ENGEN Medical Benefit Fund

Administered by Discovery Health

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

Applying to become a member of Engen Medical Benefit Fund (with underwriting)

Thank you for applying to join Engen Medical Benefit Fund. This document is an application for membership form. It also contains the conditions of application. Please make sure you read and understand the Terms and Conditions of Engen Medical Benefit Fund which can be found at **www.engenmed.co.za**.

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. EMBF 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 of membership (Section 9).
3. The main applicant must sign sections 5, 8, and 9, and must sign and date any changes. Once completed, please email it to **application@engenmed.co.za**.
4. Please attach a copy of the identity document for each person you want to register on your membership (including your dependants) to this application form. We also accept valid passports and birth certificates for children.
5. To follow up on this application, please call **0860 100 345** or email **newbusiness_queries@engenmed.co.za**.
6. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.

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 or your employer, the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
- 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 9 of this form) of membership of Engen Medical Benefit Fund.

1. About yourself (main applicant)

When do you want your cover to start? D D M M Y Y Y Y (e.g. 01 MM YYYY)

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

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

Race African | Coloured | Indian/Asian | White | Other | Do not want to disclose

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.

Monthly salary **R** .

Communication preference Email | Post | SMS

By choosing email or SMS, you will receive your communication quicker and there is less of an impact on the environment.

Telephone (H) | Telephone (W)

Cellphone

Personal email

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

PO Box | Private bag | Box number

Suite | Postnet suite | Number

Suburb | Postal code

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

Physical address

Unit/Suite number | Complex name

Street number | Street name

Suburb

City | Postal code

Occupation | Tax number

2. About your spouse or partner (if applying for cover)

Title | Initials

Surname

First name(s) (as per identity document)

Previous or maiden name

ID or passport number

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

Race African | Coloured | Indian/Asian | White | Other | Do not want to disclose

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.

Telephone (H) | Telephone (W)

Cellphone

Email

Tax Number

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

Dependant 1

Title | Initials

Surname

First name(s) (as per identity document)

ID or passport number

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

Race African | Coloured | Indian/Asian | White | Other | Do not want to disclose

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, child)

If your dependant is 21 years and older, are they:

Married? Yes No | Financially dependent on you? Yes No

Disabled? Yes No | A full-time student? Yes No

Does your dependant earn an income? Yes ☐ No ☐

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

Dependant 2

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

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, child)

If your dependant is 21 years and older, are they:

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

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

Dependant 3

Title Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

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, child)

If your dependant is 21 years and older, are they:

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

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

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4. Your employer warranty (this section must be signed by the HR or payroll contact)

Name of employer

Employer or billing number

Employee number

Date of employment D D M M Y Y Y Y

Branch name

Branch number

Monthly Salary **R** .

The employer will reconfim the income stated above

Please make sure your employer completes this warranty. If this application form is sent without an employer warranty, we cannot process the application.

Employer warranty

1. We warrant that the main applicant detailed in Section 1 is an employee of our organisation.
2. Engen Medical Benefit Fund may bill us for the amount due for this dependant(s) in the same way as it does for the main member registered on this membership of Engen Medical Benefit Fund.

Authorised signature

Date D D M M Y Y Y Y

Please do not sign an incomplete application form

Name/s

Designation

5. Your banking details

Please give us the details you would like to use for your claim refunds.

Please note: We cannot accept credit card account details. You may only use a South African bank account.

Bank name

Account number

Branch code - -

Account holder

Type of account Cheque Savings

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

ID Number

If third party account is a Joint account Company account Trust account

Please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required

By signing below, you agree that once claims have been refunded into the bank account you have chosen, Engen Medical Benefit Fund will not be responsible in any way for the amounts refunded, if these details are incorrect.

Signature of main applicant

Please do not sign an incomplete application form.

6. Previous medical scheme details

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

Main applicant

Name	Scheme name	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes No		
			Yes No		
			Yes No		
			Yes No		

If all dependants were on the same medical scheme as completed above, please tick here to confirm this

If any of your dependants applying for cover belonged to different medical schemes, please provide the relevant information:

Dependant name	Scheme name	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7. Your health questions

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

Please take note that if you have any disorder, symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 7.18 below. Indication of existing medical conditions on this application does not automatically enroll you/your dependants on the Fund's Disease Management programmes. For more information of the Fund's Disease Management programmes visit www.engenmed.co.za

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

7.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast **Yes** ☐ **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, other skin conditions.

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

7.2 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, 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	Medicine used for this condition and dosage	Date of last treatment taken

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

7.4 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	Medicine used for this condition and dosage	Date of last treatment taken

7.5 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, post traumatic stress disorders, counselling, bulimia and any other psychological conditions.

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

7.6 Metabolic or endocrine conditions Yes ☐ No ☐

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

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

7.7 Abdominal conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, portal hypertension, alcoholic liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, Irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ascites (fluid in the abdomen).

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

7.8 Brain and nerve conditions Yes ☐ No ☐

Example: stroke, epilepsy, seizures, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, other chronic headaches, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt), intellectual disability, CVA, bleeding on the brain.

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

7.9 Breathing and respiratory conditions Yes ☐ 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.

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

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

Example: arthritis (any form), ongoing/intermittent joint or muscular 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, physical disability, prosthesis, and internal insertion of surgical implants,amputation.

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

7.11 Kidney or urinary conditions including current or past dialysis **Yes** ☐ **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 the bladder), bladder infections, other bladder or kidney problems.

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

7.12 Blood conditions **Yes** ☐ **No** ☐

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

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

7.13 Eye conditions **Yes** ☐ **No** ☐

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment.

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

7.14 Ear, nose and throat (ENT) and dentistry conditions **Yes** ☐ **No** ☐

Examples: 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.

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

7.15 Male urogenital conditions Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), tumours, undescended testes, phimosis, urinary incontinence, retention, infertility.

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

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

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

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

7.18 Have you or any of your dependants ever 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	Medicine used for this condition and dosage	Date of last treatment taken

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 HIV *Care* 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.

8. Privacy Statement

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.
10. You understand, accept and consent that we may process your personal information for the following purposes:

Part 2: Applying for and administering your membership

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. 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. 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 already given your consent for the disclosure of this information to that third party; or
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@inforegulator.org.za**.

9. Engen Medical Benefit Fund terms and conditions for managing your membership

Terms and conditions for membership

These terms and conditions record your rights and responsibilities for your membership of the Fund. They may change from time to time. You may ask us for the latest 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 registered on your membership will be bound by these terms and conditions. Where applicable, you also acknowledge and confirm that your employer may communicate with us about this application and your membership of the Fund.

Who you may apply for

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

For anyone to be treated as financially dependent, you must have a responsibility to provide financially for that dependant. We might ask you to give us proof of your financial responsibility. You may be called the principal or main member in our future communications to you.

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 for those the persons currently registered on the membership 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 at application stage 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 21 years of age or older.

Your legal address

We will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. 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 Discovery Health (Pty) Ltd 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 Discovery Health (Pty) Ltd 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 to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers). 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 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 changes. This includes information about your health and the health of those on your membership. We 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 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.

About becoming a member

The Fund might not pay for certain expenses immediately after you become a member.

Certain 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 condition-specific waiting periods. The Fund and Administrator will let you know if this applies to you or any of those on your membership.

Dual membership of medical schemes
It is illegal to be a member of more than one medical scheme at the same time. You and those on your membership must terminate any other cover held before we activate your membership of the Fund.

Repaying money owed to the Fund

We have 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 claim payment amounts that are due to be paid to you. If you are an Engen employee and in active employment, your Employer will contact you regarding salary deductions in respect of debt owed to the Fund.

Signature of new main member

Date D D M M Y Y Y Y

Please do not sign an incomplete application form.

Signature of current main member, if applicable

Date D D M M Y Y Y Y

Please do not sign an incomplete application form.
I confirm the information is accurate and complete.

10. Third Party Bank Details - Annexure A

Banking details for a third party

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds.

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (accountholder) ID, passport or driving licence
- A copy of the main member's ID, passport or driving licence

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
  - State that the account can be used
  - State the membership details (including the membership or policy numbers) for which the bank account will be used
  - Include the details of the signatory
  - Be dated and signed by an authorised person on behalf of the company
- A copy of the company's certificate of registration.
- A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
  - Show the trustees
  - Be dated and signed by an authorised person on behalf of the trust
  - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.