



Contact details

Tel: 0860 101 252 • PO Box 652509, Benmore 2010 • www.retailmedicalscheme.co.za

Retail Medical Scheme membership form (without underwriting)

Who we are

Retail Medical Scheme, (the Scheme) registration number 1176, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, (the Administrator) registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Retail Medical Scheme and takes care of the administration of your membership.

How to complete this form

- 1. Please use one letter per block, complete with black ink and print clearly. Alternatively, complete digitally.
2. To avoid administration delays, please ensure this application is completed in full.
3. Submit the completed and signed form to your People Team Department.
4. Please attach a copy of your and any dependant that must also be registered identity document to this application form. We also accept valid SA driver's licences, passports and birth certificates for children.
5. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
6. You must attach a membership certificate from your current medical scheme to this form. If you do not provide it, we will not be able to process this application.

1. About yourself (main applicant)

Form fields for personal information including: Your cover will start on, Date of employment, Employee number, Title, Surname, First name(s), Previous or maiden name, ID or passport number, Tax number, Gender, Date of birth, Race, Marital status, Telephone (H), Telephone (W), Cellphone, Physical address, Unit/Suite number, Complex name, Street number, Street name, Suburb, City, Postal code.



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.

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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. 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.

## 6. 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

Please sign that you have read and understand this statement

Date 

D	D	M	M	Y	Y	Y	Y
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## 7. 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 

D	D	M	M	Y	Y	Y	Y
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**Please do not sign an incomplete application form**

## **8. 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

### 9. For office use only

Membership commencement date

Y	Y	Y	Y	M	M	D	D
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Group number (billing category)

Underwriting?

Yes

No

Late joiner penalty

Yes

No

Additional details or comments


### 10. Approval by the Scheme

This application form has been duly approved.

Name

Signature

Date

Y	Y	Y	Y	M	M	D	D
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