APPLICATION FOR MEMBERSHIP 2024

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

This document is a membership application form. Please refer to Section 7 and 8 of this form, for important information about membership, and also refer to the Member Guide on our website **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 become a member. 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 (PTY) Ltd (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.

IMPORTANT INFORMATION

The following documents must be attached to this application form. Failure to do so will result in the application not being processed.

- Certified copies of Identification Documents/Birth Certificates for you and all your dependants being registered
- Certified copy of your marriage certificate if applicable
- Membership certificates for all medical schemes that you and your dependants belonged to previously
- Please submit completed form and all required supporting documentation to your Payroll Administrator

NOTE:

- **A separate form must be completed for the following**:
  - Change of address/contact details
  - Change of bank details
  - Cancellation of a dependant's registration
  - Registration of new spouse/partner, births/adoptions and additional adult and child dependants for whom application to be registered on Libcare was not made at the same time as for the Principal Member. Registration and amendments are strictly subject to the Rules and approval of the Scheme. 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.
- **Once we receive your application form the following will take place**:
  - Should any details be missing, or should we require more information for underwriting purposes, we will contact you via telephone, email or care of your Payroll Administrator.
  - If waiting periods and/or late-joiner penalties apply, we will issue an Underwriting Acceptance & Declaration letter, which will indicate any conditions applicable to your membership. You may accept the offer by signing and returning the letter to us care of your Payroll Administrator, for us to activate your membership.
  - If all is in order, we will activate your membership and send a membership certificate to you.
  - Within four working days of activation of your membership, your membership card/s will be issued for delivery/collection by you.

How to complete the form

- Please print clearly using CAPITAL letters and one character per block.
- Mark with an ‘x‘ where necessary.
- Should you have any queries, please contact the Libcare Contact Centre during office hours on **0800 12 CARE (2273)** for assistance.
- Please initial and date any changes you make to any details you have already completed.

LIBAMI001

Non-disclosure of information

Non-disclosure is when you intentionally or unintentionally do not disclose certain material details about yourself and your dependants you wish to have registered, when you complete the application form to join Libcare. 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 you or a 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 you or 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 you and/or 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 you or 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 membership of 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

Membership start date D D M M Y Y Y Y (e.g. 01)

Surname

Title

First name | Second name

Third name | Preferred name

Initials | Gender M F

Date of birth D D M M Y Y Y Y | SA ID/Passport number

Tax payer number

Telephone (H) | Telephone (W)

Cellphone | Fax

E-mail address

Postal address

Postal code

Physical address

Postal code

Job title

Have you had previous medical aid cover? If yes, please provide details below, and attach the relevant membership certificate/s. Yes ☐ No ☐

Have condition-specific waiting periods, exclusions or late-joiner penalties ever been imposed on you when applying 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

Please tick – FOR STATISTICAL PURPOSES ONLY

Ethnic group Asian ☐ Black ☐ Coloured ☐ Indian ☐ White ☐

Marital status Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life partner ☐

2. Details of person/s you are applying to register as your dependant/s

It is compulsory to complete this section if you have any dependants you would like to register. Registration of a dependant is strictly subject to the Rules of the Scheme. (Please refer to page 1 of this form, regarding supporting documents). Please note that ex-spouses do not qualify to be registered/remain registered on Libcare.

2.1 Dependant 1 - Spouse/Life Partner

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

Surname

First name Second name

Third name Preferred name

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, e.g. pension, salary? Yes ☐ No ☐

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 that we are in a committed relationship akin to a 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 2

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

Foster or adopted child ☐ Other ☐ (please specify)

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

Surname

First name Second name

Third name Preferred name

Relationship to Principal Member

SA ID/passport number Gender M ☐ F ☐

Postal address

Postal code

Physical address

Postal code

Is your dependant:

Financially dependent on you? Yes ☐ No ☐ Living with a mental/physical disability? Yes ☐ No ☐

Full time Scholar/Full time Student? Yes ☐ No ☐ Grade/Year of study?

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

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

2.3 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 Date of birth D D M M Y Y Y Y

Surname

First name Second name

Third name Preferred name

Relationship to Principal Member

SA ID/passport number Gender M ☐ F ☐

Postal address

Postal code

Physical address

Postal code

Is your dependant:

Financially dependent on you? Yes ☐ No ☐ Living with a mental/physical disability? Yes ☐ No ☐

Full time Scholar/Full time Student? Yes ☐ No ☐ Grade/Year of study?

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

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

2.4 Dependant 4

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

Foster or adopted child ☐ Other ☐ (please specify)

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

Surname

First name Second name

Third name Preferred name

Relationship to Principal Member

SA ID/passport number Gender M ☐ F ☐

Postal address

Postal code

Physical address

Postal code

Is your dependant:

Financially dependent on you? Yes No Living with a mental/physical disability? Yes No

Full time Scholar/Full time Student? Yes No Grade/Year of study?

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

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

2.5 Dependant 5

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

Foster or adopted child Other (please specify)

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

Surname

First name Second name

Third name Preferred name

Relationship to Principal Member

SA ID/passport number Gender M F

Postal address

Postal code

Physical address

Postal code

Is your dependant:

Financially dependent on you? Yes No Living with a mental/physical disability? Yes No

Full time Scholar/Full time Student? Yes No Grade/Year of study?

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

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

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 you or 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 you or 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. chest pain/angina; heart attack; heart failure; heart valve defects/disease; rheumatic fever; high blood pressure (hypertension); high cholesterol; heart murmurs; palpitations; cardiomyopathy; congenital heart disease; stents; pacemaker; previous heart surgery; circulatory problems/disorders; varicose veins; deep vein thrombosis (DVT) or any other heart or circulatory problems; shortness of breath; coronary heart disease; valvular heart disease or heart valve replacement; any autoimmune conditions; any congenital conditions; etc.

Yes No

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. asthma; novel coronavirus; bronchospasm; tuberculosis (TB); coughing up blood; emphysema; bronchiectasis; chronic obstructive pulmonary disease; pneumonia; cystic fibrosis; bronchitis; sarcoidosis; shortness of breath or any other breathing problems; interstitial lung disease; chronic cough > 3 months; any autoimmune conditions; any congenital conditions; etc.

Yes No

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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; kidney stones; kidney or urine tests; kidney removal (nephrectomy); other bladder problems, urinary tract or kidney problems; neurogenic bladder; any autoimmune conditions; any congenital conditions; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. abnormal pap smears results; abnormal menstrual bleeding; endometriosis; miscarriage; laser treatment cervix; laparoscopies; menopause; any polycystic ovarian syndrome; infertility; ectopic pregnancy and/or other gynaecological problems; missed periods; ovarian cyst; any autoimmune conditions; any congenital conditions; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. heartburn; GORD (reflux); oesophageal disease; duodenal ulcers; gastric ulcers; hernias; colon problems; Crohn's disease; ulcerative colitis; diverticulitis; gall bladder problems; liver problems; hepatitis; cirrhosis; portal hypertension; alcoholic liver disease; liver failure; haemochromatosis; 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	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. 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; eye infections; any autoimmune conditions; any congenital conditions; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. diabetes mellitus (“high blood sugar”); hypoglycaemia (“low blood sugar”), underactive thyroid; overactive thyroid; thyroid surgery; Cushing’s syndrome; Addison’s disease; parathyroid disease; Paget’s disease; growth deficiency; metabolic disorders; Conn’s syndrome; pituitary gland problems or any other endocrine or glandular problems; lupus; Sjogren’s syndrome; diabetes insipidus; thyroid disease; osteoporosis; any autoimmune conditions; any congenital conditions; etc

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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; recurrent back pain; degenerative disc disease; scoliosis; kyphosis; spinal stenosis; gout; fractures; physical disabilities; osteoporosis; ankylosingspondylitis; arthritis; (rheumatoid; osteoarthritis; other); gout or any other bone or skeletal disorders; joint or muscular problems or operations; injury; any autoimmune conditions; any congenital conditions; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. epilepsy; stroke (CVA); bleeding on the brain; migraine; brain injuries; spinal cord injuries; hemiplegia; quadriplegia; paraplegia; hydrocephalies; ventricular peritoneal shunt; paralysis; cerebral palsy; multiple sclerosis; narcolepsy; motor neuron disease; myastheniagravis; Parkinson's disease; Alzheimer's disease; Down syndrome; any other neurological problems; other chronic headaches; seizures; brain shunt; intellectual disability; any autoimmune conditions; any congenital conditions; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. non-cancerous or cancerous growths or lumps or tumours including but not limited to: melanoma; lymph gland cancer; abnormal mammogram results; breast disease/cancer or any other tumours; growths and cancers; skin lesions; abnormal pap smear results and disorders of the skin; fibrocystic breast disease;fibroadenoma; lump in breast; abscess; abnormal PSA (Prostate Specific Antigen) result; any autoimmune conditions; any congenital conditions; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. anaemia; haemophilia; lupus; platelet disorders; lymphoma; pulmonary embolism; leukemia; deep vein thrombosis (DVT); polycythaemia vera; blood clotting diseases; haemochromatosis; other bleeding disorders; any autoimmune conditions; any congenital conditions; etc.

Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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; tumours; undescended testes; phimosis; urinary incontinence; abnormal PSA (prostate specific antigen) results; infertility; any autoimmune conditions; any congenital conditions; etc. Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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 you or 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

17. **Expected hospitalisation:** Are you or 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	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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 you or any of your dependants been hospitalised and/or had a surgical procedure in the past 12 months? Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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 you or any of your dependants using any prescribed medication not listed above?** If yes, please provide the details below. Yes ☐ No ☐

NAME OF PATIENT	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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	DIAGNOSIS/ CONDITION	DATE FIRST DIAGNOSED	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. Bank details for refund of claims and savings payments

Banking details are required in order to reimburse you for any monies owed to you as a result of claims or savings refunds

Bank account owner (Mark with an X) Principal Member ☐ Third party ☐

Bank name

Branch name

Account type Cheque ☐ Transmission ☐ Savings ☐ Other ☐

Full name of account holder

Account number

Please note: If the above bank account is not yours, please insert the third party's ID number.

Third party's ID number

For third party account holder: Submit the following with this form: A copy of the third party's ID and a bank statement/letter of confirmation (not older than **three months**) from the bank.

Signature of bank account holder Date D D M M Y Y Y Y

Signature of principal Member Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct.

5. Employer information

This section must be completed by your Payroll Administrator

Name of employer

Employer telephone number

Employer fax number

Employer e-mail address

LIBAMI001

Pay point code

Employee number

Number of dependants

Dependants subsidised Yes No

Date of joining the Scheme D D M M Y Y Y Y (0 1)

Date of employment D D M M Y Y Y Y

Monthly contributions breakdown at date of application

MEMBER'S SHARE OF CONTRIBUTION	EMPLOYER'S SHARE OF CONTRIBUTION	TOTAL MONTHLY CONTRIBUTION	MEMBER'S PENSIONABLE SALARY

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 Representative's full name

Company Representative's signature

Date D D M M Y Y Y Y

6. Declaration by Principal Member

1. I, the undersigned, hereby apply for myself and my nominated dependants to be registered on the Libcare Medical Scheme ("**the Scheme**").
2. I understand that this application, together with any supporting documents and the Rules of the Scheme, form the basis of my contract with the Scheme
3. **Acceptance of risk**
   - 3.1. I further agree and understand that, notwithstanding any statement made to the contrary by any person, membership will not commence and no liability whatsoever will attach to the Scheme as a result of this application, unless and until express written notice of acceptance (also referred to as a Welcome letter) has been given by the Scheme and the contribution has been loaded on the employer payroll system.
   - 3.2. I warrant that none of my nominated dependants nor I are beneficiaries of another registered medical scheme. Where an active membership exists, I shall make arrangements to cancel such membership upon Libcare's acceptance of my application for membership.
4. **Scheme Rules and benefits**
   - 4.1. I accept that the Scheme Rules will be made available on request and I agree that I and my nominated dependants will be bound by the Scheme Rules and will abide by them.
   - 4.2. The Scheme shall not be bound in any way by any representations or undertakings made or given by any person except as contained in the registered Rules of the Scheme.
   - 4.3. I understand that certain benefits may be pro-rated if my membership commences after 1 January of a year.
5. **Waiting periods and late joiner penalties**
   - 5.1. I understand that the Scheme may impose waiting periods and/or late joiner penalties in respect of myself and/or any of my nominated dependants subject to the requirements of the Medical Schemes Act No. 131 of 1998, and the Regulations thereto.
   - 5.2. I understand that the Scheme will inform me of any such waiting periods and/or late joiner penalties, in the form of an acceptance letter which, if I accept the terms, I am required to sign and return to the Scheme in order for the further processing of my application to proceed in terms of the Scheme Rules.
6. **Banking details**
   - 6.1. I agree to advise the Scheme in writing of any changes to my banking details, and I undertake to do so within at least 2 working days of the changes being required to take effect for any Scheme payments to or from my account.

6.2. I understand that failure to do so will result in me being liable for any subsequent banking charges or other costs/losses incurred due to the use of the incorrect banking details.

7. **Contributions and repaying amounts owed to the Scheme**

7.1. I hereby acknowledge that any credit extended by the Scheme to me, in terms of the Scheme Rules, is a debt due by me and must be repaid by me to the Scheme by 31 December of the same benefit year, or at the time I resign from the Scheme (whichever date comes first) regardless of the date of commencement of membership. I further acknowledge that interest may be charged on all amounts due and owing by me to the Scheme.

7.2. I accept that the Scheme has the right to collect contributions owed to the Scheme in line with my contractual obligation.

7.3. I accept that the Scheme has the right to amend monthly contributions and benefits from time to time.

7.4. I understand that if contributions or other amounts due are not paid, that the Scheme will suspend my membership resulting in the non-payment of benefits irrespective of when services were obtained and that if such amounts remain outstanding, that my membership will be terminated.

7.5. I agree that any amounts owing by me to the Scheme may be offset against any future claim payment amounts that are due to be paid to me.

7.6. I also accept that I will be responsible for any cost associated with the recovery of any arrear contributions or other debts.

8. **Disclosure of information**

8.1. I understand and acknowledge that when I include my nominated dependants on my application, Libcare will process their personal information for the processing and assessing of my application and eligibility for membership. By submitting my dependants' relevant personal information, I hereby confirm that I am duly authorised to share such information with Libcare.

8.2. I confirm that the information provided in this application and in any other documents submitted in support of this application is true, correct and complete and that I have not withheld, concealed or misstated any information.

8.3. I furthermore confirm that I understand that my membership will become null and void should the above statement be found to be incorrect and that in such an event all monies paid in respect of my membership may be forfeited and that the Scheme may furthermore be entitled to recover any amounts paid for services rendered from the healthcare service provider and/or myself.

8.4. I undertake to promptly advise the Scheme of any change in status of my health or the health of any of my nominated dependants that occurs prior to the date of registration with the Scheme and acknowledge that the additional information may be subject to underwriting. I acknowledge that not doing so may lead to the Scheme reconsidering the basis of my membership application.

8.5. I understand that should there be any additional information required by the Scheme that is not received within 10 days, that the Scheme has the authority to pend my application for membership.

8.6. I indemnify Libcare Medical Scheme and its Trustees, agents and Administrator against any claim, of whatever nature, which may be made against them as a result of or arising out of the disclosure of any personal health information in fulfilling this agreement.

8.7. I irrevocably authorise any healthcare service provider or other person who has attended to me or my dependants in the past, or who will attend to us in the future, or who may be in possession of information about me or my nominated dependant/s, including health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to the Scheme or any entity contracted by the Scheme in order to fulfill its functions, duties and obligations in terms of this agreement, on request, and I agree that this authorisation shall remain in force after my/ their death/s or termination of registration of any of us.

8.8. I further acknowledge that my personal information and that of my dependants shall be retained as part of the records of the Scheme for as long as it is required by the Scheme for lawful purposes, as may be required by applicable legislation and for historical, statistical or research purposes subject to the requirements of applicable law.

8.9. I understand that my nominated dependants and I may have access to our personal information held by Libcare and its Administrator, and may request Libcare to correct any inaccurate information subject to the provisions of applicable legislation.

8.10. I understand that should any of my nominated dependants or I have any concern about the processing of our personal information, we may raise the matter with the Principal Officer. I also understand that we may also lodge a complaint with the Information Regulator.

8.11. I consent thereto that the Scheme may use my anonymised /de-identified information for statistical purposes and trend analysis.

9. **Termination of membership**

9.1. I hereby acknowledge that any monies owed to the Scheme by me, may be collected by the Scheme at any time, provided that I have been given information regarding the amount due. In addition, credit extended by the Scheme to me in terms of the Rules of the Scheme will become payable in full upon resignation of my membership of the Scheme and that interest may be charged on all amounts due and owing to the Scheme.

9.2. I further acknowledge that on resignation of my membership, any contributions owing to the Scheme will be deducted from any amounts due to me by my employer.

9.3. For this purpose, I hereby permit the Scheme to advise my employer of any contribution amounts due to the Scheme where applicable and I consent to such deductions by my employer.

9.4. I understand that according to the Scheme Rules, if I leave the employment of the Company (excluding retirement), my Libcare membership will cease at the end of the last month of employment.

I acknowledge that I have read and understand the content of this application form. I have had an opportunity to question and consider same and I agree to the consequences. My signature below confirms that I agree with the terms and conditions above. Please complete in full:

Signed at _____ on D D M M Y Y Y Y

Signature of Principal Member _____

Print name _____

SA ID/Passport number _____

LIBAMI001

7. 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.
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 and 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 Scheme membership/benefit and to pursue their legitimate 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 Scheme membership or providing services related to the Scheme membership;
   - for the administration of your Scheme membership profile and Scheme benefits;
   - for the provision of managed care services to you on your Scheme 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 Scheme membership;
   - to profile and analyse risk for Scheme-only reporting purposes;
   - to share your personal information with external healthcare providers for them to assess or evaluate certain clinical information, in the event that you are subject to such a clinical assessment;
   - to investigate and/or remedy fraud, waste and abuse.
     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 Scheme membership application, to conduct Scheme 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 or financial advisers). 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 Scheme 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, which non-Scheme business includes separate applications/subscriptions to or benefits from rewards or loyalty programmes or similar, which have no contractual relationship with the Scheme, and the Administrator may only do so on receipt of explicit written consent in each instance of such sharing of information 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 the Scheme membership 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 Scheme membership or Scheme benefits 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 the Scheme or its Administrator 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

LIBAMI001

8. 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.