APPLICATION TO ADD DEPENDANTS 2022

This form is to add a dependant

Contact details

Tel: 0800 12 CARE (2273) • PO Box 653418, Benmore, 2010 • www.libcare.co.za

Libcare Medical Scheme (referred to as Libcare or the Scheme), registration number 1197, is the medical scheme to which you are applying to register a dependant. This is a not-for-profit entity, registered with the Council for Medical Schemes as a closed membership scheme which provides cover for eligible full-time permanent staff members and eligible retirees of the Liberty Group, and their eligible dependants.

Discovery Administration Services (referred to as the Administrator), registration number 2004/006809/07, is a separate company to Libcare, and is accredited by the Council for Medical Schemes to provide administration services to medical schemes, including Libcare and its members.

How to complete this form:

- Please print clearly using CAPITAL letters and one character per block
- Registration and amendments are subject to the rules of the Scheme.
- Scheme must be notified within 30 days of any changes in your details or status, or that of your registered dependant/s.
- Should you have any queries, please contact the Libcare Contact Centre on 0800 12 CARE (2273) for assistance.
- Please submit completed form and all required supporting documentation to your Payroll Administrator.
- We will send you or your employer, the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).

Non-disclosure of information

Non-disclosure is when you intentionally or unintentionally do not disclose certain material details about your dependants you wish to have registered, when you complete the application form. Any non-disclosure of material information or any other fraudulent act may result in cancellation or suspension of your membership.

Examples of material information you must disclose accurately and in full:

- Any medical condition/s that your dependant have at the date of application.
- Any medical condition/s that was diagnosed in the past 12 months – this includes conditions that were diagnosed but managed with lifestyle changes e.g. change in diet.
- Any medical condition for which medical advice, care or treatment was sought in the past 12 months, even if medical advice was not obtained from a doctor but from another healthcare service provider such as a pharmacist.
- Any medical, dental or surgical treatment that your dependants are currently undergoing or expecting to undergo. Please advise whether such treatment is or will be as a result of injuries sustained in a motor vehicle accident or any other trauma. Please also advise whether an undertaking for future medical expenses was issued to any of your dependants by the Road Accident Fund. If applicable, please attach certified copies of any such undertakings received from the Road Accident Fund.

If any of your dependants experience any new symptoms or obtain medical advice or treatment or counselling for a new condition, between the time of submitting this application form and your date of a dependant's registration with the Scheme, please inform the Scheme thereof immediately.

What will happen if you don't disclose all material medical information on the application form?

- Libcare may terminate your membership immediately, and reverse all claims that have been paid from the date that you joined the Scheme.
- The Scheme may impose waiting periods on your re-joining, and depending on the circumstances, may also take criminal or civil legal action in certain cases (e.g. fraud).
- You may also be guilty of an offence as provided for in the Medical Schemes Act 131 of 1998 and liable on conviction to a fine or imprisonment or both.

How do you avoid non-disclosure?

- Read all questions carefully.
- Please ensure that when completing this form, you provide complete, up-to-date and accurate information at all times.
- Be honest and disclose all relevant and required information.
- Give as many details as reasonably possible when answering the health questions on the application form.

When you sign this application, you confirm that you have read and understood the conditions applicable to your membership, including the Rules of the Scheme and that you agree to them. The full set of the Rules of the Scheme is available on request. The Member Guide available on our website is a summary of the Rules. www.libcare.co.za.

1. Details of Principal Member

THIS SECTION MUST BE COMPLETED

Membership number

Initials Surname

First name(s)

SA ID/Passport number Country of issue

Please choose a registration commencement date for your dependant/s you are applying for. This date must be the same for all your dependant/s you are applying registration for.

Registration start date D D M M Y Y Y Y

2. Registration of spouse/partner/additional adult or child dependant/s

- **WHEN APPLYING TO REGISTER YOUR CHILD UNDER 21, PLEASE ATTACH A CERTIFIED COPY OF THE DEPENDANT'S ID OR BIRTH CERTIFICATE**
- **WHEN APPLYING TO REGISTER YOUR ADULT CHILD OVER 21, PLEASE ATTACH PROOF OF FULL-TIME STUDY OR OTHER RELEVANT DOCUMENTATION AND A CERTIFIED COPY OF THE DEPENDANT'S ID**
- **WHEN APPLYING TO REGISTER YOUR SPOUSE, PLEASE CONFIRM DATE OF MARRIAGE AND ATTACH A CERTIFIED COPY OF YOUR MARRIAGE CERTIFICATE AND YOUR SPOUSE'S ID**
- **WHEN APPLYING TO REGISTER YOUR PARTNER, PLEASE COMPLETE THE PARTNERSHIP DECLARATION UNDER SECTION 2.1 AND PROVIDE A CERTIFIED COPY OF YOUR PARTNER'S ID**
- **REGISTRATION OF DEPENDANTS IS NOT AUTOMATIC AS EACH CASE WILL BE EVALUATED INDIVIDUALLY RELATIVE TO THE LIBCARE ELIGIBILITY RULES**
- **THE TRUSTEES WILL ASSESS ALL APPLICATIONS TO REGISTER "OTHER" DEPENDANTS AND YOU WILL BE NOTIFIED AS TO WHETHER REGISTRATION HAS BEEN APPROVED OR NOT.**

2.1 Spouse/Life Partner

Title Initials Date of birth D D - M M - Y Y Y Y

Surname

First name/s

Relationship to Principal Member Spouse Life Partner

SA ID/passport number Gender M F

Telephone (H) - Telephone (W) -

Cellphone -

E-mail address

Postal address

Postal code

Physical address

Postal code

Does the dependant receive an income, eg. pension, salary? Yes No

If yes, what is the montly income? **R** .

Has this dependant had previous medical aid cover? Yes No

If yes, please provide details below and attach membership certificate/s.

Have condition-specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

NAME OF PREVIOUS MEDICAL SCHEME/S	MEMBERSHIP NUMBER/S	DATE JOINED	DATE RESIGNED	REASON FOR LEAVING

2.1.1 Addition of Spouse/Life Partner

If addition is:

- Due to civil or customary marriage or civil union an official registration certificate and/or declaration from a duly certified person must accompany this application form;
- In respect of a Life Partner relationship, the partnership declaration below must be completed and signed.

2.1.2 Life partner declaration

If the addition is for a Life Partner not legally married nor married according to customary or civil union and you cannot give us a marriage certificate, you must complete the following section in full.

We declare we are in committed relationship akin to marriage, based on mutual dependency and that we live together at the same residence. We understand that by signing this declaration, we agree to tell the Scheme about 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 suspend/terminate/annul both our registrations on Libcare.

Signature of Principal Member

Date D D M M Y Y Y Y

Signature of Life Partner

Date D D M M Y Y Y Y

If both parties have not signed and dated the above section, we will halt the application process until we receive the section signed and dated by both parties.

2.2 Dependant 1

Child below 21 ☐ Child 21 and over ☐ Aged parent (excluding parents-in-law) ☐ Sibling ☐

Foster or adopted child ☐ Other ☐ (please specify)

Title Initials Gender M ☐ F ☐

Full names

Surname

Relationship to Principal Member

SA ID/passport number Date of birth D D M M Y Y Y Y

Postal address

Postal code

Physical address

Postal code

If adult, is the dependant financially dependent on the Principal Member? Yes ☐ No ☐

Does the dependant receive an income, e.g. pension, salary? Yes ☐ No ☐

If yes, what is the monthly income? **R** .

Has this dependant had previous medical scheme cover? Yes ☐ No ☐

If yes, please provide details below and attach membership certificate/s, kindly stating reason for cancelling membership.

Have condition-specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes ☐ No ☐

NAME OF PREVIOUS MEDICAL SCHEME/S	MEMBERSHIP NUMBER/S	DATE JOINED	DATE RESIGNED	REASON FOR LEAVING

Complete below: for "other" dependant/s that their registration is not automatic as each case will be evaluated individually relative to the Libcare Scheme Rules

Is the dependant entirely reliant on you for family care and support? Yes ☐ No ☐

Please state reasons and attach affidavit

Does the dependant live with you? Yes ☐ No ☐

Please state reasons including starting date and attach affidavit

Is the dependant a student? Yes ☐ No ☐

If yes, please state whether full-time, part-time, name of academic institution and expected period of study. Also attach proof of student registration for the current academic year.

2.3 Dependant 2

Child below 21 ☐ Child 21 and over ☐ Aged parent (excluding parents-in-law) ☐ Sibling ☐

Foster or adopted child ☐ Other ☐ (please specify)

Title Initials Gender M ☐ F ☐

Full names

Surname

Relationship to Principal Member

SA ID/passport number Date of birth D D M M Y Y Y Y

Postal address

Postal code

Physical address

Postal code

If adult, is the dependant financially dependent on the Principal Member? Yes ☐ No ☐

Does the dependant receive an income, e.g. pension, salary? Yes ☐ No ☐

If yes, what is the monthly income? **R** .

Has this dependant had previous medical scheme cover? Yes ☐ No ☐

If yes, please provide details below and attach membership certificate/s, kindly stating reason for cancelling membership.

Have condition-specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes ☐ No ☐

NAME OF PREVIOUS MEDICAL SCHEME/S	MEMBERSHIP NUMBER/S	DATE JOINED	DATE RESIGNED	REASON FOR LEAVING

Complete below: for "other" dependant/s that their registration is not automatic as each case will be evaluated individually relative to the Libcare Scheme Rules

Is the dependant entirely reliant on you for family care and support? Yes ☐ No ☐

Please state reasons and attach affidavit

Does the dependant live with you? Yes No

Please state reasons including starting date and attach affidavit

Is the dependant a student? Yes No

If yes, please state whether full-time, part-time, name of academic institution and expected period of study. Also attach proof of student registration for the current academic year.

2.4 Dependant 3

Child below 21 Child 21 and over Aged parent (excluding parents-in-law) Sibling

Foster or adopted child Other (please specify)

Title Initials Gender M F

Full names

Surname

Relationship to Principal Member

SA ID/passport number Date of birth D D M M Y Y Y Y

Postal address

Postal code

Physical address

Postal code

If adult, is the dependant financially dependent on the Principal Member? Yes No

Does the dependant receive an income, e.g. pension, salary? Yes No

If yes, what is the monthly income? **R** .

Has this dependant had previous medical scheme cover? Yes No

If yes, please provide details below and attach membership certificate/s, kindly stating reason for cancelling membership.

Have condition-specific waiting periods, exclusions or late joiner penalties ever been imposed on this dependant on application for membership of any other medical scheme/s? Yes No

NAME OF PREVIOUS MEDICAL SCHEME/S	MEMBERSHIP NUMBER/S	DATE JOINED	DATE RESIGNED	REASON FOR LEAVING

Complete below: for "other" dependant/s that their registration is not automatic as each case will be evaluated individually relative to the Libcare Scheme Rules

Is the dependant entirely reliant on you for family care and support? Yes No

Please state reasons and attach affidavit

Does the dependant live with you? Yes ☐ No ☐

Please state reasons including starting date and attach affidavit

Is the dependant a student? Yes ☐ No ☐

If yes, please state whether full-time, part-time, name of academic institution and expected period of study. Also attach proof of student registration for the current academic year.

3. Medical details

IT IS COMPULSORY TO ANSWER EACH QUESTION AND TO FULLY DISCLOSE RELEVANT INFORMATION IN EACH CASE. FAILURE TO DISCLOSE INFORMATION MAY RESULT IN ANY OR EACH OF THE FOLLOWING: THE APPLICATION NOT BEING PROCESSED, CANCELLATION OF MEMBERSHIP WITHOUT REFUND OF CONTRIBUTIONS PAID, REVERSAL OF CLAIMS PAID, OR LEGAL ACTION. FAILURE TO DISCLOSE INFORMATION MAY BE CONSTRUED AS FRAUD. WE MAY ALSO USE THE INFORMATION ON THE PREVIOUS MEMBERSHIP CERTIFICATE TO DETERMINE IF WE CAN APPLY WAITING PERIODS.

Current primary doctor you/your family consult

Name and surname

Telephone ☐☐☐ - ☐☐☐☐☐☐☐ How long has he/she been your doctor? ☐☐ year/s

Practice Number ☐☐☐☐☐☐☐☐☐☐☐☐☐

If there is any confidential health information that you are not comfortable disclosing on this application form (in respect of yourself or any of the dependants you are applying to register);

Please contact the Libcare clinical case manager on 0800 12 CARE (2273) during office hours, within 7 working days of submitting the application form.

- The case manager will ensure that, where applicable, the relevant authorisation/enrolment on a healthcare management programme takes place.
- Please be aware that if you do not record disclosure of health information either on this application form or via the confidential disclosure facility referred to above, it could result in claims for the health conditions being rejected for payment or reversed, and possible termination of your membership in the event of a material non-disclosure.

Have any of your dependants applying for registration on the Scheme sought any advice, been diagnosed with, or treated for any of the following conditions in the past 12 months? Please take note that if any of your dependants have any symptoms or conditions not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 20.

1. **Heart or circulatory conditions:** e.g. heart failure; heart valve defects/disease; heart murmurs; congenital heart disease; circulatory problems/disorders; varicose veins; deep vein thrombosis (DVT); or any other heart or circulatory problems; 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; peripheral vascular disease; any autoimmune conditions; any congenital conditions etc. Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

2. **Breathing or respiratory conditions:** e.g. novel coronavirus; bronchospasm; coughing up blood; shortness of breath or any other breathing problems; asthma; 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 etc. Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

3. **Kidney or urinary conditions, including past or current dialysis:** e.g. blood in urine; kidney/renal failure; polycystic kidneys; recurrent kidney or bladder infections; glomerulonephritis; nephrotic syndrome; urinary incontinence; neurogenic bladder; kidney stones; kidney or urine tests; kidney removal (nephrectomy); other bladder problems; urinary tract or kidney problems; any autoimmune conditions; any congenital conditions; any autoimmune conditions; any congenital conditions etc. Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

4. **Gynaecological and obstetric conditions:** e.g. laser treatment cervix; laparoscopies; menopause; other gynaecological problems; abnormal pap smear results; abnormal menstrual bleeding; endometriosis, miscarriage; polycystic ovarian syndrome; infertility; ectopic pregnancy; missed periods; ovarian cyst; any autoimmune conditions; any congenital conditions etc. Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

5. **Skin conditions:** e.g. eczema; acne; dermatomyositis; pemphigus; psoriasis; scleroderma or any other skin disorders; any autoimmune conditions; any congenital conditions etc. Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

6. **Digestive system conditions:** e.g. duodenal ulcers; alcoholic liver disease; haemochromatosis; heartburn; GORD (reflux); oesophageal disease; gastric ulcers; hernias; colon problems; Crohn's disease; ulcerative colitis; diverticulitis; gall bladder problems; liver problems; hepatitis; cirrhosis; portal hypertension; liver disease; liver failure; pancreatitis; cystic fibrosis or any other digestive system problems; spastic colon/irritable bowel syndrome (IBS); any autoimmune conditions, any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

7. **Ear, nose or throat and dentistry conditions:** e.g. deafness/hearing problems/hearing aid; cochlear implant; ear infections; sinus problems; nasal surgery; speech impairments; harelip; cleft palate; tonsillitis; adenoiditis; vertigo or any other nose or throat problems; throat surgery; orthodontics; dental implants, extractions; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

8. **Eyes conditions:** e.g. eye infections/blindness (partial or full); eye surgery; lens implants; cataracts; glaucoma; retinitis pigmentosa; retinal detachment; retinopathy macular degeneration; corneal transplant; keratoconus; corneal ulcer; uveitis; squint; ptosis; impaired vision or any other eye or eyesight problems; any abnormality of eyelids; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

9. **Endocrine or metabolic conditions:** e.g. pituitary gland problems or any other endocrine or glandular problems; lupus; Sjogren's syndrome; 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 etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

10. **Musculoskeletal (bone or muscles) conditions:** e.g. neck or back problems or operations; fractures; joint or muscular problems or operations; recurrent back pain; degenerative disc disease; scoliosis; kyphosis; spinal stenosis; gout; injury; physical disabilities; osteoporosis; ankylosing spondylitis; arthritis; (rheumatoid; osteoarthritis; other); gout or any other bone or skeletal disorders; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

11. **Neurological/brain and nerve conditions:** e.g. ventricular peritoneal shunt; epilepsy; stroke (CVA); bleeding on the brain; migraine; other chronic headaches; brain injuries; seizures; spinal cord injuries; hemiplegia; quadriplegia; paraplegia; hydrocephalies; brain shunt; paralysis; cerebral palsy; multiple sclerosis; narcolepsy; motor neuron disease; myastheniagravis; Parkinson's disease; intellectual disability; Alzheimer's disease; Down syndrome; any other neurological problems; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

12. **Mental health/psychological conditions:** e.g. depression; anxiety; psychosis; suicide attempts; bipolar disorders; stress related; schizophrenia; Tourette's syndrome; anorexia nervosa; received advice; counselling or treatment for alcohol or drug abuse; attention deficit disorder; bulimia; any other psychological problems; trauma counselling or post traumatic stress disorders; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

13. Tumours or growths: e.g. lymph gland cancer; abnormal pap smear results and disorders of the skin; skin lesions; breast disease; non-cancerous tumours; cancerous tumours; cancer of any organ; fibrocystic breast disease; fibroadenoma; lump in breast; abscess; abnormal mammogram result; abnormal PSA (Prostate Specific Antigen) result; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

14. Blood or immune deficiency conditions: e.g. Platelet disorders; deep vein thrombosis; anaemia; polycythaemiavera; blood clotting diseases; leukaemia; lymphoma; pulmonary embolus; haemophilia; haemochromatosis; other bleeding disorders; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

15. Male urogenital conditions: e.g. prostate disorder; urogenital defects; varicocele; infertility; tumours; undescended testes; phimosis; urinary incontinence; abnormal PSA (prostate specific antigen) results; any autoimmune conditions; any congenital conditions etc.

Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

16. Pregnancy: Are any of your dependants currently pregnant? Yes ☐ No ☐

If the answer to this question is “yes”, when is the expected date of delivery? D D - M M - Y Y Y Y

Name of patient/s

Name of treating Doctor/other healthcare professional

Contact number of treating Doctor/other healthcare professional

LIBAAD001

17. **Expected hospitalisation:** Are any of your dependants planning to or reasonably expecting to be hospitalised (including pregnancy), or to undergo a procedure in hospital in the next 12 months? Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

18. **Hospitalisation or previous surgical procedures not listed above:** Have any of your dependants been hospitalised and/or had a surgical procedure in the past 12 months? Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

19. **Are any of your dependants using any prescribed medication not listed above?** If yes, please provide the details below. Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

20. **Other medical conditions or surgical procedures:** Is there any other condition or symptom, which is not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received, e.g. flu, seasonal sinusitis, etc. Yes ☐ No ☐

NAME OF PATIENT	SYMPTOMS/ MEDICAL DIAGNOSIS	DATE FIRST DIAGNOSED/ SYMPTOMS	DESCRIPTION OF TREATMENT AND MEDICINE USED (INCLUDING DOSAGE)	DATE OF LAST SYMPTOMS, CONSULTATION AND /OR HOSPITALISATION	ARE YOU OR YOUR DEPENDANT/S CURRENTLY RECEIVING TREATMENT?	NAME AND CONTACT NUMBER OF TREATING DOCTOR/OTHER HEALTHCARE PROFESSIONAL
					Yes ☐ No ☐	
					Yes ☐ No ☐	
					Yes ☐ No ☐	

4. Employer information

This section must be completed by your Payroll Administrator

Name of employer

Employer telephone number -

Employer fax number -

Employer e-mail address

Pay point code

Label

Employee number

Number of dependants

Dependants subsidised Yes No

Date of joining the Scheme D D - M M - Y Y Y Y

Date of employment D D - M M - Y Y Y Y

Monthly contribution breakdown at date of application

Member's share of contribution	Employer's share of contribution	Total monthly contribution	Monthly salary of applicant
			R

Payroll Administrator details

Name

Surname

Date D D - M M - Y Y Y Y

Designation

COMPANY STAMP

Employer declaration

I confirm that the applicant detailed in Section 1 is an employee of the Company and is eligible to be registered as a member of Libcare, in compliance with the employment contract and the registered Rules of the Libcare Medical Scheme/ I declare that all documentation attached has been checked for correctness and is in order.

Company Representatives's full name

Company Representatives signature

Date D D - M M - Y Y Y Y

5. Declaration by Principal Member

THIS SECTION MUST BE COMPLETED

I declare that to the best of my knowledge the information given above is true and correct.

Signature of Principal Member

Date D D - M M - Y Y Y Y

6. Libcare Medical Scheme Privacy Statement

Our Privacy Statement – How we will process and disclose your personal information and communicate with you

Definitions

The Scheme refers to Libcare Medical Scheme, registration number 1197, registered with the Council for Medical Schemes.

Administrator refers to Discovery Administration Services (Pty) Ltd, registration number 2004/006809/07.

You and your refers to the member and the dependants on the medical scheme which may include your spouse, children and other dependants as the case may be.

LIBAAD001

Your personal information refers to all personal information the Scheme has about you, or data subjects who are related to you or under your authority ("other data subjects") (as relevant). It includes:

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

Process(ing) (of) information means the lawful and reasonable automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information to ensure that such processing is adequate, relevant and not excessive given the purpose for which it is processed.

Competent person means anyone who is legally competent to consent to any action or decision being taken for any matter concerning a member or dependant, for example a parent, legal guardian or a legal representative appointed by a court to manage the finances, property, or estate of another person unable to do so because of mental or physical incapacity.

1. When you engage with the Scheme and its Administrator, you entrust us with personal information about yourself, your family. We are committed to protecting your right to privacy. The Scheme and its Administrator will keep your personal information confidential.
2. The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information, in a manner that is compliant, ethical, adheres to industry best practice and applicable protection of personal information legislation as enacted from time to time.
3. We have a duty to take all reasonably practicable steps to ensure your personal information is complete, accurate, not misleading and updated on a regular basis. To enable this, we will always endeavour to obtain personal information from you directly. Where we are unable to do so, we will make use of verifiable independent third party data sources. Thus, your personal information comprises information you may have given us yourself or we may have collected from other sources.
4. You have the right to object to the processing of your personal information and have a choice whether or not to accept these terms and conditions. However, it is important to note that the Scheme and its Administrator require your acceptance to activate and service your medical scheme membership. If you do not accept these terms and conditions, we cannot activate and service your medical scheme membership.
5. If you share your personal information with any third parties, we will not be responsible for any loss suffered by you or your employer (where applicable).
6. You understand and/or acknowledge that when you include your spouse and/or dependants on your application, we will process their personal information for the activation of the dependant's registration on the membership/benefit and to pursue their legitimate interest. By submitting your dependants' relevant personal information, you hereby confirm that you are duly authorised to share such information with us. We will furthermore process their information for the purposes set out in this Privacy Statement.
7. If you are giving consent for a person under 18 (a minor) you confirm that you are a competent person.
8. You agree that the Scheme and its Administrator may process your personal information for the following purposes:
   - to verify the accuracy, correctness and completeness of any information provided to the Scheme and its Administrator in the course of processing an application for membership or providing services related to the membership;
   - for the administration of your membership profile and benefits;
   - for the provision of managed care services to you on your membership;
   - for the provision of relevant information to a contracted third party who requires this information in order to provide a healthcare service to you on your membership;
   - to profile and analyse risk;
   - to share your personal information with external health providers for them to assess or evaluate certain clinical information, in the event that you are subject to such a clinical assessment.

   Examples of how this will happen include:

   8.1. Sharing your personal information with your chosen financial adviser during the application process to help the Administrator, if necessary, while we process your membership application;
   8.2. Getting your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus or industry regulatory bodies ("relevant sources") and further processing of such information to consider your membership application, to conduct underwriting or risk assessments, or to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete;
   8.3. Getting information from and sharing with your employer information that is relevant to your application;
   8.4. Communicating with you about any changes in your membership, including your contributions or changes and enhancements to the benefits you are entitled to on your membership;
   8.5. Transferring your personal information outside the borders of the Republic of South Africa where appropriate, for example to administer claims incurred in the Common Monetary Area, or if you provide an email address which is hosted outside the borders of South Africa. 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.
   8.6. The Scheme will share your personal information (including personal health information) with third parties for purposes of Scheme business in accordance with applicable law, the Scheme Rules and as further detailed in your Scheme application form. Should you wish for the Scheme to share your personal information (including personal health information) that forms part of the Scheme's records, with third parties for purposes of non-Scheme business, the Scheme will only permit the sharing of such information if you have provided the Scheme with a written, informed consent to this effect that complies with applicable law. Please note that the Scheme's Administrator is expressly prohibited from sharing your personal information as obtained from the Scheme's records with third parties for purposes of non-Scheme Business, and the Administrator may only do so on receipt of explicit written consent in each instance from **both** the Scheme and yourself.
9. You consent and agree that:

- we may process your information, including personal and special personal information, to adhere to South African legislative reporting obligations and to perform transaction monitoring activities;
- we may communicate such personal information to local Regulatory Bodies if any Legislative reportable matters are identified.

10. By signing this application form, you authorise the Scheme and its Administrator to obtain and share information about your creditworthiness with any credit bureau or credit providers' industry association or industry body, for the purpose of servicing your membership in line with the Scheme rules. This includes information about credit history, financial history, judgments, default history and sharing of information for purposes of risk analysis, tracing and any related purposes.
11. We may process your information using automated means (without human intervention in the decision-making process) to make a decision about you or your application for membership or benefit in line with the Scheme rules. You may query the decision made about you in this process.
12. The Scheme and its Administrator have the right to communicate with you electronically about any changes on your membership, including your contributions or changes and improvements to the benefits you are entitled to on your membership.
13. The Scheme has a duty to keep you updated about any Scheme offers and Scheme new products that are made available from time to time.
14. You may opt out of Electronic Marketing on www.libcare.co.za. We will store your personal information to enable us to action this request and action it as soon as reasonably possible.
15. You have the right to know what personal information the Scheme holds about you. If you wish to receive this information, please complete a 'PAIA Form to Request Access to Records' on www.libcare.co.za and specify the information you would like. We will take all reasonable steps to confirm your identity before providing details of your personal information.
    We are entitled to charge a fee for this service and will let you know what it is at the time of your request.
16. You agree that the Scheme and its Administrator may keep your personal information until you ask us to delete or destroy it. You have the right to ask us to update, correct or delete your personal information, unless the law requires us to keep it. Where we cannot delete your personal information, we will take all practical steps to de-personalise it.
17. Where the Scheme and its Administrator are required by law to collect and keep personal information, we shall do so. At a minimum, this includes the following legislation:
    - Medical Schemes Act, 1998
    - The Consumer Protection Act, 2008
    - The Protection of Personal Information Act, 2013
    - Electronic Communications and Transactions Act, 2002
    - Promotion of Access to Information Act, 2002
18. You agree that the Scheme and its Administrator may transfer your personal information outside South Africa:
    - if you give us an email address that is hosted outside South Africa, for the purpose of enabling us to correspond with you at that address; or
    - to administer certain services in terms of Scheme Rules, for example, cloud services.
      When we share your information to administer certain services, we will ensure that any country, company or person that we pass your personal information to agrees to treat your information with the same level of protection as we are obliged to.
19. If the Scheme or its Administrator becomes involved in a proposed or actual amalgamation, transfer or merger, acquisition or any form of sale of any assets, as appropriate, we have the right to share your personal information with third parties in connection with the transaction. In the case of such an event, the new entity will have access to your personal information.
20. The Scheme may change this Privacy Statement at any time. The current version is available on www.libcare.co.za.
21. If you believe that the Scheme or its Administrator have used your personal information contrary to this Privacy Statement, you have the right to lodge a complaint with the Information Regulator, under the Protection of Personal Information Act (POPIA), but we encourage you to first make use of our 0800 12 CARE (2273) number in the first instance to access all Libcare services, as all your day-to-day queries and administration are dealt with there. If you wish to raise any matter/escalation with the Scheme, you may do so through the Principal Officer at tracey.unser@liberty.co.za. If, thereafter, you feel that we have not resolved your complaint adequately, kindly contact the Information Regulator at: The Information Regulator (South Africa)
22. JD House |27 Stiemens Street | Braamfontein |Johannesburg |PO Box 31533 |Braamfontein |Johannesburg |2001 | POPIAComplaints@inforegulator.org.za or PAIAComplaints@inforegulator.org.za.

Signature of Principal Member

Date D D - M M - Y Y Y Y

7. Important information applicable to Libcare Medical Scheme membership

Definitions

The Scheme refers to Libcare Medical Scheme, registration number 1197, registered with the Council for Medical Schemes.

Administrator refers to Discovery Administration Services (Pty) Ltd, registration number 2004/006809/07, an authorised financial services provider, the administrator and managed care organisation for Libcare Medical Scheme.

Scheme Rules for membership

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

When you sign the letter of confirmation of your personal details, or begin using your membership card to access benefits, you confirm that you have read and understood these terms and conditions and you agree that you and those on your membership will be bound by these and Scheme Rules. Please speak to the Administrator if there is anything you do not understand.

Where applicable you also acknowledge and confirm that you, or your employer, may communicate with us in regard to your membership of the Scheme.

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 administer the membership and 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.

Giving and getting information

You must give true, correct and complete information

Information about you and those on your membership must be true, correct and complete. This includes the details you give in this document and in future dealings with us.

Your address for legal notices

The Scheme or its 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 its Administrator may record telephone calls

The Scheme and its Administrator may record telephone conversations with you and with those on your membership. The recordings and all information we get during the recordings will be processed and kept as required by law.

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

The Scheme and its Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including medical practitioners, contracted service providers, financial advisers, credit bureaus, industry regulatory bodies ("relevant sources") to consider a claim for medical expenses. We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete.

You give your permission that the Scheme and its Administrator may get any information that is relevant to your membership from your employer.

Tell the Scheme or its Administrator immediately if your information changes

You must tell the Scheme in writing if any of your information, changes. This includes information about your health and the health of those on your membership. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership/s

The Scheme may cancel any membership if you and those on your membership:

- do not give us information that later turns out to be relevant to this membership
- 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.

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

As a member of the Scheme

The Scheme might not pay for certain expenses.

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. Please speak to the Administrator with regard to any waiting periods applicable to your membership and those on your membership.

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 on your membership must terminate any other cover held.

You must ensure contributions are paid on time

As the Principal Member of the Scheme, you are responsible for ensuring that your contributions and the 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.

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.

You must repay any medical savings owing if you leave the Scheme

As a member, you may have money available in advance to use for medical expenses during the year. This money is allocated to an account called the 'Medical Savings Facility'. 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 over the year.

By signing this document 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.