Applying to become a member of Malcor Medical Aid Scheme in 2025

MALCOR MEDICAL AID SCHEME
Administered by Discovery Health

Contact details
Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

Thank you for deciding to apply to join the Malcor Medical Aid Scheme. This document is an application form for membership.

It also contains some rules for membership. Please make sure you read and understand these rules.

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the terms and conditions for membership (section 10).
3. Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.
4. Main applicant to sign and date any changes.
5. Once completed, your employer contact must email the completed and signed form to **membership@totalmed.co.za**.
6. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

Once you send us your application form, this is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will activate your membership and send you a letter of confirmation when we are offering standard terms of acceptance (no waiting periods). For any non-standard terms, we will issue a counter-offer letter which will indicate any conditions applicable to your membership (waiting periods). **You may accept the offer by signing and returning this letter for us to activate your membership.**
- 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).
- We will send you a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- You will then get a pack in the post or this may be handed to you by your employer contact.

If you do not hear from us seven days after sending us your application form, please contact us on **011 372 1500.**

When you sign this application, you confirm that you have read and understood the terms and conditions (section 10 of this form) for membership and agree to them.

I consent to my spouse and/or adult dependant acting on my behalf and providing my personal information, including health information, to Discovery Health for the purpose of my application to join Malcor Medical Aid Scheme. Yes ☐ No ☐

1. About yourself (main applicant)

When do you want your cover to start? D 0 D 1 M M Y Y Y Y

Title ☐☐☐☐ Initials ☐☐☐☐☐

Surname

First name/s (as per identity document)

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

Occupation

Tax number

Total monthly earnings **R** (only complete when choosing Plan D)

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

ID or passport number

Telephone (H) Telephone (W)

Cellphone

Email

Postal address (Post collected from post box, suite or private bag)

☐ PO Box ☐ Private bag Box number

☐ Suite ☐ Postnet suite Number

Suburb Postal code

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

Physical address:

Unit/Suite number Complex name

Street number Street name

Suburb

City Postal code

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

Title Initials

Surname

First name(s) (as per identity document)

Gender M ☐ F ☐ Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

Telephone (H) Telephone (W)

Cellphone

Tax number

Email

Partnership declaration

In the event that you are not legally married and unable to produce a marriage certificate, we require that you complete the below section fully. We hereby declare that we are in a long-term, committed relationship that is akin to a marriage and that we reside together at the same residence.

We understand that by signing this declaration we agree to inform the Scheme of any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that should the information provided regarding our relationship or residency be false in any way, the Scheme reserves the right to terminate both our memberships. Should the below section not be signed and dated by both parties, the application process will be halted until such time as the section has been duly signed and dated by both parties.

Signature of main applicant Date D D M M Y Y Y Y

Signature of partner Date D D M M Y Y Y Y

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

When do you want cover to start D 0 D 1 M M Y Y Y Y

Dependant 1

Title | Initials | Surname

First name(s) (as per identity document)

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

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

Married? Yes No Financially dependent on you? Yes No

Is your dependant a student? Yes No Is your dependant disabled? Yes No

Does your dependent earn an income? Yes No

How much does your dependant earn each month? (Gross income) **R** .

Dependant 2

Title | Initials | Surname

First name(s) (as per identity document)

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

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

Married? Yes No Financially dependent on you? Yes No

Is your dependant a student? Yes No Is your dependant disabled? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) **R** .

Dependant 3

Title | Initials | Surname

First name(s) (as per identity document)

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

Relationship to main member (For example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

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

Married? Yes No Financially dependent on you? Yes No

Is your dependant a student? Yes No Is your dependant disabled? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) **R** .

Dependant 4

Title Initials Surname

First name(s) (as per identity document)

Gender M F Date of birth D D M M Y Y Y Y

Race African Coloured Indian/Asian White Other Do not want to disclose

You are not compelled to provide the information required on race. The scheme is required by the Council for Medical Schemes to collect this data and it will be used for statistical purposes.

ID or passport number

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

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

Married? Yes No Financially dependent on you? Yes No

Is your dependant a student? Yes No Is your dependant disabled? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? (Gross income) **R** .

4. Please select your health plan

Malcor Plan:

Plan A Plan B Plan C Plan D

You have the right to ask for help in selecting a health plan that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the plan you select.

5. About your employer

Please ask your employer to complete this section.

Name of employer Employer or billing number

Employer number Date of employment Y Y Y Y M M D D

Branch name Branch number

Employer's signature

Designation

6. Banking details for claim refunds

If your contributions will be paid by your employer as a salary deduction, you only need to give us banking details for claim refunds. By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded if the banking details supplied were incorrect. If we are paying a third party bank account, the main member must insert the ID number of the third party.

Bank name

Branch name Branch code - -

Name of account holder

Account number Account type Current Transmission Savings

If we are paying a third party bank account, the main member must insert the ID number of the third party.

ID or passport number

If the third party bank account is a joint account, company account or trust account please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required

Signature of account holder

7. Previous medical scheme details (please give us proof in the form of a membership certificate)

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. We may also use the information on the membership certificate to determine if we can apply waiting periods.

Main applicant

Name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

If all dependant/s were on the same medical schemes as completed above, please tick here to confirm this. ☐

If any of your dependant/s applying for cover belonged to different medical schemes, please complete this section

Dependant name	Scheme name	Start date	End date if already resigned	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

8. Your health questions

We use this information only for lawful purposes, for example, enabling us and our administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customised information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve Scheme's financial modelling, to assist the Scheme to better assess and mitigate its risk and other beneficial uses. A condition specific waiting period will only be imposed on your membership if you or your dependant received or were recommended any medical advice, diagnosis, care or treatment within a 12-month period ending on the date on which this application is considered to be fully and properly made.

You must tell us in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for.

The main applicant, spouse or partner and all dependant/s applying for cover needs to complete section 8.

Have you or **any dependant** in this application ever experienced, been investigated, treated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders.

Please take note that if you have any disorder, symptom or condition not listed in the questions below, you should highlight and provide full details of this symptom or condition in response to question 8.18 below. Indication of existing medical conditions on this application does not automatically enrol you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrolment visit www.malcormedicalaid.co.za.

8.1 Tumours, growths, cancerous, non-cancerous and disorders of the skin and breast **Yes** ☐ **No** ☐

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

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

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

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, Deep Vein Thrombosis, Pulmonary embolus, varicose veins.

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

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

Example: 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.

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

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

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

8.5 Mental health Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling, any autoimmune conditions, any congenital conditions, bulimia and any other psychological conditions.

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

8.6 Metabolic or endocrine conditions Yes ☐ No ☐

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

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

8.7. Abdominal conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gallbladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, stomach ulcers, malabsorption, ulcerative colitis, diverticulitis, any autoimmune conditions, any congenital conditions, irritable bowel syndrome (IBS), hemorrhoids, long standing constipation/diarrhoea, ascites (fluid in the abdomen).

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

8.8 Brain and nerve conditions Yes ☐ No ☐

Example: stroke, epilepsy, seizures, other chronic headaches, cerebral palsy, multiple sclerosis, motor neuron disease, myasthenia gravis, migraine, parkinson's disease, paraplegia, hemiplegia, quadriplegia, spinal cord injury, hydrocephalus, brain shunt (VP shunt), intellectual disability, CVA, bleeding on the brain, any autoimmune conditions, any congenital conditions.

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

8.9 Breathing and respiratory conditions Yes ☐ No ☐

Example: asthma, ventilator, oxygen therapy, CPAP, 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.

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

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

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, lupus, Sjögren's syndrome, scleroderma, polymyositis, dermatomyositis, polyarteritis nodosa, Wegener's granulomatosis, sarcoidosis, fibromyalgia degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis, and internal insertion of surgical implants, amputation, any autoimmune conditions, any congenital conditions.

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

8.11 Kidney or urinary conditions including current or past dialysis Yes ☐ No ☐

Example: kidney failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

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

8.12 Blood conditions Yes ☐ No ☐

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting disorders/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia ,haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions, varicose veins.

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

8.13 Eye conditions Yes ☐ No ☐

Example: cataract, intra-ocular pressure, visual disturbances, night blindness, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, eye surgery, blurred vision, eye infections, blindness (partial or full), retinal detachment, any autoimmune conditions, any congenital conditions.

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

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

Example: otitis media (middle ear infection), otitis externa (ear canal infection), hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

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

8.15 Male urogenital conditions Yes ☐ No ☐

Example: prostate disorders, urogenital defects, varicocele, abnormal PSA tests (prostate specific antigen), undescended testes, phimosis, urinary incontinence, retention infertility, any autoimmune conditions, any congenital conditions.

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

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

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

8.17 Have any of your dependant/s received medical advice or treatment for symptoms not diagnosed by a medical professional, in the last 12 months before this application? Yes ☐ No ☐

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

8.18 Have you or any of your dependants ever been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side-effects, not mentioned in the questions above, in the last 12 months before this application? **Yes** ☐ **No** ☐

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

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 100 698** within seven working days from the date we activate your Malcor Medical Aid Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIV *Care* Programme. Malcor Medical Aid Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before Malcor Medical Aid Scheme starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. If you do not let us know about you or your dependants HIV status within 7 days of your membership being active, we may end your Malcor Medical Aid Scheme membership.

9. Malcor Medical Aid Scheme – Privacy Statement – how we will process and disclose your Personal Information and communicate with you

When you engage with Malcor Medical Aid Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants and beneficiaries, where applicable. To view and read our Privacy Statement, please follow this link: **https://www.malcormedicalaid.co.za/wcm/medical-schemes/malcor/assets/malcor-privacy-statement.pdf.**

Signature of main applicant ☐ Date D D M M Y Y Y Y

10. Malcor Medical Aid Scheme terms and conditions for membership

Who "we" are

Malcor Medical Aid Scheme, registration no 1547, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Malcor Medical Aid Scheme, and an authorised financial services provider.

10.1. **Rules for membership**

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

Where applicable you also acknowledge and confirm that the financial adviser you or your employer appointed, may communicate with us on this application and your membership of the Scheme.

You give permission that the Scheme Parties can share your medical information and other relevant Personal Information about you and your dependant/s with your chosen financial adviser. The information will be shared so that he or she can help us if necessary while we process your membership application. Please speak to your financial adviser or us if there is anything you do not understand.

10.2. **Who you are applying for**

You may apply to join the Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Scheme rules. For anyone to be treated as financially dependent for this application, you must have a legal responsibility to provide financially for that dependant. We might ask you to give us proof of financial or legal responsibility. You may be called the principal member or main member in our future communications to you.

10.3. **Acting for others**

You confirm you have the right to act for others

By signing this document, you confirm that:

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

10.4. **Giving and getting information**

You must give true, correct and complete information

To consider your application for membership, the Scheme must learn more about you and those you apply for. Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with the Scheme Parties. It is important that you tell the Scheme Parties about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for more information about themselves.

Your legal address
We will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

Malcor Medical Aid Scheme and Discovery Health (Pty) Ltd may record telephone calls
The Scheme Parties may record telephone conversations with you and with those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

Malcor Medical Aid Scheme and Discovery Health (Pty) Ltd may get information about you from other relevant sources
To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers or financial advisers). you agree that the Scheme Parties can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. The Scheme Parties may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of the Scheme, is true, correct and complete. You give your permission that the Scheme Parties may get any information that is relevant to your application from your employer.

Tell Malcor Medical Aid Scheme or Discovery Health (Pty) Ltd immediately if your information changes
You, your employer or your financial adviser must tell us in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership/s
The Scheme may cancel any memberships immediately, if you and those you apply for:
- do not give the Scheme Parties information that later turns out to be relevant to this application
- give the Scheme Parties any information that is not true, correct and complete
- do not tell the Scheme Parties about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

10.5. **About becoming a member**
The Scheme might not pay for certain expenses immediately after you become a member
The Scheme may apply waiting periods under certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. Please speak to your financial adviser or us to find out if waiting periods apply to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted
It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time
As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time.

10.6. **Repaying money owed to the Scheme**
The Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you if there is any amount that you owe to the Scheme. You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number MAL CLWBCK will be used.

Signature of main member

Date Y Y Y Y M M D D

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

11. Third Party Bank Details - Annexure A

Banking details for a third party

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds and / contribution debit orders

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

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

Documents we need for a joint bank account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the joint owners.

Documents we need for a company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of the persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
  - State that the account can be use
  - State the membership details (including the membership or policy numbers) for which the bank account will be used
  - Include the details of the signatory
  - Be dated and signed by an authorised person on behalf of the company
- A copy of the company's certificate of registration.
- A copy of the main member's ID, passport or driving licence

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
  - Show the trustees
  - Be dated and signed by an authorised person on behalf of the trust
  - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.

I consent to my spouse and/or adult dependant acting on my behalf and providing my personal information, including health information, to Discovery Health for the purpose of my application to join Malcor Medical Aid Scheme. ☐