

# Application for Addition of Dependants



Contact us

Tel: 0860 100 078 • PO Box 652509, Benmore 2010 • www.medipos.co.za

## Who we are

MEDiPOS Medical Scheme is the medical scheme you are applying to become a member of, registration number 1548. This is a not-for-profit organisation registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as "the Administrator") is a separate company and an authorised financial services provider (registration number 1997/013480/07), which takes care of the administration of your membership of MEDiPOS.

Complete this form if you want to add dependant/s to your MEDiPOS membership.

## How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively complete electronically by typing in the fields below.
2. Read and understand the terms and conditions for membership (section 9).
3. Sign the application form.
4. Please make sure the main member signs and dates any changes.
5. Please attach a copy of each dependant's identity document to this application. We also accept valid passports and birth certificates for children.
6. It is imperative that all sections of this form be completed in full. Failing to do this may cause a delay in the processing, as the incomplete form will be returned to your employer.
7. Hand the completed and signed form to your human resources department.

## Once you send us 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 letter, a notification or an email to let you know when your dependant/s' application is considered to have been fully and completely accepted. This date may differ from the date on which you sign the application form.
- After accepting your dependant/s' application to join MEDiPOS, we will send you a notification and an email confirming acceptance. You will then get a membership pack in the post.
- When you sign this application, you confirm that you have read and understood the terms and conditions (section 9 of this form) for membership as well as the Privacy statement, and agree to them.

## 1. Main member details

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

## 2. Adding a spouse or partner (if applying for cover)

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

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

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

Marital status Married  Single  Divorced  Widowed

Date of marriage to main applicant. Please attach a copy of your official marriage certificate.

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Telephone (H)

Telephone (W)

Cellphone

Email

### Addition of spouse to an existing membership

If the addition of spouse to an existing membership is:

- Due to legal and registered marriage within the last month, an official marriage certificate must accompany this application form;
- For a spouse married for more than a month, full underwriting will apply;
- As a result of a long-standing relationship or in terms of common-law practice, the partnership declaration must be completed and signed.
- Please choose a date you want cover to start for all dependant/s you are applying for. This date must be the same for all your dependant/s applying for cover.

Cover start date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

### 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. Registration of a PARTNER is subject to the following definition as defined in the rules of the Scheme:

- "Partner" is a person with whom the member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.
- 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 member

Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Signature of partner

Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

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

Only complete this section if you are adding a child or adult dependant.

When do you want your cover to start? 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

#### 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 Scheme 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 etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If over 18 years, provide cellphone number

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

If the dependant is disabled, please confirm type of disability Permanent  Temporary

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

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

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

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 over 18 years, provide cellphone number

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

If the dependant is disabled, please confirm type of disability Permanent  Temporary

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

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

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

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 over 18 years, provide cellphone number

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

If the dependant is disabled, please confirm type of disability Permanent  Temporary

Does your dependant earn an income? Yes  No  How much does your dependant earn each month? R

**Dependant 4**

Title     Initials        
Surname   
First name(s) (as per identity document)   
ID or passport number

Gender M  F  Date of birth

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

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

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 over 18 years, provide cellphone number

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

If the dependant is disabled, please confirm type of disability Permanent  Temporary

Does your dependant earn an income? Yes  No  How much does your dependant earn each month? R

#### 4. Dependant classification and proof required

Definition of Dependant	Documentation required
Spouse	Marriage certificate or affidavit for customary/common law marriage
Natural child	ID, birth certificate (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Natural child with different surname to main member	ID, birth certificate, affidavit (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Stepchild	ID, birth certificate, affidavit (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Adopted child	ID, full birth certificate, legal proof of adoption (if > 21 and a student and/or financially dependent, proof of study or affidavit to be submitted)
Traditional/polygamous spouse	ID, affidavit/certificate of customary union
Parents/siblings of main member	ID, affidavit of financial dependency, proof of income
Common-law partner/same gender partner	ID, affidavit

#### 5. Your employer warranty (needs to be signed/stamped by the HR or payroll contact)

Please make sure your employer completes this warranty if the member falls under an employer group.

1. We warrant that the member detailed in section 1 of this application form is an employee of our organisation.
2. MEDIPOS may bill us for the amount due for this dependant in the same manner as for other employees with MEDIPOS.

Authorised signatories	<input type="text"/>	<input type="text"/>
Names	<input type="text"/>	<input type="text"/>
Designation	<input type="text"/>	<input type="text"/>
Employee number	<input type="text"/>	<input type="text"/>

#### 6. Previous medical scheme details

Please give us the details of all registered South African medical schemes, that the dependant/s you want to add, previously belonged to. We will use this information to determine if we need to apply any waiting periods. Please give us proof in the form of a membership certificate.

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

## 7. Your spouse, partner or dependant/s' health questions

Treating healthcare provider's name

Practice number           Telephone

Email

We may be able to use certain previous medical information for your dependants(if applicable) we have from previous policies. However, it is still your obligation to disclose any and all relevant information as required. By ticking this box you agree that we may utilise this information for the purposes noted below.

Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Scheme requiring that you undergo a medical examination, at the Scheme's cost. Should that medical examination reveal a current health condition, waiting periods may apply in respect of such current condition.

**Please give full medical details of all dependant/s in this application form.**

**Please answer ALL questions by ticking "Yes" or "No".** If you answered 'Yes', please provide full details in the sections provided.

### 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, fibroadenosis, lump in breast, abscess, abnormal mammogram result, any autoimmune conditions, any congenital conditions, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

### 7.2. 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, deep vein thrombosis, pulmonary embolus, and varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

### 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 period, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

### 7.4. Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or having difficulty falling pregnant?

Yes  No

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.5. Mental health**Yes  No 

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**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, overweight, obesity, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.7. 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, malabsorption, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colorectal symptoms/conditions Crohn's disease, ulcerative colitis, diverticulitis, irritable bowel syndrome (IBS), hemorrhoids, long-standing constipation/diarrhea, ascites (fluid in the abdomen), any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**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, constipation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**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 > 3-months, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

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

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**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, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.12. Blood conditions**Yes  No 

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.13. Eye conditions**Yes  No 

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.14. 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.15. Male urogenital conditions**Yes  No 

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.16. Are you or any of your dependants expecting to have medical investigations or surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital/been in casualty in the last 12 months?**Yes  No 

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**7.17. Have you or any of your dependants received or not yet received medical advice or treatment for symptoms, not yet diagnosed by a medical provider, 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**HIV and AIDS**

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 100 078** within seven working days from the date we activate your membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme. MEDIPOS may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme 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 dependant's HIV status within seven days of your membership being active, we may end your membership.

## 8. MEDiPOS Medical Scheme Privacy Statement

When you engage with MEDiPOS Medical Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants, beneficiaries and life assureds, where applicable. To view and read our Privacy Statement, please follow this link: <https://www.medipos.co.za/wcm/medical-schemes/medipos/assets/privacy-statement.pdf>

Signed at (town or city)

on 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Signature of main member

## 9. Terms and Conditions applicable to MEDiPOS Medical Scheme membership

### Definitions

**The Scheme** refers to MEDiPOS Medical Scheme, registration number 1548, 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 healthcare organisation for and a subsidiary of the Discovery Group.

### 9.1. Scheme rules for membership

The rules of the Scheme record your rights and responsibilities for your membership of MEDiPOS Medical Scheme. They may change from time to time. You may ask us for a copy of these rules at any time or view them on [www.medipos.co.za](http://www.medipos.co.za).

When you sign this application, you confirm that you have read and understood the terms and conditions and you agree that you and those on your membership will be bound by these and the Scheme Rules.

Please speak to the Administrator if there is anything you do not understand.

### 9.2. Who you are applying for

You may apply to join MEDiPOS Medical Scheme on your own or together with other people – your spouse, /partner, your children 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 responsibility to provide financially for that dependant. We might ask you to give us proof of financial means or responsibility. You may be called the principal member or main member in our future communications to you.

### 9.3. 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 on your membership in any matter relating to membership
- You have received permission from your spouse/partner and any dependant(s) over 18 to act for them in any matter relating to their membership.

### 9.4. 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 on your membership must be true, correct, and complete. This includes the details you have given in this application form and in future dealings with us. It is important that you tell us 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.

#### Your legal address

The Scheme or Administrator 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.

#### The Scheme and Administrator may record telephone calls

The Scheme and Administrator 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.

#### The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including healthcare providers, contracted service providers, credit bureaus or industry regulatory bodies (“relevant sources”) and further process such information to conduct risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse. We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct, and complete. You give your permission that the Scheme and Administrator may get any information that is relevant to your application from your employer.

#### Tell the Scheme or Administrator immediately if your information changes

You must inform the Scheme or Administrator in writing if any of the information you gave in your application for membership changes between the day you signed the 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**

The Scheme may cancel your membership if you and those you apply for:

- do not give us information that later turns out to be relevant to your application
- give us any information that is not true, correct and complete;
- do not tell us about any relevant changes (including about your health and the health of those on your membership) between the day you sign this document, and the day cover starts.

Providing false information may lead to criminal charges being brought against you. You will also have to pay any amount owing to the Scheme as a result of this cancellation.

**9.5. The Scheme might not pay for certain expenses immediately after you become a member**

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will advise if any waiting periods apply to your membership and the membership of those you apply for. Please speak to the Administrator with regard to any waiting periods applicable to your membership.

**9.6. You must ensure contributions are paid on time**

As the main member of the Scheme even if your contributions will be paid via your employer, you are responsible for ensuring that your full contributions and the full contributions of those on your membership 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 with prior notification.

**9.7. Repaying money owed to the Scheme**

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

Signature of main member

Date 

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---