UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

UKZN MEDICAL SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 11 33 22, PO Box 652509, Benmore 2010, www.discovery.co.za

Applying to become a member of the University of KwaZulu-Natal Medical Scheme in 2017 (with underwriting)

This application form should be completed by new employees who join the Scheme within 30 days of their date of employment.

Thank you for applying to join the University of KwaZulu-Natal Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand the rules.

Who we are

The University of KwaZulu-Natal Medical Scheme (referred to as 'the Scheme'), registration number 1520, 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 'we' 'us' and 'our' or 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.

What you must do

Please go through these steps:

Step 1: Fill in the form in black ink, using one letter per block. Please print clearly.
Step 2: Read and understand the rules for membership (section 10).
Step 3: Sign sections 6, 9 and section 10.
Step 4: Please make sure the main applicant signs and dates any changes.
Step 5: Please hand the completed application to your employer contact.
Step 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, 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 activate your membership and send you or your employer a letter of confirmation when we are offering standard terms of acceptance (no waiting periods or late-joiner penalties). For any non-standard terms, we will issue a counter-offer letter which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). You may accept the offer by signing and returning this letter for us to activate your membership.
- We will send you or your employer 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.

If you do not hear from us seven days after sending us your application form, please contact us on 0860 100 345 or your employer contact person

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.
If you have any questions, please let us know. Once we have assessed your application, we will let you know if you have been accepted and what will happen next.

1. About yourself (main applicant)

When do you want cover to start? 2 0 Y Y M M 0 1 Employee number (compulsory)

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Previous or maiden name

Preferred communication: Email ☐ Post ☐

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

Preferred language: English ☐ Afrikaans ☐

ID or passport number Country of issue

Telephone (H) (W)

Cellphone (F)

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

UKZNNB01

1. About yourself (main applicant)

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

Physical address

Suite or unit number | Complex name

Street number | Street name

Suburb | Postal code

Occupation | Tax number

Gross monthly salary R

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

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Sex M F | Date of birth Y Y Y Y M M D D

Previous or maiden name

ID or passport number | Country of issue

Telephone (Home) | (Work)

Cellphone | Tax number

Email

Partnership declaration

If you are not legally married and unable to produce a marriage certificate, you must complete the section below in full. We hereby declare that we are in a long-term, committed relationship that is like 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 if the information we give about our relationship or residency is false in any way, the Scheme reserves the right to end both our memberships. If the below section is not signed and dated by both parties, the application process will be stopped until both parties sign and date this declaration.

Signature of main applicant | Signature of partner

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

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

Dependant 1

Title | Initials | Surname

First name(s) (as per identity document)

Preferred name | Sex M F | Date of birth Y Y Y Y M M D D

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

ID or passport number | Country of issue

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

Married? Yes ☐ No ☐ | Financially dependent on you? Yes ☐ No ☐ | Disabled? Yes ☐ No ☐ | A 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)

Preferred name | Sex M F | Date of birth Y Y Y Y M M D D

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

ID or passport number | Country of issue

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

Married? Yes ☐ No ☐ | Financially dependent on you? Yes ☐ No ☐ | Disabled? Yes ☐ No ☐ | A student? Yes ☐ No ☐

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

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

Dependant 3

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

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

ID or passport number Country of issue

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

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐ Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

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

4. The Medical Savings Account on the Standard Plan

Standard Plan ☐

Refund Medical Savings Account claims on the Standard Plan at Scheme Rate ☐ or Cost ☐

By selecting the Cost option, you confirm that claims will automatically pay from your Medical Savings Account, once the General Benefit Pool is depleted.

5. Employer contact details (employer to complete)

Person dealing with this application

Contact name Designation

Telephone Fax

Email address

Preferred means of communicating: Email ☐ Post ☐ Date of employment Y Y Y Y M M D D

Employer name Employer number

Paypoint or school name Paypoint or school number

Department name Department number

Please make sure your employer completes this warranty. If this application form is not sent with an employer warranty, we cannot process the application form.

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. The Scheme may ask us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised signatory

Name

Designation

6. Your banking details

6.1 Your contributions

If you will be paying your contribution in full, please complete this section:

Please note: We cannot accept credit card account details.

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

Please choose the date you would like us to debit your account:

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

Signature of account holder

6.2 Your claim refunds

If you do not want to use the same banking details for your contribution and claim refunds, please give us the details you would like to use:

If you do not provide banking details, we cannot refund your claims.

Please note: We cannot accept credit card account details.

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

By signing below, 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.

Signature of account holder

7. 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	End date if already resigned	Are they still a member?	Reason for leaving
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	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
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	
		YYYYMMDD	YYYYMMDD	Yes ☐ No ☐	

8. Your health questions

Treating healthcare professional's name

Practice number

Telephone

Email

8. Your health questions *(continued)*

8.A. Only the main applicant, spouse or partner and any adult dependant applying for cover need to complete section 8.A.

Main applicant

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Your blood type ☐☐☐☐☐☐☐☐☐☐ Your allergies ☐☐☐☐☐☐☐☐☐☐

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐☐☐☐☐☐☐☐☐☐

Spouse or partner

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Your blood type ☐☐☐☐☐☐☐☐☐☐ Your allergies ☐☐☐☐☐☐☐☐☐☐

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐☐☐☐☐☐☐☐☐☐

Adult 1 (any dependant 21 years or older)

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Your blood type ☐☐☐☐☐☐☐☐☐☐ Your allergies ☐☐☐☐☐☐☐☐☐☐

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐☐☐☐☐☐☐☐☐☐

Adult 2 (any dependant 21 years or older)

How tall are you? ☐ . ☐☐ metres How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Your blood type ☐☐☐☐☐☐☐☐☐☐ Your allergies ☐☐☐☐☐☐☐☐☐☐

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **"No"**, have you smoked in the last 24 months? Yes ☐ No ☐ If **"Yes"**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐☐☐☐☐☐☐☐☐☐

8.B. 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.

8.1 Tumours and growths **Yes** ☐ **No** ☐

Example: abnormal pap smear results, pre-cancerous skin lesions, breast disease, non-cancerous tumors, cancerous tumors, fibrocystic breast disease, fibroadenoma, fibroadenosis, lump in breast, abnormal mammogram result, abnormal PSA (prostate specific antigen) result.

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

8. Your health questions *(continued)*

8.2 Heart and circulation conditions **Yes** ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, congenital heart disease, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker.

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

8.3 Gynaecological and obstetrics conditions **Yes** ☐ **No** ☐

Example: abnormal Pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility.

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

8.4 Are you or any of your dependant/s pregnant? **Yes** ☐ **No** ☐

Patient name		

8.5 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 rehabilitation, suicide attempt, counselling, bulimia and any other psychological conditions.

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

8.6 Metabolic or endocrine conditions **Yes** ☐ **No** ☐

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

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

8.7 Abdominal conditions **Yes** ☐ **No** ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic liver disease, liver failure, haemochromatosis, pancreatitis, cystic fibrosis, gall bladder, gall stones, GORD (reflux), heartburn, oesophageal disease, hernias, atrophic gastritis, ulcers, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis.

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

8.8 Brain and nerve conditions **Yes** ☐ **No** ☐

Example: stroke, epilepsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, cerebral palsy, Parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, mental retardation, CVA.

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

8. Your health questions *(continued)*

8.9 Breathing and respiratory conditions **Yes** ☐ **No** ☐

Example: asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia.

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

8.10 Musculoskeletal (back, bone and muscle pain) **Yes** ☐ **No** ☐

Example: arthritis (any form), ongoing back pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, fractures, physical disability.

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

8.11 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, bladder infections, other bladder or kidney problems.

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

8.12 Blood conditions **Yes** ☐ **No** ☐

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

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

8.13 Eye conditions **Yes** ☐ **No** ☐

Example: cataract, keratoconus, corneal ulcer, uveitis, glaucoma, squint, ptosis, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blurry vision, blindness (partial or full), retinal detachment.

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

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

Examples: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery.

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

8. Your health questions *(continued)*

8.15 Male urogenital conditions **Yes** ☐ **No** ☐

Example: prostate disorders, urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence.

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

8.16 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	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.17 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	Medical diagnosis	Date first diagnosed	Date of last symptoms, consultation and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D
		Y Y Y Y M M D D	Y Y Y Y M M D D		Y Y Y Y M M D D

8.18 Have you or any of your dependant/s been diagnosed with or received treatment for, any condition not mentioned in the questions above, in the last 12 months before this application? **Yes** ☐ **No** ☐

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

HIV and AIDS

You do not need to disclose the HIV status of you or your dependant/s on this form if you do not feel comfortable doing so. However, if you, or one or more of your dependants, are HIV positive, you or they must call us on **0860 11 33 22** within seven working days from the date we activate your University of KwaZulu-Natal Medical Scheme 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. A 12-month condition-specific waiting period may apply to this condition. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your UKZN Medical Scheme membership.

9. Fair Collection Notice – how we will process and disclose your Personal Information and communicate with you

1. This Fair Collection Notice ("Notice") explains how we obtain, use, disclose and otherwise process personal information, which may include health and financial information ("Personal Information"), as required by the Protection of Personal Information Act ("POPIA").
2. Acceptance of these terms and conditions is voluntary, but is a requirement for activation and servicing of your UKZN membership. If you do not accept these terms and conditions, we cannot activate and service your membership.
3. Please note:
   a. We may amend this Notice from time to time. Please check our website periodically to inform yourself of any changes;
   b. You have the right to object to the processing of your Personal Information;
   c. Should you believe that we have utilised your Personal Information contrary to applicable law, you will first resolve any concerns with us. If you are not satisfied with such process, you have the right to lodge a complaint with the Information Regulator, under POPIA.
4. UKZN and Discovery Health (Pty) Ltd (we/us) will keep any information, including Personal Information relating to yourself and your dependant/s and/or beneficiaries, supplied to us in this application or collected from other sources ("Your Personal Information") confidential.

   You confirm that when you provide us with your Personal Information, your dependant/s and/or beneficiaries have provided you with the appropriate permission to disclose their Personal Information to us for the purposes set out below and any other related purposes. In the event that you providing information and signing consent on behalf of a minor (person younger than 18 years old) that you are a competent person and authorised do so on their behalf.
5. You agree to us processing and disclosing Your Personal Information in the following manner:

   We may collect, collate, process, store and disclose your Personal Information:
   a. For the administration of your health plan;
   b. For providing managed care services to you or any dependant/s on your health plan;

9. Fair Collection Notice – how we will process and disclose your Personal Information and communicate with you *(continued)*

c. For providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your health plan;
d. To profile and analyse risk;
e. For academic research conducted by any company within the Discovery Group and/or contracted research and survey providers in South Africa as well as outside the borders of the Republic.

Examples of how this will happen includes:

a. Getting Your Personal Information from other relevant sources, including any entity that is part of Discovery Limited, medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ("Sources"), and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the Sources that your Personal information is true, correct and complete;
b. Getting and sharing any information that is relevant to your application from or with your employer, if you have joined as a member of an employer group;
c. Communicating with you about any changes in your health plan, including your contributions or changes and enhancements to the benefits you are entitled to on the health plan.
d. Transferring your Personal Information outside the borders of the Republic of South Africa where appropriate, for example to administer the ISOS and Africa Benefit, if you provide an email address which is hosted outside the borders of South Africa, or for processing, storage or academic research. We will ensure that anyone to whom we pass your personal information agrees to treat your information with the same level of protection as we are obliged to;
e. Making use of external health specialists to assess or evaluate certain clinical information. Your Personal Information will be shared with such specialist/s in the event that you or your dependant/s are subject to such a clinical assessment.

6. If asked to do so, we will share your Personal Information with a third party if you have already given your consent for the disclosure of this information to such third party or if a contractual relationship exists in terms of which we are obliged to provide the information to such third party.
7. We 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 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.
8. We may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including personal information about any judgement or default history.
9. UKZN and any entity within the Discovery Group will keep you updated on information about any offers or new products Discovery may make available at any time. Please contact us if you do not wish to receive any telephonic direct marketing information from us.
10. If we want to share your information for any other reason, we will do so only with your permission.
11. You have the right to request a copy of the Personal Information we hold about you. To do this, simply complete the 'Data Subject Request Form' on www.discovery.co.za/legal and specify what information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information. Please note that any such Data Subject Request may be subject to a payment of a legally allowable fee.
12. You have the right to contact and ask us to update, correct or delete your personal information.
13. You agree that we may retain Your Personal Information until such time as you request us to destroy them (unless we are obliged by law to retain it, regardless of such request)
14. If the Scheme, Discovery Health (Pty) Ltd or Discovery Limited becomes involved in a proposed or actual merger, acquisition or any form of sale of some or all its assets, we may use and disclose your Personal Information to third parties in connection with the evaluation of the transaction. The surviving company, or the acquiring company in the case of a sale of assets, would have access to your Personal Information which would continue to be subject to this Notice.
15. UKZN and Discovery Health (Pty) Ltd are required to collect and retain information in terms of the following legislation (amongst others):
    15.1. The Medical Schemes Act, 1998
    15.2. The Consumer Protection Act, 2008
    15.3. The Protection of Personal Information Act, 2013
    15.4. Electronic Communications and Transactions Act, 2002
    15.5. Promotion of Access to Information Act, 2000
    Legislation specific to Discovery Health (Pty) Ltd only:
    15.6. Financial Advisory and Intermediary Services Act, 2002
    15.7 Companies Act, 2008

Signature of main applicant

Please do not sign an incomplete application form

10. University of KwaZulu-Natal Medical Scheme ("UKZN") rules for membership

10.1 Who "we" are

UKZN, registration no 420, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Discovery Health Medical Scheme, and an authorised financial services provider

10.2 Rules for membership

The rules of UKZN records your rights and responsibilities for your membership of UKZN. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the rules and you agree that you and those you apply for will be bound by them.

Where applicable you also acknowledge and confirm that your employer appointed, may communicate with us on this application and your membership of UKZN

You give permission that we can share your medical information

10. University of KwaZulu-Natal Medical Scheme ("UKZN") rules for membership *(continued)*

and other relevant personal information about you and your dependant/s. The information will be shared so that he or she can help us if necessary while we process your membership application.

10.3 Who you are applying for

You may apply to join UKZN on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the UKZN 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 responsibility. You may be called the principal member or main member in our future communications to you.

10.4 Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

- you have the right to apply for membership and to act for those you apply for in any matter relating to this application;
- you have received permission from your spouse and any dependant/s over 18 to act for them in any matter relating to this application.

10.5 Giving and getting information

You must give true, correct and complete information

To consider your application for membership, UKZN 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 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. 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.

UKZN and Discovery Health (Pty) Ltd may record telephone calls

We 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.

UKZN 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 Discovery Health (Pty) Ltd and UKZN 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. We 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 UKZN, is true, correct and complete. You give your permission that we may get any information that is relevant to your application from your employer.

Tell Medical Scheme or Discovery Health immediately if your information changes

You or your employer 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.

10.6 About becoming a member

UKZN might not pay for certain expenses immediately after you become a member

UKZN may have waiting periods that apply in certain circumstances. This means there may be a set time period before UKZN starts paying for any general or specific medical conditions. Please speak to your employer 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 UKZN 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 UKZN, 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.

10.7 Repaying money owed to the Scheme

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

You must repay any medical savings owing if you leave UKZN

When you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the 'Medical Savings Account'. If you leave UKZN before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to UKZN over the year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you.

Signature of main applicant

Date 2 0 Y Y M M D D

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