Continuation form

Application to register a dependant as the main member

Contact details
Tel: 0860 002 133 • PO Box 652509, Benmore 2010 • www.sabmas.co.za

This document is an application form to register a dependant as the main member on an existing membership. It also contains some terms and conditions for membership. Please make sure you read and understand the terms and conditions..

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one block per letter, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. This form must be completed by the person applying to be the registered as the principal member.
4. To be completed and returned to **membership@sabmas.co.za**
5. Where a minor(-18 yrs) will be the new main member, we require the Legal guardian's name, surname, ID number and signature. Proof of legal guardianship to be submitted with the form.

By signing this application, you confirm that the information provided is true and correct.

1. About the new main member

Date membership of new main member starts D D M M Y Y Y Y

Membership number

Tax Number

Title Initials Surname

First name(s) (as per identity document)

Preferred name Gender M F

Race African Coloured Indian/Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose. Date of birth D D M M Y Y Y Y

Marital Status Married Single Divorced Widowed Preferred language English Afrikaans

Previous Maiden Name

ID or passport number

Country of issue

Telephone (H) (Work)

Cellphone

Physical Address

Code

Postal Address

SABCON001

Please note that this form expires on 31/03/2023. Up to date forms are available on www.sabmas.co.za.

Code

Email address

Preferred means of communicating (where appropriate) Email Email Type: Home Work Post

In which country do you live?

2. Details of the current main member

If you need to register a dependant as the main member, please attach a certified copy of the death certificate.

What you must do

You need to submit the following with this form:

Title Initials Surname

First name(s) (as per identity document)

Preferred name Gender M F

Race African Coloured Indian/Asian White Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose. Date of birth D D M M Y Y Y Y

ID or passport number

Country of issue

3. Banking details for the new main member's monthly contribution (if applicable)

What you must do

Submit the following with this form: 1. Copy of ID 2. Bank statement/letter of confirmation from the bank.

Bank name

Branch name Branch code - - -

Account number

Name of account holder

Type of account Cheque Savings

I agree to inform the Scheme in writing of any changes that may occur.

Signature of account holder

Please do not sign an incomplete application form.

Signature of new main member

Please do not sign an incomplete application form.

Please note: If you are using someone else's bank account, the account holder must sign above to confirm this.

4. Account holder's physical address (Own; Third Party; Company/Trust)

Physical address

Suite/Unit number Complex name

Street number Street name

Suburb

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

Suite Postnet Suite Number

PO Box | Private Bag | Number

Suburb | Postal code

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

5. Banking details for claim refunds

What you must do

You need to submit the following with this form:

- Copy of the account holder's ID
- Bank statement or letter of confirmation from the bank not older than three months. Please note: only an original bank statement will be accepted

If we do not have banking details, we cannot refund your claims. You can only use a South African bank account.

Same as section 4? Yes | No

Bank Name

Branch Name | Branch code

Account number

Name of account holder

Type of Account Cheque | Savings

I agree to inform the Scheme in writing of any changes that may occur.

Signature of new main member

Please do not sign an incomplete application form.

By signing the above, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will no longer be responsible in any way for the amounts refunded.

6. Privacy Statement for SABMAS administered by Discovery Health (Pty) Ltd

Definitions
The Scheme refers to SAB Medical Aid, registration number 1209, registered with the Council for Medical Schemes.

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

Discovery Group refers to Discovery Limited, registration number 1999/007789/06, including all subsidiaries of the group. Subsidiaries in the Group are authorised financial services providers.
Process(ing) (of) information means any automated or manual activity of collecting, verifying, recording, analysing, organising, storing, updating, distributing and removing or deleting personal information.

You and your refers to you the member and your registered dependants on your medical scheme plan.
Your personal information refers to all personal information the Discovery Group has on you, or persons which are related to you or under your authority (as relevant). It includes:

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

Competent person means anyone who is legally competent to consent to any action or decision being taken for any matter concerning a member or dependant for example a parent, legal guardian or a legal representative appointed by a court to manage the finances, property, or estate of another person unable to do so because of mental or physical incapacity.

1. When you engage with the Scheme and Administrator, you trust us with personal information about yourself or your family. We are committed to protecting your right to privacy.
2. The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in a manner that is compliant, ethical, adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time.
3. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always endeavour to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources.
4. Please note you have the right to object to the processing of your Personal Information.

5. **SAB Medical Aid and Discovery Health (Pty) Ltd** (we/us) will keep any information, including Personal Information relating to yourself and your dependant/s and/or beneficiaries, supplied to us in this application or collected from other sources confidential.
6. Where you have joined as a member of an employer group, your employer holds your application form and information relating to such application. We may request such information regarding your application from your employer, which will, for the avoidance of doubt, be limited to specific information that is strictly relevant to your application.
7. 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 related to your application. By submitting your dependants' relevant personal information, you hereby confirm that you are duly authorised to share such information with us. We will furthermore process their information for the purposes set out in this Privacy Statement.
8. Each party accepts responsibility to the extent that the processing activities of personal information fall under the control of that party and agrees to indemnify the other party/ies against any loss or damage, direct or indirect, that an employee may suffer because of any unauthorised use of the employees' personal information or if a breach of the employees' personal information occur, but only if the processing of that personal information is controlled by that party.
9. You agree to us processing and disclosing your Personal Information in the following manner:
   We may collect, collate, process, store and disclose your Personal Information:
   9.1. For the administration of your health plan;
   9.2. For providing managed care services to you or any dependant/s on your health plan;
   9.3. For providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan;
   9.4. To analyse risk trends and profiles;
   9.5. For academic research conducted by any company within the Discovery Group and/or contracted research and survey providers in South Africa as well as outside the borders of the Republic;
   9.6. To share your personal information with external health providers for the purposes of evaluating certain clinical information, in the event that you require medical treatment.

   Examples of how this will happen includes:
   9.6.1. Sharing your Personal Information with your chosen financial adviser during the application process to help us, if necessary, to process your membership application;
   9.6.2. Obtaining and sharing your Personal Information with other relevant sources, including any entity that is part of Discovery Limited, medical practitioners, contracted service providers, health information exchanges, financial advisers, credit bureaus or industry regulatory bodies ("Sources"), and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal Information is true, correct and complete;
   9.6.3. Getting and sharing any information that is strictly relevant to your application from or with your employer, if you have joined as a member of an employer group;
   9.6.4. Communicating with you about any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen;
   9.6.5. Making use of external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependant/s are subject to such a clinical assessment.
10. If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.
11. You consent and agree that:
    - we may process your information, including personal information, to adhere to South African Legislative reporting obligations and to perform transaction monitoring activities;
    - we may communicate such personal information to local Regulatory Bodies as well as to other entities in the Discovery Group if any Legislative reportable matters are identified.
12. We may provide your Personal Information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship or where you or your dependant/s have applied for a product or benefit from such entity, provided you have given your consent to such entity for us to do so. This information will be provided for the administration of your or your dependant's products or benefits with other entities within the Discovery Group.
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. You may query the decision made about you.
14. We may provide any credit bureau, credit providers or industry association with any information about your consumer credit record, including Personal Information about any judgement or default history.
15. If we want to share your Information for any other reason, we will do so only with your permission.
16. You have the right to request a copy of the Personal Information we hold about you. If you wish to access this information, please complete a 'PAIA Form to Request Access to Records' available. This form can be found on https://www.discovery.co.za/corporate/privacy/and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information in respect of this request. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
17. You have the right to contact and ask us to update, correct or delete your Personal Information.
18. You agree that we may retain your Personal Information until such time as you request us to destroy it (unless we are obliged by law to retain it, regardless of such request, for the pursuit of our legitimate business purpose). Where we cannot delete your personal information, we will take all practical steps to anonymize it.
19. If the Scheme, Discovery Health (Pty) Ltd or Discovery (Ltd) becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose your Personal Information to third parties in connection with the evaluation of the transaction. The surviving company, or the acquiring company in the case of a sale of assets, would have access to your Personal Information which would continue to be subject to this Privacy Statement.
20. You have the right to ask us to update, correct or delete your personal information by completing the Request foYr Deletion or Correction of Information Form available on the Scheme's Website at https://www.discovery.co.za/corporate/privacy/.

21. We are required to collect and retain information in terms of the following legislation (amongst others):
    - The 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, 2000

    Legislation specific to Discovery Health (Pty) Ltd only:
    - Financial Advisory and Intermediary Services Act, 2002
    - Companies Act, 2008
22. You agree that we may transfer your personal information outside South Africa:
    - If you give us an email address that is hosted outside South Africa; or
    - for processing, storage or academic research; or
    - to administer certain services, for example, cloud services.
      When we share your information to administer certain services, we will ensure that any country, company or person that we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to do in South Africa. Unless you specifically give us consent to share your personal information with such person (or company).
23. You have the right to know what personal information the Scheme holds about you. If you wish to access this information, please complete a 'PAIA Form to Request Access to Records' available. This form can be found on www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information in respect of this request. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
24. We may change this Privacy Statement from time to time. The most updated version will always be available on www.sabmas.co.za.
25. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator. However, we encourage you to first follow our internal complaints process to resolve the complaint or contact the Information Officer at privacy@discovery.co.za. If, thereafter, you feel that we have not resolved your complaint adequately kindly contact the Information Regulator at: JD House |27 Stiemens Street | Braamfontein |Johannesburg |PO Box 31533 |Braamfontein |Johannesburg |2001 | POPIAComplaints@inforegulator.org.za or PAIAComplaints@inforegulator.org.za.

Signature of main applicant

Date D D M M Y Y Y Y

7. Medical Scheme terms and conditions for membership

1. ***Who "we" are***

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

2. ***Terms and conditions for membership***

The terms and conditions of SAB Medical Aid records your rights and responsibilities for your membership of SAB Medical Aid. They may change from time to time. You may ask SAB medical Aid for a copy at any time. When you sign this application, you confirm that you have read and understood the terms and conditions and you agree that you, and those for whom you apply, will be bound by these and scheme rules. Where applicable you also acknowledge and confirm you, or your employer appointed contact, may communicate with us on this application and your membership to SAB Medical Aid. The information will be shared so that he or she may contact us if necessary while we process your membership application. Please speak to your employer if there is anything you do not understand.

3. ***Acting for others***

You may apply to join SAB Medical Aid on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the SAB Medical Aid terms and conditions.

For anyone to be treated as financially dependent for this application, you must be responsible for providing financially for that dependant.

We might ask you to provide us with proof of financial responsibility.

You will be referred to as the principal member or main member in our future communications to you.

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 for whom you are applying in any matter relating to this application.
- You have received permission from your spouse and any dependants over the age of 18 to act on their behalf in any matter relating to this application.
- In the event that you are signing on behalf of a minor (person younger than 18 years old) that you are a competent person and authorised to sign on their behalf.

4. ***Giving and getting information***

You must give true, correct and complete information

To consider your application for membership, SAB Medical Aid must learn more about you and those for whom you apply. This information must be true, correct and complete. This includes the details you provide in this application form and in future dealings with us. It is important that you inform us of any medical condition, symptom or illness relating to you or those for whom you are applying, even if you do not consider it relevant to your application. We may ask for more information about those for whom you are applying if they are 18 years of age or older.

Your legal address

We will send documents to you at the address you selected as the communication channel at which you prefer to be contacted. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have provided, or at any other address you have supplied. It is your responsibility to make sure we have the correct address for you.

SAB Medical Aid and the administrator may record telephone calls

SAB Medical Aid and the administrator may record telephone conversations with you and with those for whom you are applying. The recordings and all information we obtain during the recordings will be processed and retained as required by law.

We may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that we may obtain information about you and those for whom you are applying from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you provide on this application and in respect of any matter pertaining to or that arises during your membership of SAB Medical Aid, is true, correct and complete. You give your permission that we may obtain any information that is strictly relevant to your application and membership from your employer.

Inform us immediately if your information changes

You or your employer must inform us in writing should any of the information you have provided, in your application for membership, changes between the day you sign this document and the day your membership commences. This includes information regarding your health and the health of those for whom you apply. If at any stage you become a direct paying member, we require advance notice of any administrative changes, such as cancellation of membership, as we cannot accept backdated changes.

5. ***When SAB Medical Aid may cancel your membership/s***

SAB Medical Aid may suspend or cancel any membership immediately, if the member or dependant/s on the membership is found guilty of abuse of privilege of the Scheme. It is very important for the member and dependants to provide true, correct and complete information on the application form and in their dealings with the Scheme.

6. ***Becoming a member***

SAB Medical Aid might not pay for certain expenses immediately after you become a member

SAB Medical Aid may have waiting periods that apply in certain circumstances. This means there may be a set time period before SAB Medical Aid begins paying for any general or specific medical conditions.

Please speak to your employer or one of our consultants to find out if waiting periods apply to your membership and the memberships of those for whom you are applying.

Resign from your current medical aid when accepted

It is illegal to be a member of more than one medical aid at the same time. You and those for whom you are applying must resign from your current medical aid when you receive notice from SAB Medical Aid by letter, email or SMS informing you that you and those for whom you have applied have been accepted.

7. ***Contributions***

As the main member of SAB Medical Aid, 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. The Scheme has the right to amend monthly contributions and benefits from time to time.

8. ***Repaying money owed to the Scheme***

SAB Medical Aid has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you should there be any such amount owed to the Scheme.

If the legal guardian signs the application form, then the below field must be completed:

ID Number	
Name and surname	

Signature of principal applicant

Date D D M M Y Y Y Y

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

8. Terms and Conditions

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

I/We, the undersigned:
warrant that the account information I/we have provided above is an account in my/our name and that the information furnished by me/us in this authority and mandate is true and correct;

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

Reference number

This Agreement reference numbers are SAB CONTRI, SABCLAWBAC

Signature of bank account holder

Date D D M M Y Y Y Y

Please only sign if you have read and understood this statement

In addition to the above terms, the policyholder must agree to the following:

1. I confirm that I have the right to give SAB Medical Aid the authority to debit such account on a monthly basis. Furthermore, I will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by SAB Medical Aid to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
2. hereby authorize SAB Medical Aid to verify the banking details as provided above for the purpose of setting up a debit order, in need.
3. I confirm that the account listed above complies with the Financial Intelligence Centre Act ("FICA").
4. I confirm that if I miss a premium collection date I authorize that SAB Medical Aid may deduct a double debit of my premiums the following month.

I, _____ (Full name(s) and surname according to your identity document), as the policy holder, give SAB Medical Aid and its subsidiaries in their relevant capacities permission to change my banking details.

Date D D M M Y Y Y Y

Signature of main member

Date D D M M Y Y Y Y

Please only sign if you have read and understood this statement