

Contact details

Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • www.engenmed.co.za

Application to add dependants

Complete this form if you want to add dependants to your Engen Medical Benefit Fund membership

Who we are

Engen Medical Benefit Fund (referred to as 'the Fund'), registration number 1572, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the terms and conditions for membership (section 8).
3. Sign the application form.
4. You, as the main member must sign and date any change made to this form.
5. Your HR department must email it to application@engenmed.co.za.
6. Please attach a copy of each dependant's identity document to this application form. We also accept valid passports and birth certificates for children.
7. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.

Once you submit 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.
- We will send you a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made.
- We will send you, 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 set of updated membership cards.
- You can also find the latest version of the card on the Discovery App.

If you do not hear from us seven days after sending your application form, please contact us on **0860 100 345** or your local HR office.

When you sign this application, you confirm that you have read and understood the terms and conditions (Section 8 of this form) of the Fund. You can find a copy of the Rules at www.engenmed.co.za.

1. About the main member

Membership number	<input type="text"/>
ID or passport number	<input type="text"/>
Member's name	<input type="text"/>
Member's surname	<input type="text"/>

Physical address

Unit/Suite number	<input type="text"/>	Complex name	<input type="text"/>
Street number	<input type="text"/>	Street name	<input type="text"/>
Suburb	<input type="text"/>		
City	<input type="text"/>	Postal code	<input type="text"/>

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

<input type="checkbox"/> PO Box	<input type="checkbox"/> Private Bag	Box number	<input type="text"/>																		
<input type="checkbox"/> Suite	<input type="checkbox"/> Postnet Suite	Number	<input type="text"/>																		
Suburb	<input type="text"/>															Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Please choose a date you want cover to start for all dependant/s you are applying for. This date must be the same for all your dependant/s applying for cover.

Cover start date

D	O	D	1	M	M	Y	Y	Y	Y
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2. Adding a spouse or partner (if applying for cover)

Only complete this section if you are adding a spouse or partner.

Title	<input type="text"/>	Initials	<input type="text"/>								
Surname	<input type="text"/>										
First name(s) (as per identity document)	<input type="text"/>										
Previous or maiden name	<input type="text"/>										
ID or passport number	<input type="text"/>										
Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of birth <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Race	African <input type="checkbox"/>	Coloured <input type="checkbox"/>	Indian / Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Do not want to disclose <input type="checkbox"/>								
<i>You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.</i>											
Marital status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>								
Date of marriage to main applicant (where applicable). Please attach a copy of an official certificate	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>			D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Telephone (H)	<input type="text"/>	<input type="text"/>	Telephone (W) <input type="text"/>								
Cellphone	<input type="text"/>	<input type="text"/>									
Personal email	<input type="text"/>										

Addition of spouse to an existing membership

If addition of spouse or partner to an existing membership is:

- As a result of a legal and registered marriage within the last three months, an official certificate must accompany this application form to avoid underwriting.
- For a spouse married for a period of more than three months, full underwriting will apply

3. Adding an adult dependant or child (applying for cover)

Complete this section with their details if you are adding a child or adult dependant.

Dependant 1

Title	<input type="text"/>	Initials	<input type="text"/>								
Surname	<input type="text"/>										
First name(s) (as per identity document)	<input type="text"/>										
ID or passport number	<input type="text"/>										
Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of birth <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Race	African <input type="checkbox"/>	Coloured <input type="checkbox"/>	Indian/Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Do not want to disclose <input type="checkbox"/>								

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

Relationship to main member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child. Please supply legal proof or an affidavit confirming that you are responsible for family care and support of the dependant.)

6.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breastYes No

Example: 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	Medication used for this condition and dosage	Date of last treatment

6.2 Heart and circulation conditionsYes 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, deep vein thrombosis, pulmonary embolus, varicose veins.

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

6.3 Gynaecological and obstetrics conditionsYes 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	Medication used for this condition and dosage	Date of last treatment

6.4 Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or difficulty falling pregnant?Yes No

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

6.5 Mental healthYes No

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (like 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	Medication used for this condition and dosage	Date of last treatment

6.6 Metabolic or endocrine conditionsYes 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	Medication used for this condition and dosage	Date of last treatment

6.7. Abdominal conditionsYes No

Example: hepatitis, cirrhosis, portal hypertension, liver disease, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, ulcerative colitis, Crohn's disease, diverticulitis, constipation, any autoimmune conditions, any congenital conditions

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

6.8 Brain and nerve conditionsYes 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), Intellectual disability, CVA, bleeding on the brain, any autoimmune conditions, any congenital conditions.

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

6.9 Breathing and respiratory conditionsYes No

Example: asthma, ventilator, oxygen therapy, CPAP, 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	Medication used for this condition and dosage	Date of last treatment

6.10 Musculoskeletal (back, bone, injury and muscle pain)Yes No

Example: arthritis (any form), ongoing/ intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis and internal insertion of surgical implants, amputation, any autoimmune conditions, any congenital conditions.

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

6.11 Kidney or urinary conditions including current or past dialysisYes No

Example: kidney and/or renal failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty 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	Medication used for this condition and dosage	Date of last treatment

6.12 Blood conditionsYes No

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions, varicose veins.

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

6.13 Eye conditionsYes No

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, 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	Medication used for this condition and dosage	Date of last treatment

6.14 Ear, nose and throat (ENT) and dentistry conditionsYes 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	Medication used for this condition and dosage	Date of last treatment

6.15 Male urogenital conditionsYes No

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), 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	Medication used for this condition and dosage	Date of last treatment

6.16 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	Medication used for this condition and dosage	Date of last treatment

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

6.18 Have you or any of your dependants been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side effects 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	Medication used for this condition and dosage	Date of last treatment

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0800 001 615** within seven working days from the date we activate your Engen Medical Benefit Fund membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme. Engen Medical Benefit Fund may have waiting periods that apply in certain circumstances. This means there may be a set time period before Engen Medical Benefit Fund starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. If you do not let us know about you or your dependants HIV status within 7 days of your membership being active, we may end your Engen Medical Benefit Fund membership.

7. Privacy Statement 2025**Definitions**

The Fund refers to Engen Medical Benefit Fund ("the Fund"), registration number 1176, registered with the Council for Medical Schemes.

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

We, us, our refer collectively to the Fund and the Administrator.

You and your refer to:

- the member and the dependants on the Fund, which may include your spouse, children and other dependants, collectively "your dependants".

Your personal information includes information about race, gender, sex, pregnancy, biometrics, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and date of birth of the individual amongst other things.

Process(ing) (of) information means the lawful and reasonable automated or manual activity of collecting, recording, organising, using, storing, updating, distributing and removing or deleting personal information to ensure that such processing is adequate, relevant and not excessive given the purpose for which it is processed.

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.

How we will process and disclose your personal information and communicate with you

Part 1: Introduction

1. 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.
2. This Privacy Statement applies to you if you engage with us physically through our offices, or virtually through our website (<https://www.engemed.co.za>), email and mobile applications such as the Discovery App, social media platforms, over the phone, or otherwise as may be the case from time to time.
3. When you engage with us, you entrust us with personal information about you.
4. We are committed to protecting your right to privacy. We will keep your personal information confidential. We are serious about protecting your personal information and continue to develop and update our security systems, processes and data governance policies.
5. 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. Thus, your personal information comprises information you may have given to us yourself or we may have collected from other sources.
6. You have the right to object to the processing of your personal information and have a choice whether or not to accept these terms and conditions. However, it is important to note that we require your acceptance to activate and service your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your membership of the Fund.
7. You understand and/or acknowledge that when you include your dependants on your application, we will process their personal information for the activation of the benefit and to pursue their legitimate interest. By submitting your dependants' relevant personal information, you hereby confirm that you are duly authorised to share such information with us.
8. If you are giving consent for a person under 18 (a minor) you confirm that you are their parent or legal their parent or legal guardian and that you give consent for us to process their personal information for the purposes covered in this Privacy Statement.
9. If you share your personal information with any third parties, we will not be responsible for how they use this information nor be responsible for any loss suffered by you.

Part 2: Applying for and administering your membership

10. You understand, accept and consent that we may process your personal information for the following purposes:
 - 10.1. to verify the accuracy, correctness and completeness of any information provided to us in the course of processing an application for membership or providing services related to the membership;
 - 10.2. for the administration of your benefit option;
 - 10.3. for the provision of managed care services to you on your benefit option;
 - 10.4. for the provision of relevant information to a contracted by the Scheme and/or its administrator who requires this information to provide a healthcare service to you on your benefit option;
 - 10.5. to profile and analyse risk;
 - 10.6. to share your personal information with external healthcare providers for them to assess or evaluate certain clinical information, when you are subject to such a clinical assessment; and/or
 - 10.7. to investigate and/or remedy fraud, waste and abuse.
11. By signing this application form, you expressly consent that, for purposes of processing your application for membership, underwriting, determining contributions, collections of funds due to the Fund from you, and/or any other matter relevant to administering your membership to the Fund we can obtain and share information about your creditworthiness, or the creditworthiness of any payer of your contribution. This includes information about credit history, financial history, judgments, default history and sharing of information for purposes of risk analysis, tracing and any related purposes.
12. Examples of who we will obtain and share your personal information for the above purposes include but is not limited to:
 - 12.1. All relevant sources, including medical practitioners, contracted service providers, credit bureaus, or industry regulatory bodies ("relevant 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 relevant sources that your personal information is true, correct and complete;
 - 12.2. If you have joined as a member of an employer group, getting from and sharing with your employer information that is relevant to your application;
 - 12.3. Communicating with you about any changes to your benefit option, including your contributions or changes and enhancements to the benefits you are entitled to on the benefit option you have chosen;
 - 12.4. Transferring your personal information outside the borders of the Republic of South Africa where appropriate, or if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research.
 - 12.5. Sharing your personal information to be processed by healthcare providers via a health information exchange to improve members' treatment and healthcare outcomes.
13. We have the right to communicate with you electronically about any changes on your benefit option, including your contributions or changes and improvements to the benefits you are entitled to.
14. We may process your personal and/or depersonalised information for the following purposes:
 - 14.1. for research and analysis; or
 - 14.2. to support the early identification of medical conditions and/or other lifestyle risks and to encourage you to change your lifestyle to lessen the impact of such conditions; or

- 14.3. to provide personalised advice to you about risks to your health, how you may become healthier (such as by seeing a healthcare practitioner, having additional tests done or activating benefits) and the rewards and incentives which you may receive as a result of undertaking these activities. We will provide this advice to you based on market and behavioural research and analysis carried out using your personal, special and or depersonalised information. We may communicate this advice to you using the Discovery App or other communication channels.
15. 15. You agree that we may transfer your personal information outside South Africa only:
- 15.1. if you give us an email address that is hosted outside South Africa; or
- 15.2. to administer certain services, for example, cloud services.
16. When we share your information, we will ensure that the company, person or regulatory body (in or outside of South Africa) whom we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to.

Part 3: Sharing your information with third parties

17. 17. If a third party asks us for any of your personal information, we will share it with them only if:
- 17.1. you have already given your consent for the disclosure of this information to that third party; or
- 17.2. we have a legal or contractual duty to give the information to that third party.
18. 18. We will provide your personal information to any Discovery Limited entity for the following purposes only:
- 18.1. to allow for the administration of your profile/membership/plan with the entity with whom you or your dependant/s already have a relationship; or
- 18.2. where you or your dependant/s have applied for a product, service or benefit from such an entity for the purposes of underwriting.
19. Your personal information may be shared with third parties such as academics and researchers, including those outside South Africa. We ensure that the academics and researchers will keep your personal information confidential and all data will be made anonymous to the extent possible and where appropriate. No personal information will be made available to an academic or research party unless that party has agreed to abide by strict confidentiality protocols that we require. If we and/or the academic and researcher publish the results of this research, you will not be identifiable.

Part 4: Your Consent

20. You consent and agree to the terms and conditions set out above and that:
- 20.1. we may process your information, including personal and special personal information, for the purposes set out above and understand that in doing so we are required to adhere to South African legislative reporting obligations and to perform transaction monitoring activities;
- 20.2. we may communicate such personal information to local regulatory bodies as well as to other relevant governance structures of Discovery Health if any Legislative reportable matters are identified.
21. We may process your information using automated means (without human intervention in the process) to make a decision about you or your application for membership of the Fund. You may query the decision made about you.
22. We will not use your data in electronic marketing campaigns.
23. Unless required by law to keep your personal information for a certain period of time or purpose, you agree that we may keep your personal information until you ask us to delete or destroy it. You have the right to ask us to update, correct or delete your personal information, unless the law requires us to keep it. Where we cannot delete your personal information, we will take all practical steps to de-identify it, and for purposes of proof, retain a secure copy of your request.
24. If we become involved in a proposed or actual amalgamation, transfer or merger, acquisition or any form of sale of any assets, as appropriate, we have the right to share your personal information with third parties in connection with the transaction. In the case of such an event, the new entity will have access to your personal information.
25. Where we are required by law to collect and keep personal information, we shall do so. At a minimum, this includes the following:
- 25.1. Legislation applicable to us:
- 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, 2002
- 25.2. Legislation specific to the Administrator only:
- Financial Advisory and Intermediary Services Act, 2002

Part 5: General

26. The Fund may change this Privacy Statement at any time. It is your responsibility to check our website regularly to ensure that you are aware of these changes. By continuing to be a member you agree that the latest version will apply to you. The current version is available on www.engenmed.co.za
27. You have the right to know what personal information we hold about you. If you wish to receive this information please complete a 'PAIA Form to Request Access to Records' on www.engenmed.co.za and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information in respect of this request. We are entitled to charge a fee for this service and will let you know what it is at the time of your request.

If you believe that we have used your personal information in a way that is contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator, under POPIA, but we encourage you to first follow our internal escalation and/or disputes process to resolve the matter. We explain the escalation and/or disputes process on the website www.engenmed.co.za or contact the Fund's Information Officer at lesley.shaw@engenoil.com.

If, thereafter, you feel that we have not resolved your complaint adequately kindly contact the Information Regulator at: The Information Regulator (South Africa) | JD House | 27 Stiemens Street | Braamfontein | PO Box 31533 | Braamfontein | 2017 | Tel: **+27 (0) 10 023 5200** | POPIAComplaints@info regulator.org.za.

8. Engen Medical Benefit Fund Rules for managing membership

Rules for membership

The Rules of the Fund record your rights and responsibilities for your membership. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the terms and conditions and you agree that you and, those for whom you apply, will be bound by these terms and conditions and the Fund Rules.

Who you may apply for

You may apply for your immediate dependants to be added to your membership – your spouse, your partner, your children and dependants who are financially dependent on you as defined in the Fund rules.

For anyone to be treated as financially dependent, you must have a responsibility to provide and care for that dependant. We might ask you to give us proof of their dependency.

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 act on behalf of the persons you are applying to register on your membership, and in any matter relating to their membership;
- you have received permission from your spouse and any dependant/s over 18 to act for them.

Giving and getting information

You must give true, correct and complete information

Information about you and those on your membership must be true, correct and complete. This includes the details given during the application stage and in future dealings with us. It is important that you inform us of any medical condition, symptom or illness relating to those for whom you are applying, even if you do not consider it relevant to the application. We may ask for more information about those for whom you are applying, if they are 21 years of age or older.

Your legal address

We will send documents to you at your preferred. If it is necessary to send you any legal notices or summonses, our legal team will serve those at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Fund and the Administrator may record telephone calls

We may record telephone conversations with you and with those on your membership. The recordings and all information we get during the recordings will be processed and kept as required by law.

The Fund and the Administrator may get information about you from other relevant sources

To consider your claim for medical expenses, you agree that we can get information about you and those on your membership from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give and in respect of any matter pertaining to, or that arose during your membership of the Fund, is true, correct and complete. You give your permission that we may get any information that is relevant for your membership from your employer.

Tell the Fund or the Administrator immediately if your information changes

You or your employer must inform us in writing of any changes to the information provided. This includes information about the health of the persons you are applying for. We also need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Fund may cancel your membership/s

The Fund may cancel your membership, or the membership of any of your dependants, immediately if you and those on your membership:

- do not give us information that later turns out to be relevant to your membership;
- give us any information that is not true, correct and complete;
- do not tell us about any relevant changes (including about the health of those you are applying for) when they occur.

Contributions

As the main member of the Fund, you are responsible for ensuring that your contributions and the contributions for your dependants are paid on time every month, to avoid suspension of benefits. The Fund has the right to amend monthly contributions and benefits from time to time.

You must ensure contributions are paid on time.

Your dependants may not have immediate access to benefits

The Fund might not pay for certain expenses immediately after we have activated the membership(s) of those persons you are applying for. Waiting periods may apply in certain circumstances. This means there may be a set time period during which the Fund will not pay for claims related to any general or specific medical conditions. The Fund and Administrator will let you know if this applies in any way to the persons you are applying for in this application.

Dual membership of medical schemes

It is illegal to be a member of more than one medical scheme at the same time. Any person you are applying for must terminate any other cover held.

Repaying money owed to the Fund

The Fund has the right at any time to collect from you any amount that you owe to the Fund. We will notify you if there is any amount that you owe to the Fund.

Any money you owe to the Fund may be deducted from any future refund amounts that are due to be paid to you.

I declare to have read and understood the terms and conditions above.

Signature of new main member

Date

D	D	M	M	Y	Y	Y	Y
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I confirm the information is accurate and complete.