Applying to become a member of SAB Medical Aid (full underwriting)

Contact details
Tel: 0860 002 133 • PO Box 10436, Johannesburg, 2000 • www.sabmas.co.za

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.

3Sixty Health (Pty) Ltd, registration number 1978/001109/07, is an accredited administration and managed care service provider responsible for administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. 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 Schemes for statistical purposes only. You are not compelled to provide this information.
3. **Read and understand the Privacy Statement and terms and conditions for membership (sections 9 and 10).**
4. **Please sign sections 6, 9 and 10**.
5. Please make sure the principal applicant signs and dates any changes.
6. Please fax this completed and signed form with any supporting documents to 010 593 2074 or email it to application@sbmas.co.za.
7. Please **attach a copy of each applicant's identity document.** We also accept valid passports and unabridged birth certificates for children.
8. Please read sections 11 and 12 to understand who qualifies as a dependant and possible underwriting that may be applied.

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.
- If you have waiting periods and/or late joiner penalties, we will issue a counter-offer letter which will indicate any conditions applicable to your membership. You may accept the offer by signing and returning the 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 a welcome letter, SMS or an email to let you know when your application is fully and completely registered. This date may differ from the date on which you sign the application form.
- You will then receive your welcome pack.

If you do not hear from us within seven days after sending us your application form, please contact us on **0860 002 133**.

By signing this application, you confirm that you have read and understood the terms and conditions for membership and agree to them (available on the Scheme's website at www.sabmas.co.za).

1. About yourself (main applicant)

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

Title | Initials | Surname

First name/s (as per identity document)

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

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

Occupation | Tax number

ID or passport number | Country of issue

Telephone (H) | (W)

Cellphone | Fax

Email

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

PO Box | Private Bag | Box number

Suite | Postnet Suite | Number

Suburb | Postal code

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

Physical address:

Suite/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 | Date of birth D D M M Y Y Y Y

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 | Fax

Email

Tax number

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. 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. 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.

Since when have you and your partner been in this relationship that is like a marriage D D M M Y Y Y Y

Signature of main applicant | Signature of partner

Please do not sign an incomplete application form

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

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

Dependant 1

Title | Initials | Surname

First name/s (as per identity document)

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

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

ID or passport number | Country of issue

Telephone | Work

Cellphone | Fax

Email

Relationship to principal member (For example, mother, child etc. Where your child is not biological, please state relationship, ie adopted child, foster child. Please provide legal proof.)

If your dependant is 18 years and older, are they:

Financially dependent on you? Yes No

Disabled? Yes No

A full-time student? Yes No Does your dependant earn an income? Yes No

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

Dependant 2

Title | Initials | Surname

First names

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

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

ID or passport number | Country of issue

Telephone | Work

Cellphone | Fax

Email

Relationship to principal member (For example, mother, child etc. Where your child is not biological, please state relationship, ie adopted child, foster child. Please provide legal proof.)

If your dependant is 18 years and older, are they:

Financially dependent on you? Yes No

Disabled? Yes No

A full-time student? Yes No Does your dependant earn an income? Yes No

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

Dependent 3

Title | Initials | Surname

First name/s (as per identity document)

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

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

ID or passport number | Country of issue

Telephone | Work

Cellphone | Fax

Email

Relationship to principal member (For example, mother, child etc. Where your child is not biological, please state relationship, ie adopted child, foster child. Please provide legal proof.)

If your dependant is 18 years and older, are they:

Financially dependent on you? Yes No

Disabled? Yes No

A full-time student? Yes No Does your dependant earn an income? Yes No

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

4. Please select your option

Comprehensive Option Essential Option

If you choose the Essential Plan

Please complete this if you have selected the Essential Plan. Essential members will need to nominate two chosen GPs. To make sure you are still able to get the treatment you need, you will be able see a doctor, who is not your chosen GP, three times a year. Thereafter, there will be a penalty co-payment for all non-nominated or out of area GP visits. This penalty will be applied in addition to the existing 20% surcharge on consultations.

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

** Please make sure that the dependant information you give above is the same as the dependant information in section 3 of this form.

5. Your employment details (to be completed by the employer)

Date Payroll Received Application D D M M Y Y Y Y

Name of employer | Employer or billing number

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

Branch name | Branch number

Department name

Employee's monthly salary **R** .

If the employee is joining SAB Medical Aid more than 3 months after they were employed, please confirm if it is because of one of the following reasons

Employer warranty

1. Their spouse or partner resigned, was retrenched or is disabled: Yes No
2. They were a wage earner and now earn a salary or they were a temporary or contract worker and are now permanent: Yes No
3. They are now offered medical aid due to their new salary level or job grade: Yes No

Authorised signature

Please do not sign an incomplete application form.

HR Name and Surname

Email Address

Designation

Date D D M M Y Y Y Y

EMPLOYER STAMP

6. Banking details for claims refund

Please give us the details you would like us to use to refund your claims. Please note: We cannot accept credit card account details.

Bank name

Branch name

Branch code - - -

Account number

Type of account Cheque Savings

Accountholder

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

Signature of account holder

Original hand signature required

Signature of principal member

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

If the third party bank account is a joint account company account 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.

7. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you belonged to previously. We will use this information to determine if we need to apply any waiting periods, late joiner penalty fees or both. Please give us a membership certificate as proof of membership to these schemes.

Were all your dependants on the same medical scheme/s Yes No

If not, please complete your dependants' previous medical scheme cover details below:

Main applicant

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

8. Your health questions

In the preceding 12 months, have any of your dependant/s in this application **ever** experienced, or received treatment for, or currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customized information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modeling,to assist the Scheme to better assess and mitigate its risk and other beneficial uses. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a within a 12-month period ending on the date on which this application is considered to be fully and properly made.

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

8.1. Tumours, growths and disorders of the skin

Yes ☐ No ☐

Example: abnormal pap smear results, skin lesions, eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abscess, 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	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

8.2. Heart and circulation conditions

Yes ☐ No ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease.

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

8.3. Gynaecological and Obstetric 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	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

8.4. Are any of your dependants pregnant? **Yes** ☐ **No** ☐

Are 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
		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 **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, 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	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

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

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

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

8.7. Abdominal conditions **Yes** ☐ **No** ☐

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

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

8.8. Brain and nerve conditions Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, 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	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

8.9. Breathing and respiratory conditions Yes ☐ No ☐

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment
		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, fractures, 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 failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment
		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, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, any autoimmune conditions, any congenital conditions, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders.

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

8.13. 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	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

8.14. Ear, nose and throat (ENT) and dentistry conditions Yes ☐ No ☐

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

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

8.16. 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
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y
		D D M M Y Y Y Y	D D M M Y Y Y Y		D D M M Y Y Y Y

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/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

8.18. 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
		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 your dependant/s or yours on this form if you do not feel comfortable doing so. However, if you or one or more of your dependant/s are HIV positive, you or they must call us on 0861 638 633 within seven working days from the date we activate your SAB Medical Scheme membership. We treat this information in the strictest confidence. 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 SAB Medical Scheme membership.

9. Privacy Statement for SABMAS administered by 3Sixty Health (Pty) Ltd

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

Administrator refers to 3Sixty Health (Pty) Ltd, registration number 1978/001109/07, an accredited administration and managed care service provider.

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 3Sixty Health (Pty) Ltd 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 3Sixty 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 3Sixty Health (Pty) Ltd 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 3Sixty Health, 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 3Sixty Health (Pty) Ltd, if any Legislative reportable matters are identified.
12. We may provide your Personal Information to any other entity within 3Sixty Health (Pty) Ltd, 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 3Sixty Health (Pty) Ltd.
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.
    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 and 3Sixty Health (Pty) 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 scale of assets, would have access to your Personal Information which would continue to be subject to this Privacy Statement.

20. 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 3Sixty Health (Pty) Ltd only:
    - Financial Advisory and Intermediary Services Act, 2002
    - Companies Act, 2008

21. 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).

22. You have the right to know what personal information the Scheme holds about you. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.

23. We may change this Privacy Statement from time to time. The most updated version will always be available on www.sabmas.co.za.

24. 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@3Sixtyhealth.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

10. 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. 3Sixty Health (Pty) Ltd, registration number 1978/001109/07, is an accredited administration and managed care service provider responsible for 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 3Sixty Health (Pty) Ltd, 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

11. Member and dependant information

Members	Requirements
New members joining SAB Medical Aid within 90 days of employment	• The member and dependants may join the Scheme and no underwriting will apply.
Members transferring from another medical scheme	• Voluntary transfer of members and dependants will not be subject to underwriting if you apply on 1 January of the new year. Proof of previous medical scheme cover must be provided.
	• Selective transferring of membership to SAB Medical Aid during the course of the year will be subject to underwriting. A three-month general waiting period may apply and/or a condition-specific waiting period from the previous medical scheme may be carried over.
Current employees of SAB Medical Aid joining the Scheme for the first time	• The member and dependants' membership may be subject to underwriting. The underwriting may include a late joiner penalty, where applicable.

Dependant Information

Please take note of additional requirements and eligibility criteria for the various dependant categories listed below:

Dependant Category	**Requirements**
Spouse	• Please include a copy of the marriage certificate when submitting this form. • Waiting periods and/or late joiner penalties will not apply to a spouse joining SAB Medical Aid within three months of marriage.
Fiancé/Fiancée/Partner	• A fiancé/fiancée/partner may qualify as a dependant if the member can demonstrate to the Scheme's satisfaction that he/she is in a committed and serious relationship with the member, akin to a marriage. • Please include an affidavit confirming the extent of the relationship and co-habitation, the extent of mutual dependency for financial assistance and any other pertinent factors such as jointly owned property, joint lease agreements, ceded policies etc.
Child	Biological child/ren with a different surname • Please include an affidavit and an unabridged birth certificate confirming the relationship to the principal member
	Adopted child/ren • Please include proof of adoption.
	*Stepchild/ren • Please include an affidavit confirming the relationship to the principal member and birth certificates where applicable.
	Child aged 19 or older (excluding a differently abled child) • In order for a child older than 18 to qualify as a dependant, the member must demonstrate that the child is dependent on him/her for family care and support, and is not employed on a full-time basis. • Adult rates apply from the age of 21. • If your dependant is unemployed, please provide proof and extent of financial dependency (an affidavit will suffice).
	Differently abled child aged 19 or older • Please include a doctor's report confirming the nature and extent of the learning difficulty/physical disability (must be within the current year). • Adult rates apply from the age of 26.
Grandchild	• The mother/father of the child must be a registered dependant on the medical scheme. • An affidavit and court order providing legal guardianship of grandparents registered is required when the parents of the child are not registered on the member's medical scheme.
Parent/Parent in law	• A parent/parent in law may qualify as a dependant if the member can prove to the Scheme's satisfaction that he/she is dependent on the member for family care and support. • The main member's spouse must be a registered dependant on the medical scheme for a parent in law to qualify as or remain a dependant. • An affidavit from the member and the dependant confirming their financial dependency and co-habitation. • Proof of income, three month's bank statement and tax returns for both parents (where applicable).

* An abridged birth certificate along with an affidavit confirming the relationship to principal member (in the case of the father being the principal member)

12. Waiting periods (only applicable to special dependants and employees joining after 90 days of being employed)

1. Subject to the terms and conditions applicable to the admission of other members, persons who have been members of any other medical scheme for at least two years and whose applications for membership are made within three months of ceasing to be members of the other medical scheme, will be admitted without waiting periods or the imposition of new restrictions, provided a certificate of membership is furnished.
2. Membership cards are not accepted – membership certificates must be provided.
3. In the case of new beneficiaries who have not been members of any medical scheme for two years, or have had a break between membership of medical schemes of more than three months, the following waiting periods will apply:

   General waiting periods (all benefits) - three months

   Condition-specific waiting period - if applicable, 12 months for any pre-existing conditions

4. Late joiner penalties may apply
   4.1. Medical schemes may apply contribution penalties to a late joiner (beneficiaries over the age of 35) and such penalties must be applied only to the risk portion of the contribution related to the member or any adult dependants.
   4.2. Contribution penalties shall not exceed the following bands:

Penalty Bands	Maximum Penalty
1 - 4 years	5% x contribution
5 - 14 years	25% x contribution
15 - 24 years	50% x contribution
25 + years	75% x contribution

   4.3 Calculation of late joiner penalties are based on the number of years that the beneficiary has not had medical scheme coverage.

5. This rule does not apply to any member or dependant who has been involuntarily transferred. This includes members who are disabled due to trauma, divorced, retrenched, relocated, dismissed and other reasons reviewed on an adhoc basis by SAB Medical Aid. Underwriting will apply if the application is considered anti-selection or a voluntary transfer.
6. Should you wish to apply with no underwriting, you may opt to join from 1 January of the new year. Proof of previous medical scheme cover is required.

13. Third party Bank details

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

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

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

JOINT ACCOUNT

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

COMPANY ACCOUNT

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

TRUST ACCOUNT

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

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