Applying to become a member of Malcor Medical Aid Scheme in 2022

Contact details
Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

Thank you for deciding to apply to join the Malcor Medical Aid Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand these rules.

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, is the medical scheme that you are applying to become a member of. 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). We take 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 terms and conditions for membership (section 10).
3. 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.
4. Main applicant to sign and date any changes.
5. Once completed, your employer contact must fax the completed and signed form to 011 372 1578 or email it to membership@totalmed.co.za
6. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

Once you send us your application form, this is what will happen:

- If any details are missing or if we need 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 (no waiting periods). For any non-standard terms, we will issue a counter-offer letter which will indicate any conditions applicable to your membership (waiting periods). **You may accept the offer by signing and returning this letter for us to activate your membership.**
- We will send you or your employer, the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
- We will send you a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- You will then get a pack in the post or this may be handed to you by your employer contact.

If you do not hear from us seven days after sending us your application form, please contact us on **011 372 1500.**

When you sign this application, you confirm that you have read and understood the terms and conditions (section 10 of this form) for membership and agree to them.

1. About yourself (main applicant)

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

Title ____ Initials ____ Surname ____

First name/s (as per identity document) ____

Preferred name ____ Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian / Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

Date of birth D D M M Y Y Y Y Occupation ____

Tax number ____

Total monthly earnings R (only complete when choosing Plan D)

Preferred communication: Email Post By choosing email, you will receive your communication quicker and there is less of an impact on the environment.

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Fax

Email

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

PO Box Private Bag Box number

Suite Postnet Suite Number

Suburb Postal code

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

Physical address:

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

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

Title Initials Surname

First name(s)
(as per identity document)

Preferred name Gender M F

Race African Coloured Indian / Asian White Other

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

Do not want to disclose

Date of birth Y Y Y Y M M D D ID or passport number

Country of issue Telephone (H)

(W) Cellphone

Tax number

Email

Partnership declaration

In the event that you are not legally married and unable to produce a marriage certificate, we require that you complete the below section fully. We hereby declare that we are in a long-term, committed relationship that is akin to a marriage and that we reside together at the same residence.

We understand that by signing this declaration we agree to inform the Scheme of any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that should the information provided regarding our relationship or residency be false in any way, the Scheme reserves the right to terminate both our memberships. Should the below section not be signed and dated by both parties, the application process will be halted until such time as the section has been duly signed and dated by both parties.

Signature of main applicant Date D D M M Y Y Y Y

Signature of partner Date D D M M Y Y Y Y

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

Dependant 1

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian/Asian White Other

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

Do not want to disclose

Date of birth D D M M Y Y Y Y | ID or passport number

Country of issue

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

If your dependant is 21 years and older, are they: Married Yes No Financially dependent on you? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) **R** .

Is your dependant a student? Yes No Is your dependant disabled? Yes No

Dependant 2

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Gender M F

Race African Coloured Indian/Asian White Other

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

Do not want to disclose

Date of birth D D M M Y Y Y Y | ID or passport number

Country of Issue

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

If your dependant is 21 years and older, are they: Married? Yes No Financially dependent on you? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) **R** .

Is your dependant a student? Yes No Is your dependant disabled? Yes No

Dependant 3

Title | Initials | Surname

First name(s) (as per identity document) | Preferred name

Gender M F

Race African ☐ Coloured ☐ Indian / Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

Date of birth D D M M Y Y Y Y ID or passport number

Country of issue

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

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependant on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? (Gross income) **R** .

Is your dependant a student? Yes ☐ No ☐ Is your dependant disabled? Yes ☐ No ☐

Dependant 4

Title Initials Surname

First name(s) (as per identity document)

Preferred name Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian / Asian ☐ White ☐ Other ☐

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

Do not want to disclose ☐

Date of birth Y Y Y Y M M D D ID or passport number

Country of issue

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

If your dependant is 21 years and older, are they: Married? Yes ☐ No ☐ Financially dependant on you? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? (Gross income) **R** .

Is your dependant a student? Yes ☐ No ☐ Is your dependant disabled? Yes ☐ No ☐

4. Please select your health plan

Malcor Plan:

Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐

You have the right to ask for help 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.

5. About your employer

Please ask your employer to complete this section.

Name of employer Employer or billing number

Employer number Date of employment Y Y Y Y M M D D

Branch name Branch number

Employer's signature

Designation

6. Banking details for claim refunds

If your contributions will be paid by your employer as a salary deduction, you only need to give us banking details for claim refunds. By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded if the banking details supplied were incorrect. If we are paying a third party bank account, the main member must insert the ID number of the third party.

Name of account holder

Bank name

Account number

Branch name Branch code - -

Type of account Cheque Savings

If we are paying a third party bank account, the main member must insert the ID number of the third party.

ID Number

If the third party bank account is a joint account, company account or 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

Signature of account holder

7. Previous medical scheme details (please give us proof in the form of a membership certificate)

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. We may also use the information on the membership certificate to determine if we can apply waiting periods.

Main applicant

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

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

If any of your dependant/s applying for cover belonged to different medical schemes, please complete them below:

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

8. Your health questions

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

You must tell us in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for.

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

Have you or **any dependant** in this application ever experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders. Please include congenital abnormalities.

Please take note that if you have any symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 8.18 below. Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit www.malcormedicalaid.co.za

8.1 Tumours, growths and disorders of the skin Yes ☐ No ☐

Example: abnormal Pap smear results, skin lesions, eczema, psoriasis, breast disease, abscess, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen), any autoimmune conditions, any congenital conditions, or any other abnormal cancer-screening or diagnostic test result/s 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 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, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed / symptoms	Date of last symptoms, consultations and / or hospitalisation	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, 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 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	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 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, 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, bulimia 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 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 mellitus (high blood sugar), diabetes insipdus, 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 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, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, stomach ulcers, malabsorption, ulcerative colitis, diverticulitis, any autoimmune conditions, any congenital conditions, irritable bowel syndrome (IBS), hemorrhoids, long standing constipation/diarrhea, ongoing abdominal pain, ascites (fluid in the abdomen).

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 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, seizures, other chronic headaches, cerebral palsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, 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 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, 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 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 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, injury, physical disability, prosthesis, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed / symptoms	Date of last symptoms, consultations and / or hospitalisation	Medicine used for this condition and dosage	Date of last treatment 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, neurogenic 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 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, polycythaemia vera, blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia ,haemochromatosis and other bleeding disorders, 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 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, 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 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: 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 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, 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 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	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 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	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 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	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 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, if you, or one or more of your dependant/s, are HIV positive, you or they must call us on 0860 100 698 within seven working days from the date we activate your Malcor Medical Aid Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependant/s, are HIV positive, it is in your interest to register on the HIVCare Programme. A 12-month condition-specific waiting period may apply to this condition and any related conditions. When you call in to register on the HIVCare Programme, please confirm these details. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your Malcor Medical Aid Scheme membership.

9. Malcor Medical Aid Scheme – Privacy Statement – how we will process and disclose your Personal Information and communicate with you

Definitions

The Scheme refers to Malcor Medical Aid Scheme, registration no 1547, registered with the Council for Medical Schemes.

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 Scheme and a subsidiary of the Discovery Group**.**

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 or legal guardian.
Discovery Group refers to Discovery Limited, registration number 1999/007789/06, including all subsidiaries of the group. Subsidiaries in the Group are authorised financial services providers.
Process(ing) (of) information means the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information.
Sanction screening refers to the checking of a person's profile against specific sanction lists to enable the imposition of restrictive measures by competent authorities against countries, persons, groups and/or legal entities. The extent of the restriction will be guided by our applicable policies
You and your refers to the member and your registered dependants on your medical scheme plan.
Your personal information refers to all personal information the Discovery Group has on you, or data subjects which are related to you or under your authority ("other data subjects") (as relevant). It includes:

- financial information;
- information about your health, race or ethnic origin, biometrics, criminal behaviour or religion;
- your gender;
- your age;
- unique identifiers such as your identity number or, contact numbers; and

1. When you engage with the Scheme and Administrator, you trust us with personal information about yourself, your family, and in some cases, your employees. We are committed to protecting your right to privacy.
2. The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in a manner that is compliant, ethical, adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time.
3. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always endeavour to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources.
4. 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 the Scheme and Administrator 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 medical scheme membership.
5. The Scheme and Administrator will keep your personal information confidential. You may have given us this information yourself or we may have collected it from other sources. If you share your personal information with any third parties, we will not be responsible for any loss suffered by you or your employer (where applicable).
6. 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. By submitting your dependants' relevant personal information, you hereby confirm that you are duly authorised to share such information with us. We will furthermore process their information for the purposes set out in this Privacy Statement.
7. Each party accepts responsibility to the extent that the processing activities of personal information fall under the control of that party and agrees to indemnify the other party/ies against any loss or damage, direct or indirect, that an employee may suffer because of any unauthorised use of the employees' personal information or if a breach of the employees' personal information occur, but only if the processing of that personal information is controlled by that party.
8. If you are giving consent for a person under 18 (a minor) you confirm that you are a competent person and that you have authority to give their consent for them.
9. You that the Scheme and Administrator may process your personal information for the following purposes:
   - for the administration of your health plan;
   - for the provision of managed care services to you on your health plan;
   - for the provision of relevant information to a contracted third party who requires this information in order to provide a healthcare service to you on your health plan;
   - to analyse risks, trends and profiles;
   - to share your personal information with external health providers for the purposes of evaluating certain clinical information, in the event that you require medical treatment.

Examples of how this will happen include:

9.1. Sharing your personal information with your chosen financial adviser during the application process to help the Administrator, if necessary, while we process your membership application;

9.2. Obtaining and sharing your personal information with other relevant sources, including medical practitioners, contracted service providers, health information exchanges, financial advisers, credit bureaus, entities that are part of Discovery Group 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;

9.3. If you have joined as a member of an employer group, getting information from and sharing information with your employer that is relevant to your application for membership with due regard for consideration of confidentiality in respect of your state of health;

9.4. Communicating with you about any changes in your health plan, including your contributions or changes to the benefits you are entitled to on the health plan you have chosen;

10. If a third party asks the Scheme and Administrator for any of your personal information, we will share it with them only if:
    - you have already given your consent for the disclosure of this information to that third party; or
    - we have a legal or contractual duty to give the information to that third party; or
    - we need to share it with them for risk analytical or fraud detection, prevention or recovery purposes.
11. You consent and agree that:
    - We may process your information, including personal information, to conduct sanction screening against all mandatory and non-mandatory sanctions lists and to perform transaction monitoring activities;
    - We may communicate such personal information to local and international Regulatory Bodies as well as to other entities in the Discovery Group if you are matched to one of these sanctions lists.
12. The Scheme and the Administrator will provide your personal information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship; or where you or your dependant/s have applied for a product, service or benefit from such entity. This information will be provided for the administration of your or your dependant/s products or benefits with other entities within the Discovery Group, and for fraud detection, prevention of recovery purposes.
13. The Scheme and Administrator may share and combine all your personal information for any one or more of the following purposes:
    - market, statistical and academic research, including cross-company analytics; and
    - to customise our benefits and services to meet your needs; and
    - to market our services to you.

    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 a third party unless that third party has agreed to abide by strict confidentiality protocols that we require. If we publish the results of this research, you will not be identified by name.
    If we want to share your personal information for any other reason, we will do so only with your permission.
14. By accepting this privacy statement, you authorise the Scheme and Administrator to obtain and share information about your creditworthiness with any credit bureau or credit providers’ industry association or industry body. 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.
15. The Scheme and Administrator have the right to communicate with you electronically about any changes on your health plan, including your contributions or changes and improvements to the benefits you are entitled to on the health plan you have chosen.
16. We may 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.
17. The Scheme and Administrator have a duty to keep you updated about any offers and new products that are made available from time to time. The Scheme, Administrator, any entity within the Discovery Group and contracted third-party service providers may communicate with you about these.
18. 18.1. Logging into your profile on www.malcormedicalaid.co.za or the Discovery App;

    18.2. Following the unsubscribe prompts on the electronic marketing communication received;

    18.3. By informing your appointed financial adviser.

    We will store your personal information for the purpose of actioning this request and action it as soon as reasonably possible.
    You may opt out of Electronic Marketing by:
19. You have the right to know what personal information the Scheme holds about you. If you wish to receive this information please complete an ‘Access to Records Form’ attached to the PAIA manual on www.malcormedicalaid.co.za or using the link: Malcor Scheme PAIA – Malcor Medical Scheme and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information.
    We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
20. You agree that the Scheme and Administrator 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 for the pursuit of our legitimate business purpose. Where we cannot delete your personal information, we will take all practical steps to anonymize it.
21. You have the right to ask us to update, correct or delete your personal information by completing the Request for Deletion or Correction of Information Form available on the Scheme’s Website at https://www.malcormedicalaid.co.za/portal/individual/malcor-scheme-privacy
22. Where the Scheme and Administrator are required by law to collect and keep personal information, we shall do so. At a minimum, this includes the following:
    - 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

    Legislation specific to Discovery Health (Pty) Ltd only:
    - Financial Advisory and Intermediary Services Act, 2002

- Companies Act, 2008

23. You agree that the Scheme and Administrator may transfer your personal information outside South Africa:
    - if you give us an email address that is hosted outside South Africa; or
    - for processing, storage or academic research; or
    - to administer certain services, for example, cloud services.
    When we share your information to administer certain services, we will ensure that any country, company or person that we pass your personal information to agrees to treat your information with the same level of protection, as we are obliged to do in South Africa. Unless you specifically give us consent to share your personal information with such person (or company).
24. If the Scheme or Administrator becomes involved in a proposed or actual amalgamation or merger, acquisition or any form of sale of any assets, 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. The terms of this Privacy Statement will continue to apply.
25. You have the right to know what personal information the Scheme holds about you. If you wish to access this information, please complete a 'PAIA Form to Request Access to Records' available. This form can be found on www.malcormedical.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.
26. The Scheme may change this Privacy Statement at any time. The most updated version will always be available on www.malcormedicalaid.co.za or follow this link: Terms and Conditions – Malcor Medical Scheme.
27. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator. However, we encourage you to first follow our internal complaints process to resolve the complaint or contact the Information Officer at pdorfan@gmail.com. If, thereafter, you feel that we have not resolved your complaint adequately kindly contact the Information Regulator at: JD House |27 Stiemens Street | Braamfontein |Johannesburg |PO Box 31533 |Braamfontein |Johannesburg |2001 | PAIAComplaints@inforegulator.org.za or POPIAComplaints@inforegulator.org.za

Signature of main applicant ______________ **Date** D D M M Y Y Y Y

10. Malcor Medical Aid Scheme terms and conditions for membership

10.1. Rules for membership

The rules of the Scheme records your rights and responsibilities for your membership of the Scheme. 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 these terms and conditions and you agree that you and those you apply for will be bound by these and Scheme Rules.

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 of the Scheme.

You give permission that the Scheme Parties can 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 can help us if necessary while we process your membership application. Please speak to your financial adviser or us if there is anything you do not understand.

10.2. Who you are applying for

You may apply to join the Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Scheme rules. For anyone to be treated as financially dependent for this application, you must have a legal responsibility to provide financially for that dependant. We might ask you to give us proof of financial or legal responsibility. You may be called the principal member or main member in our future communications to you.

10.3. Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

10.3.1. you have the right to apply for membership and to act for those you apply for in any matter relating to this application.

10.3.2. you have received permission from your spouse and any dependant/s over 18 to act for them in any matter relating to this application.do not give the Scheme Parties information that later turns out to be relevant to this application.

10.4.
- give the Scheme Parties any information that is not true, correct and complete.
- do not tell the Scheme Parties about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

Giving and getting information

You must give true, correct and complete information

To consider your application for membership, the Scheme must learn more about you and those you apply for. Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with the Scheme Parties. It is important that you tell the Scheme Parties about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for more information about themselves.

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 these 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.

Malcor Medical Aid Scheme and Discovery Health (Pty) Ltd may record telephone calls

The Scheme Parties may record telephone conversations with you and with those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

Malcor Medical Aid Scheme and Discovery Health (Pty) Ltd may get information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses,

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

Tell Malcor Medical Aid Scheme or Discovery Health (Pty) Ltd immediately if your information changes
You, your employer or your financial adviser must tell us in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership/s
The Scheme may cancel any memberships immediately, if you and those you apply for:

10.5. About becoming a member

The Scheme might not pay for certain expenses immediately after you become a member
The Scheme may apply waiting periods under certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. Please speak to your financial adviser or us to find out if waiting periods apply to your membership and the memberships of those you apply for.

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 you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time
As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time.

10.6. Repaying money owed to the Scheme

The Scheme has the right at any time to collect from you any amountthat you owe to the Scheme. We will notify you if there is any amount that you owe to the Scheme. You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number MAL CLWBCK will be used.

Signature of main member ____________________

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

The main member must sign and date any changes
Please do not sign an incomplete application form
I confirm the information is accurate and complete

11. 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.