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 2024 (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 terms and conditions for membership (section 9). View the Scheme legal page and Privacy Statement here.
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 Fuse by logging a ticket via **https://synergy@tfg.co.za/**.
6. Please attach a copy of each dependant's identity document to this application form. We also accept valid passports and birth certificates for children.

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.
- 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.
- 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.
- 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).
- 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 Terms and conditions for membership and agree to them.

1. Main member details

Membership number	
ID or passport number	
Member's name	
Member's surname	

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? D 0 D 1 M M Y Y Y Y

Title | Initials

Surname

First names

Previous or maiden name

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

Race African Coloured Indian/Asian White Other Do not want to disclose

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

Marital status: Married Single Widowed

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

ID or passport number

Telephone (H) | Telephone (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 | Date D D M M Y Y Y Y

Signature of partner | Date D D M M Y Y Y Y

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 ar applying for. This date must be the same for all your dependants applying for cover.

Cover start date D 0 D 1 M M Y Y Y Y

Dependant 1

Title | Initials | Surname

First name(s) (as per identity document)

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

Race African Coloured Indian/Asian White Other Do not want to disclose

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

ID or passport number

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 dependant? 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 name(s) (as per identity document)

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

Race African Coloured Indian/Asian White Other Do not want to disclose

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

ID or passport number

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 name(s) (as per identity document)

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

Race African Coloured Indian/Asian White Other Do not want to disclose

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

ID or passport number

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 name(s) (as per identity document)

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

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

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

ID or passport number

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.

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.

	Name	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
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

7. Your spouse, partner or dependant/s' health questions

Have you or any dependant 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.

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 programmes 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 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.

7.1 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, abnormal mammogram result, abnormal PSA (prostate specific antigen) result, abscess, any autoimmune conditions or other skin conditions, and 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

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, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, peripheral vascular disease, any autoimmune conditions, and any congenital conditions, varicose veins.

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

7.3 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, and 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

7.4 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

7.5 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, and 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

7.6 Metabolic or endocrine conditions

Yes ☐ No ☐

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

7.7. Abdominal conditions

Yes ☐ No ☐

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

7.8 Brain and nerve conditions

Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, 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 and 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

7.9 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, and 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

7.10 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 taken

7.11 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, and 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

7.12 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, and any congenital conditions, varicose veins.

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

7.13 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, and 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

7.14 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, and 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

7.15 Male urogenital conditions

Yes ☐ **No** ☐

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

7.16 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

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	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

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	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

HIV and AIDS

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 HIV *Care* Programme. TFG Medical Aid Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before TFG Medical Aid Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. We will not indicate the 12-month condition specific waiting on a counter offer letter, if the waiting period is applied prior to activation of membership due to the sensitivity of this information. We will not indicate the 12-month condition specific waiting period on a membership certificate if the waiting period is applied due to the sensitivity of this information. If you do not let us know about you or your dependants HIV status within 7 days of your membership being active, we may end your TFG Medical Aid Scheme membership.

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

Privacy Statement

When you engage with TFG Medical Aid Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants and beneficiaries, where applicable. To view and read our Privacy Statement, please follow this link:
https://www.tfgmedicalaidscheme.co.za/wcm/medical-schemes/tfg/assets/legal/privacy-statement.pdf

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.

9. 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 terms and conditions 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 terms and conditions. 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 to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers). 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 back dated 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 CLAWBK will be used.

Signature of new main member

Date D D M M Y Y Y Y

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