Bankmed
Yours in good health

Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Applying to become a member of Bankmed in 2020

This document is a membership application form.
It also contains some rules for membership. Please make sure you read and understand these rules.

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, is the medical scheme to whom you are applying to become a member. This is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the rules for membership (section 10).
3. Please make sure the main applicant signs section 9 and 10 and dates any changes.
4. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

Please submit completed forms (signed and stamped by the employer/authorised company signatory) as follows:

ABSA Employees: E-mail pmabsateam@bankmed.co.za or fax 011 539 3000

FNB Employees: E-mail pmfnbteam@bankmed.co.za or fax 011 539 3000

SBSA Employees: E-mail pmsbsateam@bankmed.co.za or fax 011 539 300

Employees of any other banks and /or non-banking officials: E-mail application@bankmed.co.za or fax 011 539 3000

Once you send us your application form, the following will take place:

- Should any details be missing or should we require more information for underwriting purposes, we will contact you.
- We will activate your membership and send you a letter of confirmation when we are offering standard terms of acceptance. Where 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 a welcome letter, SMS or an e-mail to let you know when your application has been fully and completely submitted. This date may differ from the date on which you sign the application form.
- You will then receive a pack in the post or this may be handed to you by your employer contact.

If you do not hear from us within seven days after sending us your application form, please contact us on 0800 BANKMED (0800 226 5633).

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.

1. About yourself (main applicant)

Title		Initials		Surname	
First name(s) (as per document)					
Preferred name		Sex	M F	Date of birth	Y Y Y Y M M D D
Previous or maiden name					
Occupation				Tax number	

Where an e-mail address has been provided, electronic communication will be the default unless otherwise indicated.

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ID or passport number | | Country of issue |

Telephone (H) | | (W) |

Cellphone | | Fax |

E-mail |

Please indicate your gross monthly salary with a “x”

Income (R)	S1	S2	S3	S4	S5	S6	S7
	0 - 5 000	5 001 - 6 000	6 001 - 7 000	7 001 - 8 000	8 001 - 9 000	9 001 - 10 000	10 001+

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

☐ Suite ☐ Postnet Suite Number

☐ PO Box ☐ Private Bag Box number

Suburb Post 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/s 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)

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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 a dependent 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 Dependant 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 Principal Member (e.g. spouse, partner, grandchild)	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 DEPENDANT/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 dependant 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.

		Y Y Y Y M M D D
	Original hand signature required	
NAME	SIGNATURE	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 ☐

If you wish to receive unlimited GP visits, you must nominate a primary and secondary GP. Please place their information below. (This should be completed by Basic and Essential Plan members only):

	Name	**Primary GP name**	**Practice number**
Spouse or partner			
Dependent/s 1			
Dependent/s 2			
Dependent/s 3			
	Name	**Secondary GP name**	**Practice number**
Spouse or partner			
Dependent/s 1			
Dependent/s 2			
Dependent/s 3			

5. About your employer

Please ask your employer to complete this section.

Cover start date Y Y Y Y M M D D

Name of employer

Employer or billing number

Applicant's employee number

Date of employment Y Y Y Y M M D D

Branch name

Branch number

Physical address

Telephone

Fax

Employer e-mail address

Personnel officer

Signature of Personnel Officer
Payroll Stamp

Designation

Date Y Y Y Y M M D D

6. Your banking details

6.1 Your contributions

Should you be paying your contributions in full or in part, please complete this section:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code

Account number

Type of account ☐ Cheque ☐ Savings

Accountholder

Signature of accountholder

Original hand signature required

6.2 Your claims refund

May we use the same account from which contributions are deducted in order to refund your claims? Yes ☐ No ☐

If you do not wish to use the same banking details for your contributions and claims refunds, please provide us with the details you wish to use:

Please note: we cannot accept credit card account details

Bank name

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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 selected bank account, Bankmed will not be responsible in any way for the amounts refunded.

7. Previous medical scheme details

Are your dependant/s currently on another medical scheme? Yes ☐ No ☐

If you have ticked "Yes", have they given notice of termination to their current medical scheme? Yes ☐ No ☐

If "Yes", please attach a certificate of membership from that medical scheme reflecting the end date of membership. We cannot finalise this application without this.

If "No", please give the required notice to the current medical scheme before submitting this application, and attach a certificate of membership from that medical scheme indicating the end date of membership. We cannot finalise this application without this.

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

Dependant/s name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

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/s name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

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
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

8. Your health questions

The 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, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		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, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

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

8.3 Gynaecological and obstetrics conditions

Yes ☐ No ☐

Example: abnormal Pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed periods, ovarian cyst.

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

8.4 Are you or any of your dependants pregnant or undergoing treatment/investigation for pregnancy?

Yes ☐ No ☐

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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, 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, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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 (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, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), 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, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		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, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, Parkinson’s disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, vetriculo-peritoneal shunt (VP shunt), mental retardation, CVA, bleeding on the brain.

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

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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 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, gout, fractures, physical disability, prosthesis, amputation.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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, bladder infections, other bladder or kidney problems.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders.

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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, 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, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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: 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, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		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, tumours, undescended testes, phimosis, urinary incontinence, retention.

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

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

Patient name	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment taken
		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 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 BANKMED (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 best interest 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.

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

9.1.1. 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"), 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. 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.

9.1.2. 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.

9.1.3. Please note:

9.1.3.1. We may amend this Notice from time to time. Please check our website periodically to remain informed of any changes;

9.1.3.2. You have the right to object to the processing of your Personal Information;

9.1.3.3. 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.

9.1.4. 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.

9.1.4.1. 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 do so on their behalf.

9.1.4.2. 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.

9.1.4.3. 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 a member or his/her dependant may suffer because of any unauthorised use of the member’s or dependant’s personal information, or if a breach of the member’s or dependant’s personal information occur, but only if the processing of that personal information is controlled by that party.

9.1.5. 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:

9.1.5.1. For the administration of your health plan;

9.1.5.2. For the provision of managed care services to you or any dependant/s on your health plan;

9.1.5.3. 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;

9.1.5.4. 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;

9.1.5.5. To profile and analyse risk;

9.1.5.6. For academic research only where this is specifically approved by Bankmed.

9.1.5.7. Examples of how this will happen includes:

9.1.5.7.1. Obtaining your Personal Information from other relevant sources, including any entity that is related to the administrator, medical practitioners, contracted service providers, health information exchanges, 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;

9.1.5.7.2. 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;

9.1.5.7.3. 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;

9.1.5.7.4. 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.

9.1.6. 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.

9.1.7. 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.

9.1.8. You consent and agree that:

9.1.8.1. We may process your information, including personal and special personal information, to conduct sanction screening against all mandatory and non-mandatory sanctions lists and to perform transaction monitoring activities;

9.1.8.2. We may communicate such personal information to local and international Regulatory Bodies if you are matched to one of these sanctions lists.

9.1.9. Should you wish to share your information for any other reason, we will do so only with your permission.

9.1.10. 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.

9.1.11. 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.

9.1.12. 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.

9.1.13. Bankmed and its administrator and managed care service provider are required to collect and retain information in terms of the following legislation (amongst others):

9.1.13.1. The Medical Schemes Act, 1998

9.1.13.2. The Consumer Protection Act, 2008

9.1.13.3. The Protection of Personal Information Act, 2013

9.1.13.4. Electronic Communications and Transactions Act, 2002
9.1.13.5. Promotion of Access to Information Act, 2000
9.1.13.6. Legislation specific to the administrator and managed care service provider only:
9.1.13.7. Financial Advisory and Intermediary Services Act, 2002
9.1.13.8. Companies Act, 2008

9.1.14. You agree that Bankmed and its administrator may transfer your personal information outside South Africa:
9.1.14.1. if you give us an email address that is hosted outside South Africa; or
9.1.14.2. for processing, storage or academic research, only where this is specifically approved by Bankmed; or
9.1.14.3. 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).

9.1.15. Bankmed may change this Privacy Statement at any time. The current version is available on the Bankmed website (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

9.1.16. 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

Call: 012 406 4818
Fax: 086 500 3351
inforeg@justice.gov.za

10. Bankmed rules for Membership

10. 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 with 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 your dependants – 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. If you pay your own contribution, you will be able to identify the debit order for your monthly contributions on your bank statement, the reference number BANKMEDCON will be used. 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. You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number BANKMEDCLA will be used.

11. Debit order mandate

This signed authority and mandate refers to the application on the signed date (‘’the Agreement’’)

I, the undersigned:

- Warrant that the account information I have provided above is an account in my name and that the information furnished by me/us in this Authority and Mandate is true and correct;
- Authorise Bankmed Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by Bankmed Medical Scheme 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 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 cover starts as requested on the application form and shall continue until this Authority and Mandate is terminated by me by giving Bankmed Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to 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 membership is not activated in time for the debit order collection and there is an amount outstanding Bankmed Medical Scheme can collect that amount in the interim, upon activation. If I change the date of the debit order after activation, 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 Bankmed Medical Scheme 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 Bankmed Medical Scheme as if each payment instruction came from me personally as the account holder.
- Undertake to advise Bankmed Medical Scheme in writing of any changes to my account details and acknowledge that Bankmed Medical Scheme 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 Bankmed Medical Scheme 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 authorized will be processed through a computerized 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 Bankmed Medical Scheme whilst this Authority and Mandate was in force if such premiums or amounts were legally owing to Bankmed Medical Scheme in terms of the Agreement;
- Acknowledge that by signing this Authority and Mandate I am bound by the payment terms applicable to this Agreement.

Signature of main applicant

Date Y Y Y Y M M D D

Original hand signature required

The main applicant must sign and date any changes
Please do not sign an incomplete application form