

1. About yourself (main applicant) (continued)

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

Suite Postnet Suite Number

PO Box Private Bag Box number

Suburb Postal code

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

Physical address:

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

2. Regular dependant/s – only to be completed if you are adding a spouse, domestic partner, civil union partner, a child or a dependant grandchild

Please notify Bankmed within 30 days of any event which alters the eligibility of your registered dependant/s, i.e. if you get divorced or if you and your domestic partner separate/are no longer living together.

If you are registering a spouse/civil union partner, please attach a copy of your marriage certificate or proof of civil union.

If you are registering a newborn baby, please attach a copy of the birth certificate.

If you are registering a domestic partner, please complete and sign the Domestic Partner Declaration at the end of this section.

If you are registering a grandchild in respect of whom you are liable for family care and support, please complete and sign the Grandchild Declaration at the end of this section.

If you are registering a child or grandchild who is 27 years or older, you will need to demonstrate that you are liable for his/her family care and support in that he/she:

- is unable to support himself/herself and is financially dependent on you for family care and support (please attach an affidavit setting out details of his/her monthly income and your regular contribution to his/her living expenses); or

- is dependent on you due to mental or physical disability (please attach a medical report); or

- is a student at a registered tertiary institution and is financially dependent on you for family care and support (please attach proof of registration or an affidavit).

“Child” means your child, stepchild, legally adopted child, foster child, or a child who has been placed (or is in the process of being placed) in your custody or in the custody of your partner/spouse. Proof of dependence must be supplied annually for children (including grandchildren) who are 27 years or older. Adult contribution rates apply from the time a dependent child (or grandchild) turns 23.

Initial/s	Surname	Full name/s	Date of birth (DD/MM/YYYY)	Gender	Monthly Income (Compulsory)	Relationship (e.g. spouse, partner, grandchild)	ID number or passport number (attach copy)

DOMESTIC PARTNERSHIP DECLARATION - ONLY TO BE COMPLETED IF YOU ARE REGISTERING A DOMESTIC PARTNER

I, _____ (your name and surname) declare that I have established a domestic partnership with _____ (your domestic partner’s name and surname) and that we have been living together since _____ (date). I declare that we intend to continue living together indefinitely, and I undertake to inform Bankmed within 30 days in the event of termination of this domestic partnership.

Signed by me _____ (your signature) on this ____ day of _____ (month) _____ (year).

GRANDCHILD DECLARATION - ONLY TO BE COMPLETED IF YOU ARE REGISTERING A GRANDCHILD WHO IS DEPENDANT ON YOU FOR FAMILY CARE AND SUPPORT

I, _____ (your name and surname) declare that any grandchild included in this application is financially dependent on me for family care and support.

Signed by me _____ (your signature) on this ____ day of _____ (month) _____ (year).

3. Special dependant/s – only to be completed if you are adding a parent, parent-in-law, parent of a civil union partner or a brother/sister who is dependent on you for family care and support

PLEASE DO NOT cancel the existing membership of a special dependant with their current medical scheme (if applicable) before you have received confirmation that he/she qualifies as your dependant on Bankmed.

Please complete and sign the Special Dependand Declaration at the end of this section, regarding your special dependant/s.

Initial/s	Surname	Full name/s	Date of birth (DD/MM/YYYY)	Gender	Monthly Income (Compulsory)	Relationship to main member (e.g. mother, brother, father-in-law)	ID number or passport number (attach copy)

- Nephews and nieces are not eligible as dependant/s, unless they are in your foster care or legal guardianship exists (attach proof)
- Grandparents do not qualify as dependant/s

SPECIAL DEPENDANT DECLARATION – ONLY TO BE COMPLETED IF YOU ARE REGISTERING SPECIAL Dependand/s

I, _____ (your name and surname) declare that any special dependant indicated in the table above is unable to support himself/herself financially and that he/she is dependent on me for family care and support.

I declare that his/her income as declared in this application form is a true and accurate reflection of his/her regular monthly income from all sources.

I undertake to notify Bankmed in writing should any special dependant as registered on Bankmed, no longer be financially dependent on me for family care and support.

I accept that dependent membership of a special dependant will terminate in the event the requirements for registration as a special dependant are no longer being satisfied.

Signed by me _____ (your signature) on this ____ day of _____ (month) _____ (year).

I am aware that Bankmed reserves the right to impose waiting periods on any special dependant included in this application.

A three-month general and/or 12-month condition-specific waiting period (nine months in respect of an existing pregnancy) may be imposed if:

- the beneficiary was without medical scheme cover for three months or more, immediately preceding this application to join Bankmed
- the beneficiary was on a previous medical scheme for less than two years and applied to join Bankmed within three months of ending membership of the previous scheme (12-month condition-specific waiting period only)
- the beneficiary was on a previous medical scheme for two or more years and applied to join Bankmed within three months of ending membership of the previous scheme (three-month general waiting period only).

Bankmed will notify me in writing within one month of registration, should any of these waiting periods apply to me and/or any of my registered dependant/s, based on the information provided in this application.

I am aware that a penalty may be added to the monthly contribution payable to Bankmed in respect of any special dependant as per this application form, who is 35 years or older at the time of this application and was not registered as a member or dependant on a registered medical scheme on 1 April 2001 and/or has (at any time) been without medical scheme cover for a period of three or more consecutive months since 1 April 2001.

Bankmed will notify me in writing within one month of registration, of any penalties that may apply, based on the information provided in this application.

NAME

Original hand signature required

SIGNATURE

Y	Y	Y	Y	M	M	D	D
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DATE

4. Please select your Plan

Bankmed Plan: Essential Plan Basic Plan Core Saver Plan Traditional Plan Comprehensive Plan Plus Plan

You have the right to request assistance in selecting a health plan that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the Plan you select.

Should you select a Plan with a Medical Savings Account (Core Saver, Comprehensive or Plus Plan), the "above tariff" portions are not automatically funded from your available Medical Savings Account. Should you wish for "above tariff" portions to be paid from your Medical Savings Account, please mark with an "X". Yes No

7. Previous medical scheme details (continued)

Please give us the details of all registered medical schemes to which you previously belonged. We will use this information to determine whether we need to apply any waiting periods, late-joiner penalty fees or both. Kindly supply us with proof in the form of a membership certificate.

Main applicant

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

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

If any of your regular dependant/s applying for cover belonged to different medical schemes, please add their details below:

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

If any of your special dependant/s applying for cover belonged to different medical schemes, please add their details below:

Special dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Y Y Y Y M M D D	Y Y Y Y M M D D	Yes <input type="checkbox"/> No <input type="checkbox"/>	

8. Your health questions

Treating healthcare professional's name

Telephone

The main applicant, spouse or partner and all dependant/s applying for cover need to complete section 8.

Have you or **any dependant** in this application ever experienced, been treated for, or are currently suffering from any of the following symptoms, conditions or disorders? (Examples of conditions, symptoms or disorders are listed under each question). These are only examples and not the full list of conditions, symptoms or disorders. Please include any 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 thereof 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.bankmed.co.za

8.1 Tumours and growths

Yes No

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

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

8.2 Heart and circulatory conditions

Yes No

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

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

8.3 Gynaecological and obstetrics conditions

Yes No

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

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

8. Your health questions (continued)

8.4 Are any of your dependant/s pregnant?

Yes No

Patient name	
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8.5 Mental health

Yes No

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

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

8.6 Metabolic or endocrine conditions

Yes No

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

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

8.7 Abdominal conditions

Yes No

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

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

8.8 Brain and nerve conditions

Yes No

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

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

8.9 Breathing and respiratory conditions

Yes No

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

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

8.10 Musculoskeletal (back, bone and muscle pain)

Yes No

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

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

8.11 Kidney or urinary conditions including current or past dialysis

Yes No

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

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

8. Your health questions (continued)

8.12 Blood conditions

Yes No

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

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

8.13 Eye conditions

Yes No

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

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

8.14 Ear, nose and throat (ENT) and dentistry conditions

Yes No

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

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

8.15 Male urogenital conditions

Yes No

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

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

8.16 Are you or any of your dependant/s expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months?

Yes No

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

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

Yes No

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

8.18 Have you or any of your dependant/s been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application?

Yes No

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

HIV and AIDS

You do not need to disclose your HIV status nor that of your dependant/s on this form if you do not feel comfortable doing so. However, should you, or one or more of your dependants, be HIV positive, you or they must call us on 0800 226 5633 within seven working days from the date that your Bankmed membership is activated. We treat this information in the strictest confidence. If you, or one or more of your dependants, are HIV positive, it is in your/their interest to register on our HIVCare Programme. A 12-month condition-specific waiting period may however apply. When you call in to register on the HIVCare Programme, kindly confirm these details.

9. Bankmed Privacy Statement

This document reflects the Privacy Statement for Bankmed, administered by Discovery Health (Pty) Ltd.

1. Application of requirements of the Protection of Personal Information Act ("POPI")

1.1. This Privacy Statement explains how Bankmed and its administrator and managed care service provider (currently Discovery Health (Pty) Ltd) (we/us) obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPIA"). Any other party, including the administrator and managed care service provider, that may have access to your Personal Information via Bankmed, is prohibited from using such information for any other purpose not approved by Bankmed. The administrator and managed care service provider, in particular, can only use the information strictly in compliance with the agreement between Bankmed and the administrator and managed care service provider.

1.2. Please note:

- We may amend this Notice from time to time. Please check our website periodically to remain informed of any changes;
- You have the right to object to the processing of your Personal Information;
- Should you believe that we have utilised your Personal Information contrary to applicable law, you shall first resolve any concerns with us. Should you not be satisfied with the process, you have the right to lodge a complaint with the Information Regulator, under POPIA.

1.3. Any information, including Personal Information relating to yourself and your dependents and/or beneficiaries, supplied to us or collected from other sources ("Your Personal Information") will be kept confidential.

- You confirm that when you provide us with your Personal Information, your dependant/s and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes. In the event that you are providing information and signing consent on behalf of a minor (person younger than 18 years old) you confirm that you are a competent person and authorised to do so on their behalf.
- You understand that when you include your spouse and/or dependents on your application, we will process their personal information for the activation of the policy/benefit and to pursue their legitimate interest. We will furthermore process their information for the purposes set out in this Privacy Statement.

1.4. You agree to our processing and disclosing Your Personal Information in the following manner:

We may collect, collate, process, store and disclose your Personal Information:

- For the administration of your health plan;
- For the provision of managed care services to you or any dependant/s on your health plan;
- For the provision of 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;
- In the event of any member ceasing to be a member, any amount still owing by such member in respect of himself or his dependants shall be a debt due to the Scheme and recoverable by it. Therefore, for the provision of information to a contracted third party who performs a debt collection service to the Scheme, where you owe the Scheme an outstanding debt;
- To profile and analyse risk;
- For academic research only where this is specifically approved by Bankmed.

Examples of how this will happen includes:

a. Obtaining Your Personal Information from other relevant sources, including any entity that is related to the administrator, medical practitioners, contracted service

providers, employers, 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. This, amongst other things, will allow the Scheme and the administrator (although to a limited extent) to ensure that a member is not a member of more than one medical scheme as this is prohibited by the Medical Schemes Act;

- b. Communicating with you regarding 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 selected;
 - c. Transferring your Personal Information outside the borders of the Republic of South Africa where appropriate, if you provide an e-mail address which is hosted outside the borders of South Africa, or for processing, storage or academic research (where such research is specifically approved by Bankmed). We will ensure that anyone to whom we pass your Personal Information agrees to treat your information with the same level of protection as we are obliged to;
 - d. Utilising 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.
- 1.5. We may process your information using automated means (without human intervention in the decision making process) to make a decision about you or your application for any product or service. You may query the decision made about you.
- 1.6. 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.
- 1.7. Should you wish to share your information for any other reason, we will do so only with your permission.
- 1.8. You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Access Request Form' on www.bankmed.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your Personal Information. Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.
- 1.9. You have the right to contact and ask us to update, correct or delete your Personal Information. Bankmed and its administrator have the right to communicate with you electronically about any changes on your health plan, including your contributions or changes to the benefits you are entitled to on the health plan you have chosen.
- 1.10. 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). Where we cannot delete your personal information, we will take all practical steps to depersonalise it.
- 1.11. Bankmed and its administrator and managed care service provider 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 the administrator and managed care service provider only:
 - Financial Advisory and Intermediary Services Act, 2002
 - Companies Act, 2008

9. Bankmed Privacy Statement

This document reflects the Privacy Statement for Bankmed, administered by Discovery Health (Pty) Ltd. (continued)

- 1.12. You agree that Bankmed and its administrator 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, only where this is specifically approved by Bankmed; 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).
- 1.13. Bankmed may change this Privacy Statement at any time. The current version is available on the Bankmed website (www.bankmed.co.za). Scroll to the bottom of the webpage once you have logged in and select the "Legal" tab. Alternatively, you may click on this link to access the document: <https://www.bankmed.co.za/assets/medical-schemes/bankmed/bankmed-fair-collections-notice-final.pdf>

- 1.14. If you believe that Bankmed or its administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulatory, under POPIA, but we encourage you to first follow our internal complaints process to resolve the complaint. We explain the complaints and disputes process on the Bankmed website. You may click on this link to access the complaints and escalations process: https://www.bankmed.co.za/medicalschemes_za/bankmed/web/health/linked_content/documents/latest_info/complaints_and_escalations.pdf
- If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator, under POPIA. Contact details for the Information Regulator are:
The Information Regulator (South Africa)
SALU Building
316 Thabo Sehume Street
PRETORIA
Ms Mmamoroke Mphelo
Tel: 012 406 4818
Fax: 086 500 3351
infoereg@justice.gov.za

Signature of main applicant

Original hand signature required

Date

2	0	Y	Y	M	M	D	D
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The main applicant must sign and date any changes

10. Bankmed rules for membership

10.1 Who "we" are

Bankmed, registration no 1279, registered with the Council of Medical Schemes.

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

10.2 Rules for membership

The Bankmed rules records your rights and responsibilities pertaining to your membership of Bankmed. They may change from time to time. You may ask us for a copy at any time. When you sign this application, you confirm that you have read and understood the rules and you agree that you and, those for whom you apply, will be bound by them. Where applicable you also acknowledge and confirm that the financial adviser, you or your employer appointed, may communicate with us on this application and your membership to Bankmed. You give permission that we may share your medical information and other relevant personal information about you and your dependant/s with your chosen financial adviser. 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 financial adviser or one of our consultants should there be anything you do not understand.

10.3 Who you may apply for

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

10.4 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 for whom you are applying in any matter relating to this application.
- you have received permission from your spouse and any dependant/s over 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.

10.5 Giving and obtaining information

You must provide true, correct and complete information

To consider your application for membership, Bankmed 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 and 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 ensure we have the correct address for you.

Bankmed and Discovery Health (Pty) Ltd may record telephone calls

We 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 obtain 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 Bankmed, is true, correct and complete.

You give your permission that we may obtain any information that is relevant to your application and membership from your employer.

Inform us immediately if your information changes

You, your employer or your financial adviser 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. We require advance notice of any administrative changes such as cancellation of membership, as we cannot accept backdated changes.

When Bankmed may suspend or terminate your membership/s

Bankmed may suspend or terminate any memberships immediately, should the member or dependant/s on the membership be found guilty of abuse of privilege of the Scheme. It is very important for the member and dependant/s to provide true, correct and complete information on the application form and in their dealings with the Scheme.

10.6 Becoming a member

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

Bankmed may have waiting periods that apply in certain circumstances. This means there may be a set time period before Bankmed begins paying for any general or specific medical conditions. Please speak to your financial adviser 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 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 for whom you are applying must resign from your current medical schemes when you receive notice from Bankmed by letter, e-mail or SMS informing you that you and those for whom you have applied have been accepted.

You must ensure contributions are paid on time

As the main Bankmed member, you are responsible for ensuring that your contributions and the contributions of those for whom you are applying 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.
- suspend/ terminate membership if the contributions are in arrears.

10.7 Repaying money owed to the Scheme

Bankmed 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.

You must repay any medical savings owing should you leave Bankmed.

Once you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the 'Medical Savings Account'. Should you leave Bankmed before the year is up, you must repay the portion of medical savings you have utilised that is more than you have paid back to Bankmed over the year.

Signature of main applicant

Original hand signature required

Date

2	0	Y	Y	M	M	D	D
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**The main applicant must sign and date any changes.
Please do not sign an incomplete application form.**