account details. If we are paying a third party bank account, the main member must insert the ID number of the third party.

Bank name

Branch name

Branch code - - -

Account number

Type of account Cheque Savings

Accountholder

If we are paying a third party bank account, the main member must insert the ID number of the third party.

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

After third party ID number, please insert the following: If the third party bank account is a joint account, company account or trust account please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the TFG Medical Aid Scheme will not be responsible in any way for the amounts refunded. Please make sure that we have your correct bank account details.

Signature of account holder

Original hand signature required

7. Previous medical scheme details

Please give us the details of all registered South African medical scheme that you previously belonged to. We will use this information to determine if we need to apply any late-joiner penalty fee. Please give us proof in the form of a membership certificate.

Main applicant

Name	Scheme name	Start date	Are you still a member	End date if you have already registered	Reason for leaving
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	

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

If any of your dependants applying for cover belonged to different medical schemes, please complete below:

Dependant name	Scheme name	Start date	Are you still a member	End date if you have already registered	Reason for leaving
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes <input type="checkbox"/> No <input type="checkbox"/>	D D M M Y Y Y Y	

8. Your health questions

A. Only the main applicant, spouse or partner and any adult dependant applying for cover needs to complete section 8.A.

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.

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 8.18 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

8.1 Tumours, growth 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, abscess, abnormal mammogram result, abnormal PSA (Prostate Specific Antigen) result, any autoimmune conditions, any congenital conditions or other skin conditions.

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

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 and peripheral vascular disease.

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

8.3 Gynaecological and obstetrics conditions

Yes No

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

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

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

8.5 Mental health conditions

Yes No

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

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

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

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, constipation, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, any autoimmune conditions, any congenital conditions.

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

8.8 Brain and nerve conditions

Yes No

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, 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, down's syndrome, any autoimmune conditions, any congenital conditions.

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

8.9 Breathing and respiratory conditions

Yes No

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

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

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, prosthesis, amputation, 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
		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 and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder, bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

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

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

8.13 Eye conditions

Yes No

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

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

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

8.15 Male urogenital conditions

Yes No

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

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

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

8.17 Have any of your dependant/s received medical advice or treatment for symptoms not diagnosed by a medical professional, in the last 12 months before this application?

Yes No

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

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

HIV and AIDS

You do not need to disclose the HIV status of you or your dependant/s on this form if you do not feel comfortable doing so. However, if you or 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 TFG Medical Aid Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme. A 12-month condition-specific waiting period may apply to this condition and any related conditions. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your TFG Medical Aid scheme.

9. Privacy Statement for TFG Medical Aid Scheme administered by Discovery Health (Pty) Ltd

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.

- 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.
- 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.
- We will take all reasonable steps to keep Your Personal Information confidential. We have physical, technological and procedural security safeguards in place and will use Our best endeavours to protect Your Personal Information.
- 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.
- You understand that when You include Your spouse and/or dependents on Your application, We will Process their Personal Information in accordance with this Privacy Statement. You warrant that when You give Us Personal Information about Your spouse and/or dependants, You have received their permission to share their Personal Information with Us for the purposes set out in this Privacy Statement. You indemnify Us against any claims resulting from the sharing of Your spouse and/or dependents' Personal Information without Your spouse and/or dependents' consent.
- 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.
- 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 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;
- to comply with South African statutory reporting obligations; and
- any other reasonably required purpose relating to the administration of Your chosen TFGMAS health plan and/or Your application to join TFGMAS.

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

- 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;
- 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; and
- 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.

8. You agree that We may share Your Personal Information with a third party contracted to Us who requires Your Personal Information to provide a healthcare service to You in terms of Your TFGMAS health plan. 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.

We will ensure that anyone with whom We share Your Personal Information on the terms included in this Privacy Statement agrees to treat Your Personal Information with the same level of protection as We are obliged to.

9. You agree that 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 Your express consent for said entity within the Discovery Group to request Your Personal Information from Us, and for Us to release Your Personal Information to said entity.
10. You agree that We may share Your Personal Information with third parties with whom We have contracted, such as academics and researchers, whose research is required to evaluate Our service to You. We will ensure that 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 in any such publication.
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. You agree that 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 a decision made about You by sending Your query to Privacy@discovery.co.za.
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 in this regard.
15. You may inform the Administrator if You wish to receive any direct telephonic marketing about the Administrator's products and services.
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 the fee is at the time of Your request.
17. You agree that We may keep Your Personal Information until You ask Us to delete and/or destroy it, unless the law requires Us to keep it. You have the right to ask Us to update or amend Your Personal Information
18. 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.
19. We may change this Privacy Statement from time to time. The current version is available on www.tfgmedicalaidscheme.co.za
20. 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.
21. Contact details for the Information Regulator are:

The Information Regulator (South Africa)

JD House

27 Stiemens Street

Braamfontein

2001

POPIAComplaints@inforegulator.org.za or PAIAComplaints@inforegulator.org.za

Signature of Main Member



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

10. Terms and conditions applicable to TFG Medical Aid Scheme ("TFGMAS")

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.

2. *Scheme 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 terms and conditions and you agree that you and those you apply for will be bound by these and scheme rules.

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.

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.

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.

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. If you pay your own contributions, you will be able to identify the debit order for your monthly contributions on your bank statement, the reference number TFG CONT will be used.

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. You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number TFG CLWBK will be used.

Signature of main member

Date

D	D	M	M	Y	Y	Y	Y
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**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**

FOR COMPANY STAMP

11. Banking details for a third party - Annexure A

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

Documents we need for a third-party bank account

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

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

Documents we need for a joint bank account

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

Documents we need for a company account

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

Documents we need for a trust account

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

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