

Continuation form

Application to become the main member

Contact details

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

This document is an application form to become the main member on an existing membership.

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

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, 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. About your employer
2. Please use one letter per block, complete in black ink and print clearly.
3. This form must be completed by the person applying to be the main member.
4. To avoid administration delays, please ensure this application is completed in full.
5. To be completed and returned to your Human Resources department

1. About your employer

| | | | | | | | | | | | | | | |
|-----------------|----------------------|--------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|---|----------------------|----------------------|
| Employer name | <input type="text"/> | Date of employment | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | | | |
| Employer number | <input type="text"/> | | | | | | | | | | | | | |
| Branch name | <input type="text"/> | | | | | | | | Branch number | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> |

2. About the new main member

| | | | | | | | | | | | | | | | | | | | |
|--|----------------------------------|---------------------------------|-----------------------------------|----------------------------------|----------------------|----------------------------|----------------------------|----------------------|--------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Date membership of new main member starts | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Membership number | <input type="text"/> | | | | | | | | |
| Tax number | <input type="text"/> | | | | Job title | <input type="text"/> | | | | | | | | | | | | | |
| Title | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Initials | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Surname | <input type="text"/> | | | | | | | | |
| First name(s) (as per identity document) | <input type="text"/> | | | | | | | | | | | | | | | | | | |
| Preferred name | <input type="text"/> | | | | Sex | <input type="checkbox"/> M | <input type="checkbox"/> F | Date of birth | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | | | | |
| Marital status | <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed | | | | | | | | | | | | | | | |
| Previous/maiden name | <input type="text"/> | | | | | | | | | | | | | | | | | | |
| ID or passport number | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | Employee number | <input type="text"/> | | | | | | |
| Country of issue | <input type="text"/> | | | | | | | | | | | | | | | | | | |
| Telephone (Home) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | (Work) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Cellphone | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Physical address | <input type="text"/> | | | | | | | | | | | | | | | | | | |
| Postal address | <input type="text"/> | | | | | | | | | | Code | <input type="text"/> | | | | | | | |
| Postal address | <input type="text"/> | | | | | | | | | | Code | <input type="text"/> | | | | | | | |
| Email | <input type="text"/> | | | | | | | | | | | | | | | | | | |
| Preferred means of communicating (where appropriate) | Email | <input type="checkbox"/> | Post | <input type="checkbox"/> | E-mail type | Home | <input type="checkbox"/> | Work | <input type="checkbox"/> | | | | | | | | | | |

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In which country do you live?

3. Details of the current main member

If you need to register as the main member due to the death of the current main member, please attach a certified copy of the death certificate.

What you must do

Submit the following with this form: – Copy of ID – Bank statement/letter of confirmation from the bank.

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex Date of birth

Marital Status Married Single Divorced Widowed Preferred language English Afrikaans

ID or passport number

Country of issue

Telephone (H) (Work)

Cellphone Fax

Email address

4. Banking details for the new main member's monthly contribution (if applicable)

What you must do

Submit the following with this form: Copy of ID and Bank statement/letter of confirmation from the bank.

Bank name

Branch name Branch code - -

Account number

Name of account holder

Type of account Cheque Savings

Account holder's physical address

If Account holder is not the same as the new main member, please provide Account holder's ID number

Account holder's email address (If the account holder is a company, please state the company email address)

Account holder's contact number -

(If the account holder is a company, please state the company email address)

Please also complete the details below for company or trust accounts.

Company or trust Registration number

Signed at (town or city)

Signature of authorised party / trustee Date - -

If there are multiple authorised parties / trustees, please attach ID copies per authorised party / trustee.

I agree to inform the Scheme in writing of any changes that may occur.

Signature of account holder Signature of new main member

Due to Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holder's residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order

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mandate requirement and will not be used to update the contact details we have on system. If you wish to update any contact details please visit www.lahealth.co.za.

Please note: Should you be using someone else's bank account, the account holder must sign above to confirm this.

5. Banking details for claim refunds

What you must do

Submit the following with this form: – Copy of ID and Bank statement/letter of confirmation from the bank.

If we do not have banking details, we cannot refund your claims. You can only use a South African bank account.

Same as section 4? Yes No

Bank name

Branch name Branch code - - -

Account number

Name of account holder

Type of account Cheque Savings

Account holder's physical address

If Account holder is not the same as the new main member, please provide Account holder's ID number

Account holder's email address (If the account holder is a company, please state the company email address)

Account holder's contact number -

(If the account holder is a company, please state the company email address)

I agree to inform the Scheme in writing of any changes that may occur.

Signature of main applicant

Due to Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holder's residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system. If you wish to update any contact details please visit www.lahealth.co.za.

By signing the above, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will no longer be responsible in any way for the amounts refunded.

6. LA Health Privacy Statement - How we will process and disclose your personal information and communicate with you

Definitions

The Scheme refers to LA Health Medical Scheme, registration number 1145, registered with the Council for Medical Schemes.

Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider.

Discovery Group refers to Discovery Limited, registration number 1999/007789/06, including all subsidiaries of the Group. Subsidiaries in the Group are authorised financial services providers.

You and your refer to the member and his/her dependants who are registered as beneficiaries of the Scheme.

Your personal information refers to personal information about you, your spouse, your dependants, your beneficiaries, and your employees (as relevant). It includes information about health, financial status, gender, age, contact numbers and addresses.

Process(ing) (of) information means the automated or manual activity of collecting, recording, organising, storing, updating, distributing and removing or deleting personal information.

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 or legal guardian.

1. When you engage with the Scheme and Administrator, you trust us with personal information about yourself, your family, and in some cases, your employees. We are committed to protecting your right to privacy.

The purpose of this Privacy Statement is to set out how we collect, use, share and otherwise process your personal information.

2. 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 the Scheme and Administrator require your acceptance of these terms and conditions, otherwise we

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cannot activate and service your medical scheme membership.

3. The Scheme and Administrator will keep your personal information confidential. You may have given us this information yourself, or we may have collected it from other sources. 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).

4. You agree that the Scheme and Administrator may process your personal information for the following purposes:

- for the administration of your benefit option;
- for the provision of managed care services to you on your benefit option;
- for the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you on your benefit option;
- to analyse risks, trends and profiles ;
- to share your personal information with external healthcare providers for the purposes of evaluating certain clinical information, should you require medical treatment.

Examples of this include:

- i. Obtaining and sharing your personal information with other relevant sources, including medical practitioners, contracted service providers, health information exchanges, financial advisers, credit bureaus, entities that are part of Discovery Group or industry regulatory bodies ("relevant sources") to conduct underwriting or risk assessments, or to assess and value 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;
- ii. If you have joined as a member of an employer group, getting information from and sharing information with your employer that is relevant to your application for membership, with due regard for considerations of confidentiality in respect of your state of health;
- iii. Communicating with you about any changes to your benefit option, including changes to your contributions or the benefits you are entitled to on the benefit option you have chosen.

5. If a third party asks the Scheme and Administrator for any of your personal information, we will share it with them only if:

- you have already given your consent for the disclosure of this information to that third party; or
- we have a legal or contractual duty to give the information to that third party, or
- we need to share it with them for risk analytical or fraud detection, prevention or recovery purposes
- 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 as well as to other entities in the Discovery Group if any Legislative reportable matters are identified.

6. The Scheme and the Administrator may provide your personal information to any other entity within the Discovery Group with whom you or your dependant/s already have a relationship; or where you or your dependant/s have applied for a product, service or benefit from such entity. This information will be provided for the administration of your, or your dependant/s products or benefits with other entities within the Discovery Group, and for fraud detection, prevention or recovery purposes.

7. The Scheme and Administrator may share and combine all your personal information for any one or more of the following purposes:

- market, statistical and academic research; and
- to customise our benefits and services to meet your needs.

Information about you may be shared with third parties such as academics and researchers, including those outside South Africa. We ensure that all data about you that is shared with such third parties will be made anonymous to the extent possible and where appropriate. Note also that personal information will be made available to such third party only if that third party has agreed to abide by strict confidentiality protocols that we require. If we publish the results of any academic research, you will not be identified by name.

If we want to share your personal information for any other reason, we will do so only with your permission.

8. 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 try 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.

9. By accepting this privacy statement, you authorise the Scheme and Administrator to obtain and share information about your creditworthiness with any credit bureau or credit providers' industry association or industry body. This includes information about credit history, financial history, judgments, and default history. It also includes sharing of information for purposes of risk analysis, tracing and any related purposes.

10. The Scheme and Administrator have the right to communicate with you electronically about any changes to your benefit option, including changes to your contributions or changes to the benefits you are entitled to on the benefit option you have chosen.

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 any product or service. You may query the decision made about you.

12. The Scheme and Administrator have a duty to keep you updated about any offers and new products that are made available from time to time. The Scheme, Administrator, any entity within the Discovery Group, and contracted third-party service providers, may communicate with you about these.

13. Please let the Administrator know if you do not wish to receive any direct telephonic marketing.

14. You have the right to know what personal information the Scheme and Administrator holds about you. If you wish to receive this information please complete an 'Access Request Form', attached to the PAIA manual, on www.lahealth.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.

15. You agree that the Scheme and 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.

16. Where the Scheme and Administrator are required by law to collect and keep personal information, we shall do so. We are required to collect and keep personal information in terms of the following laws:

- 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

Legislation specific to Discovery Health (Pty) Ltd only:

- Financial Advisory and Intermediary Services Act, 2002
- Companies Act, 2008

17. You agree that the Scheme and Administrator may transfer your personal information outside South Africa:

- if you give us an email address that is hosted outside South Africa; or
- for processing, storage or academic research, or
- to administer certain services, for example, cloud services.

When we share your information with a person (or company) outside South Africa, we will require of such person (or company) to treat your information in a manner that complies with the requirements of that country and at least with the same level of protection as we are obliged to do in South Africa. Unless you specifically give us consent to share your personal information with such person (or company).

18. If the Scheme or Administrator becomes involved in a proposed or actual amalgamation or merger, acquisition or any form of sale of any assets, 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. The terms of this Privacy Statement will continue to apply.

19. The Scheme or Administrator may change this Privacy Statement at any time. The current version is available on www.lahealth.co.za.

20. If you believe that the Scheme or Administrator have used your personal information contrary to this Privacy Statement, we encourage you to first follow our internal complaints process to resolve the complaint. We explain the complaints and disputes process on the website at www.lahealth.co.za. If you are not satisfied after this process, you have the right to lodge a complaint with the Information Regulator, under POPIA. We explain the complaints and disputes process on the website www.discovery.co.za. Contact details for the Information Regulator: The Information Regulator (South Africa) | SALU Building | 316 Thabo Sehume Street | Pretoria | Tel: 012 406 4818 | Fax: 086 500 3351 | inforeg@justice.gov.za

Signature of new main member

Original hand signature required

The new main member must sign and date any changes

7. LA Health Medical Scheme rules for membership

7.1 Rules for membership

The Rules of LA Health Medical Scheme record 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.

7.2 You may be called the principal member or main member in our future communications to you.

7.3 Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

- you have received permission from your spouse and/or any dependant/s over 18 to act for them in any matter relating to this application.

7.4 Giving and getting information

You must give true, correct and complete information

To consider your application to become the main member on this LA Health Medical Scheme membership, we must learn more about you. Information about you must be true, correct and complete. This includes the details you give in this application form and in future dealings with LA Health Medical Scheme and Discovery Health (Pty) Ltd.

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.

Discovery Health (Pty) Ltd and LA Health Medical Scheme may record telephone calls

Discovery Health (Pty) Ltd and LA Health Medical Scheme may record telephone conversations with you. The recordings and all information we

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get during the recordings will be processed and kept as required by law.

Tell LA Health Medical Scheme or Discovery Health (Pty) Ltd immediately if your information changes

You, your employer or your broker must tell LA Health Medical Scheme or Discovery Health (Pty) Ltd in writing if any of the information you gave changes between the day you sign this document and the day your membership status is changed. We need advance notice of any administrative changes such as cancellation of membership, as backdated changes may not be accepted.

When LA Health Medical Scheme may cancel your membership/s

LA Health Medical Scheme may cancel any memberships immediately:

- do not give LA Health Medical Scheme and Discovery Health (Pty) Ltd information that later turns out to be relevant to this application;
- Give LA Health Medical Scheme and Discovery Health (Pty) Ltd any information that is not true, correct and complete;

7.5 You must ensure contributions are paid on time

As the main member of LA Health Medical Scheme, you are responsible for ensuring that your and those persons registered as your dependants' contributions 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. If you are paying your contributions, the reference number LAH CONT will be used on your bank statement to identify the debit order.

7.6 Repaying money owed to the Scheme

LA Health Medical Scheme has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you of any amount that you must pay to the Scheme.

You must repay any medical savings owing if you leave LA Health Medical Scheme.

If the benefit option you chose offers a medical savings account, you may have money available in advance to use for medical expenses during the year. If you leave LA Health Medical 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 LA Health Medical Scheme during the specific year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you. You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number **LAH CLAW** will be used.

Signature of new main member

Date

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| D | D | - | M | M | - | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|---|---|

8. Terms and Conditions

This signed authority and mandate refers to the application on the signed date ("the agreement")

I/We, the undersigned:

1. warrant that the account information I/we have provided above is an account in my/our name and that the information furnished by me/us in this authority and mandate is true and correct;
2. authorise LA Health Medical Scheme to issue and deliver payment instructions to my bank, recorded above, for the collection by LA Health Medical Scheme from the bank account (or any other bank or branch to which I may transfer my account) any amounts due under or in terms of this application, on condition that the sum of such payment instructions will never exceed my obligations as framed in the which shall commence on the date that the banking details are effective and shall continue until this authority and mandate is terminated by me by giving LA Health Medical Scheme no less than 20 ordinary working days written notice thereof or immediately in the event that I instruct my bank to withdraw this authority and mandate.
3. confirm that that the payment instructions mentioned above must be issued on the first working day of the month. If the change in banking details are not activated in time for the debit order collection, and there is an amount outstanding, LA Health Medical Scheme can collect that amount in the interim, upon activation of the banking details. If I change the date of the debit order after activation of the banking details, I confirm that the payment instructions must be issued and delivered on the day that I have nominated ("payment day") and thereafter on the same day in each and every successive month. If the payment day falls on a Sunday or recognised South African public holiday, the payment day will automatically be the next working day;
4. authorise LA Health Medical Scheme to track my bank account and re-present the payment instruction referred to above in the event that there are insufficient funds in my bank account to meet my obligations under or in terms of this Agreement
5. acknowledge that my bank will treat each payment instruction to pay contributions or amounts due under this agreement to LA Health Medical Scheme as if each payment instruction came from me personally as the account holder.
6. undertake to advise LA Health Medical Scheme in writing of any changes to my account details. I acknowledge that LA Health Medical Scheme will not be held responsible or liable for any claim, loss or harm that I or any third party may suffer as a result of me providing incorrect banking details herein or if the bank account is in the name of another person or entity or as a result of my failure to notify LA Health Medical Scheme of a change in banking details, or if the bank account has insufficient funds to meet my obligations under or in terms of the agreement.
7. know and understand that the withdrawals hereby authorised will be processed through a computerised system provided by South African banks. The details of each withdrawal from my bank account will be printed on my bank statement and must show the reference number of the membership inserted in the agreement so as to enable me to identify this membership;
8. acknowledge that although this authority and mandate may be terminated by me, such termination does not necessarily terminate this agreement. In the event of such termination I am not entitled to any refund of any contributions or amounts due that was withdrawn by LA Health Medical Scheme whilst this authority and mandate was in force, if such contributions or amounts were legally owing to

LA Health Medical Scheme in terms of the agreement;

9. acknowledge that by signing this authority and mandate I am bound by the payment terms applicable to this agreement.

Privacy Statement

We process your personal information, as we set out in the Scheme’s privacy statement, available at www.lahealth.co.za.
By accepting these terms and conditions or by providing personal information to us, you agree and give permission for us to use your personal information as we set out in our privacy statement. If you do not agree or give us permission to use your personal information, we may not be able to maintain your membership of the Scheme. If you believe we have acted in a way that contradicts our privacy statement, please let our privacy office know at www.lahealth.co.za.

Reference number

This Agreement reference numbers are LAH CONT, LAW CLAW

Signature of bank account holder Date

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

Please only sign if you have read and understand this statement

In addition to the above terms, the member must agree to the following:

- 1. I confirm that I have the right to give LA Health Medical Scheme the authority to debit the bank account listed above on a monthly basis. Furthermore, I will be liable for any claims, losses or damages of whatsoever nature arising out of debits made by LA Health Medical Scheme to the account as listed above should this account have insufficient funds, be incorrect or be held in the name of any other person.
- 2. I hereby authorise LA Health Medical Scheme to verify the banking details as provided above for the purpose of setting up a debit order, in need.
- 3. I confirm that the account listed above complies with the Financial Intelligence Centre Act (“FICA”).
- 4. I confirm that if I miss a contribution collection date I authorise that LA Health Medical Scheme may deduct a double debit of my contributions the following month

Signed at (town or city) on

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Y | Y | Y | Y | M | M | D | D |
|---|---|---|---|---|---|---|---|

Signature of main member
Please only sign if you have read and understand this statement