





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 member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child)

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 student? Yes  No

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

### Dependant 3

Title  Initials

Surname

First name(s) (as per identity document)

ID or passport number

Gender M  F  Date of birth

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 member (for example: mother or child. If the child is not your biological child, please state relationship, for example adopted child, foster child)

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 student? Yes  No

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

### 4. Please select your benefit option

Please select your benefit option by ticking the applicable box  Essential  Essential Plus

### 5. Previous medical scheme details

Please give us the details of all registered South African medical schemes of 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, late-joiner penalty fees, or both. Please give us proof in the form of a membership certificate.

If any of your dependants applying for cover belonged to different medical schemes, please complete below:

Dependant 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"/>	

## 6. Your health questions

### Information on symptoms, conditions or disorders (must be completed for the main applicant, spouse/partner and all dependants and must include information on conditions even if covered or not on previous memberships)

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 customised 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 (which includes whether to impose a waiting period on your membership) and any other relevant uses.

**Please note that** the Council for Medical Schemes has oversight over any irregular use of your or your dependant's health information.

**Please also note that** the Medical Schemes Act restricts the ability of the Scheme to impose waiting periods. A condition specific waiting period cannot be imposed on you or any of your dependants relating to any condition that you disclose in this application **except** if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment in respect of such a condition within a 12-month period ending on the date on which this application is considered to be fully and properly made.

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 be apply in respect of such current condition.

**Below we require you to advise us** about whether **you or any dependant/s** specified in this application **at any time** have experienced, been treated/investigated 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 take note** that if you or any of your dependants have any disorder, symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 11.18 below.

**Please also note** that you must tell us in writing if any of the information you gave, in this 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.

**Please take note further that any** indication of existing medical conditions on this application does not automatically enrol you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrolment visit [www.retailmedicalscheme.co.za](http://www.retailmedicalscheme.co.za).

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

#### 6.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast

Yes  No

Example: skin lesions,eczema, psoriasis, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abscess, any autoimmune conditions, any congenital conditions or other skin conditions.

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

#### 6.2 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, 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

**6.3 Gynaecological and Obstetric conditions**Yes  No 

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, 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

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

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

**6.5 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 other psychological conditions, 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

**6.6 Metabolic or endocrine conditions**Yes  No 

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

**6.7 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, Crohn's disease, ulcerative colitis, diverticulitis, irritable bowel syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ascites (fluid in the abdomen), any autoimmune conditions, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, colorectal symptoms/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

**6.8 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 used to drain fluid from the brain), 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 within the last 12 months	Medicine used for this condition and dosage	Date of last treatment taken within the last 12 months

**6.9 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, ventilator, oxygen therapy, CPAP, 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

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

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

**6.11 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 (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

**6.12 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

**6.13 Eye conditions**Yes  No 

Example: cataract, keratoconus, 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, intra-ocular pressure, visual disturbances, night blindness, 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

**6.14 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

**6.15 Male urogenital conditions**Yes  No 

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

**6.16 Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months?**Yes  No 

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

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

6.18 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 101 252** within seven working days from the date we activate your Retail 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 HIVCare Programme. Retail Medical Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Retail Medical 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 7 days of your membership being active, we may end your Retail Medical Scheme membership.

**7. Banking details for claim refunds**

Please provide us with your bank details for the refund of claims. You can only use a South African bank account.

Bank name

Branch name  Branch code  -  -

Type of account  Cheque/Transmission/Transaction  Savings  Account number

Name of account holder

Signature of main applicant  Date

Signature of account holder  Date

**Third party bank details**

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

If the third party bank account is a:  joint account  company account  trust account

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

By signing the above, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will no longer be responsible in any way for the amounts refunded and authorise Retail Medical Scheme to contact the account holder provided above to verify payments made or received, if necessary.

**8. Privacy Statement – how we will process and disclose your personal information and communicate with you**

When you engage with Retail 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, children, and other dependants, collectively “your dependants”, where applicable. To view and read our Privacy Statement, please follow this link: <https://www.retailmedicalscheme.co.za/wcm/medical-schemes/retail/assets/retail-medical-scheme-privacy-statement.pdf>

May the Scheme and its Administrator send you direct electronic marketing (related to the business of the Scheme) from time to time?

Yes, I agree  No, thank you

Signature of main member

Date

Please sign that you have read and understand this statement

**9. Terms and conditions**

**Rules for membership**

The Rules of Retail Medical Scheme gives you details about the rights and responsibilities for your membership of the Scheme. You may ask us

for a copy of the Rules at any time. These Rules may change from time to time.

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

### **Who you are applying for**

You may apply to join Retail Medical 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 Retail Medical 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 responsibility. You may be called the principal member or main member in our future communications to you.

### **Acting for others**

#### **You confirm you have the right to act for others**

By signing this document, you confirm that:

- you have the right to 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.

### **Giving and getting information**

#### **You must give true, correct and complete information**

To consider your application for membership, Retail Medical 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 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 information and this will be treated as if Retail Medical Scheme had asked you in your role as main member.

### **Your legal address**

We will send documents to you at the valid email address. 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 the Administrator 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.

### **The Scheme and the Administrator 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, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers). You agree that we 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, 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 Retail Medical Scheme, 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 the Scheme or the Administrator 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 backdated changes may not be accepted.

### **When the Scheme may cancel your membership/s**

The Scheme may cancel any memberships immediately, if you and those you apply for:

- do not give us information that later turns out to be relevant to this 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 you apply for) between the day you sign this document and the day cover starts.

### **About becoming a member**

#### **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 claims for any general or specific medical conditions. Please speak to your People Team Department or us to find out if waiting periods apply to your membership and the memberships of those you apply for.

### **Resign from your current medical scheme when we accept your membership**

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 as members of the Scheme.

### **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.

### **Repaying money owed to the Scheme**

The Scheme 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.

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.

### You must repay any medical savings owing if you leave Retail Medical Scheme

When you become a member, and if you chose to belong to the Essential Plus Option, 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 the Scheme 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 the Scheme during the specific year.

By signing this form, you agree to the terms as stipulated, and in particular 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

Please do not sign an incomplete application form

## 10. Annexure A : Third party bank account details

Please attach the relevant proof of bank account if you are providing a third party bank account for claims refund.

**THIRD PARTY ACCOUNT** (e.g. spouse, aunt, uncle, friend, father, son)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, Passport or Driver's Licence
- A copy of the main member's ID, Passport or Driver's Licence

**JOINT ACCOUNT**

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the joint owners

**COMPANY ACCOUNT**

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of the signatories who have authority to sign on behalf of the company
- A letter of authority stating that the account can be used, including the details of the signatory and stating the membership details for which the bank account will be used. The letter must be dated, signed by an authorised person on behalf of the company, and it must contain the membership number
- A copy of the company's certificate of registration
- A copy of the main member's ID, Passport or Driver's Licence

**TRUST ACCOUNT**

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the trustees of the account
- A copy of the Trust's certificate of registration
- A copy of the Trust resolution. The resolution must be dated, and signed by an authorised person on behalf of the Trust

## 11. For office use only

Membership commencement date

Group number (billing category)

Underwriting? Yes  No  Late joiner penalty Yes  No

Additional details or comments

  
  

## 12. Approval by the Scheme

This application form has been duly approved.

Name

Signature

Date