Permission to make certain information available to a third party

Discovery

Contact us
Tel: 0860 99 88 77, PO Box 786722, Sandton 2146, www.discovery.co.za

By completing this form, you will allow us to share your information with any third party you nominate. A third party is any person or entity that has a relationship with Discovery Holdings, Discovery Health (Pty) Ltd, your Scheme or Fund, or Vitality HealthStyle (Pty) Ltd, as well as those entities who do not have a direct relationship with Discovery Holdings (Pty) Ltd, your Scheme or Fund, or Vitality HealthStyle (Pty) Ltd.

Who we are

Discovery Holdings Limited (registration number 1999/007789/06) acts as the holding company for:

- Discovery Health (Pty) Ltd (registration number 1997/013480/07), the administrator of your Scheme or Fund
- Discovery Vitality and KeyFIT (registered as Vitality HealthStyle (Pty) Ltd registration number 1999/007736/07), referred to as Vitality in this form.

Discovery Holdings subsidiary companies are authorised financial service providers. These companies all function as separate entities.

What you must do

Please follow these three steps:
Step 1: Fill in the form.
Step 2: Sign the application form.
Step 3: Please fax the completed form to 011 539 5217 or email it to consent@discovery.co.za

When you sign this application, you confirm the information provided is true and correct.

How to complete this form

- Please use one letter per block, complete the form with black ink and print clearly.
- To avoid administrative delays, please make sure this form is completed in full.
- Incomplete application forms will not be considered as valid consent.

If your nominated third party has not given Discovery a copy of **their identity document**, please submit it with this form to prevent further delays. If we cannot identify your nominated third party, we cannot complete the request for this (applicable to section 2.5, 2.6 and 2.7).

Please note that if you only want to share your cellphone number and email address with your financial adviser, you do not have to complete this form.

Please note that credit card information can only be made available to the primary DiscoveryCard cardholder or the person who has the necessary authority (to complete a Delegation of Authority form, please contact DiscoveryCard). Please do not complete this form if this is the information you want to make available to a third party.

1. About yourself (client)

Surname

First name(s) (as per identity document)

ID or passport number Gender M F

Country of issue

Date of birth Y Y Y Y M M D D

2. About the third party (to whom we may not give specified information)

2.1 Your financial adviser ☐

Your financial adviser is your appointed financial adviser, or your employer's appointed financial adviser, who is on record and works at your or your employer's appointed intermediary house. This financial adviser may change occasionally. This means the new financial adviser will have access to the information you make available. If you want to give permission to only a specific person, please complete the **specific third party** section of this form.

Please choose the type of information you want make available: (you may select more than one option)

		From	To
Option A (biographic, financial and benefit information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D
Option B (biographic and financial information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D
Option C (medical information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D

(Refer to table 1 on page 3 for examples of these types of information).

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2. About the third party (to whom we may not give specified information) *(continued)*

2.2 Intermediary house ☐

An intermediary house is a group of financial advisers who conduct their business and give advice under one business name.

Please choose the type of information that you want make available: (you may select more than one option)

		From	To
Option A (biographic, financial and benefit information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D
Option B (biographic and financial information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D
Option C (medical information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D

(Refer to table 1 on page 3 for examples of these types of information).

2.3 Your employer contact person ☐

Your employer contact person is the contact person or representative where you work. This contact person or representative may change occasionally. This means a new contact person or representative may have access to the information you make available. Your permission only applies to the contact person at your current employer. If you change employers, this permission will end. If you want to give permission to only a specific person and not the employer contact person in general, please complete the specific third party section of this form.

Please choose the type of information you want to make available: (you may select more than one option)

		From	To
Option A (biographic, financial and benefit information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D
Option B (biographic and financial information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D

(Refer to table 1 on page 3 for examples of these types of information).

2.4 Your doctor ☐

Practice number

Doctor's first name and surname

Please choose the type of information you want to make available: (you may select more than one option)

		From	To
Option A (biographic, benefit and medical information – including Health Record containing pathology and radiology results, which may include HIV information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D
Option B (financial information)	☐	Y Y Y Y M M D D	Y Y Y Y M M D D

Please refer to the specific terms and conditions section under 'Discovery HealthID application consent' on the final page of this form.

(Refer to table 1 on page 3 for examples of these types of information)

2.5 Specific third party 1 ☐

You give permission to make information available to the third party specified below.

Surname

First name(s) (as per identity document)

ID or passport number Gender M F

Country of issue

2.6 Specific third party 2 ☐

You give permission to make information available to the third party specified below.

Surname

First name(s) (as per identity document)

ID or passport number Gender M F

Country of issue

2.7 Specific third party 3 ☐

You give permission to make information available to the third party specified below.

Surname

First name(s) (as per identity document)

ID or passport number Gender M F

Country of issue

3. About the information we may give to the third party

Please specify the type of information each specific third party may have access to and for how long the access should be valid. If you don't specify a date, we will assume the permission to be valid from the date of signature, in section 4 of this form, to continue until you revoke the permission in writing.

Third party	**Please tick the third party to which you want to make information available**				
Make all of the below available ☐					
	Specific third party 1	**Specific third party 2**	**Specific third party 3**	**From**	**To**
Biographic information				Y Y Y Y M M D D	Y Y Y Y M M D D
Benefit information				Y Y Y Y M M D D	Y Y Y Y M M D D
Financial information				Y Y Y Y M M D D	Y Y Y Y M M D D
Medical information				Y Y Y Y M M D D	Y Y Y Y M M D D

Examples of the type of information we can make available to a third party are given in the table below:

Table 1

Examples of biographic information	**Examples of benefit information**	**Examples of financial information**	**Examples of medical information**
Membership number	Plan type	Tax certificate and tax reports	Indicator of chronic condition
Date of birth	Medical Savings Account amounts available	Banking details	Prescribed Minimum Benefit chronic condition details
ID number	Medical Savings Account choice: Scheme Rate or Cost	Total contribution and breakdown	Confirmation of claims paid (excluding amounts and origin of payments)
Postal and email address	Current Medical Savings Account spent	Vitality rewards received	Claims transaction history
Physical address	Limits		Hospital procedures
Telephone numbers	Waiting period details		Procedure codes
	Self-payment Gap		Procedures done in doctors' rooms paid from Hospital Benefit
	Above Threshold Benefit		MedXpress medicine query
	Vitality activation/status/gym access		**Doctors only**
	Vitality benefit usage		Health Record (including pathology and radiology results and may include HIV-related information)
	Vitality Points Monitor		

4. Terms and conditions

4.1 This document gives Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund and Vitality HealthStyle (Pty) Ltd permission to make certain information available to the named third party or third parties selected in this form.

4.2 You agree that by making this information available, Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund and Vitality HealthStyle (Pty) Ltd are not responsible for any loss, whether direct, indirect or as a result of disclosing the information.

4.3 You agree that the named third parties receiving this information may not hold Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund or Vitality HealthStyle (Pty) Ltd responsible for any claims that result from the wrongful use or disclosure of the information by the named third parties.

4.4 You agree that once you have given permission, Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund and Vitality HealthStyle (Pty) Ltd may give all the information that falls under the selected type of information to the named third parties.

4.5 This permission will end on the date(s) specified in section 2 and 3 of this form or when your employer contract ends (if your relationship with Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund, or Vitality HealthStyle (Pty) Ltd is through your employer). You agree that if you have not given an expiry date in section 3 of this form, the permission will only end on your specific instruction in writing (or when the purpose of the permission has been served).

4.6 Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund and Vitality HealthStyle (Pty) Ltd will only share the personal, financial and medical information for you or your dependants or beneficiaries on your Health Plan, policies or investments if it is requested by a third party to which you have already given consent for disclosure and the parties with which Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund and Vitality HealthStyle (Pty) Ltd share the information agree to keep the information confidential. If Discovery Holdings, Discovery Health (Pty) Ltd, the Scheme or Fund, or Vitality HealthStyle (Pty) Ltd wants to share your information for any other reason, we will do so only with your permission.

4. Terms and conditions *(continued)*

Discovery HealthID application consent

Discovery Health (Pty) Ltd takes all reasonable steps to protect personal information and maintain confidentiality. By signing below, I request any pathology laboratory that carries out pathology investigations for me to supply the results to Discovery Health (Pty) Ltd and my medical scheme or fund, and I give Discovery Health (Pty) Ltd and my medical scheme or fund ("the Scheme"), being a medical scheme administered by Discovery Health (Pty) Ltd, permission to receive my pathology results directly from the laboratory and to store these results in my Electronic Health Record (EHR). I also give permission for Discovery Health and the Scheme to release my Electronic Health Record (EHR) to my healthcare professional specified above, to assist the healthcare professional in making an informed clinical decision. This includes details about chronic condition(s), Health Plan details, certain biographical data, and pathology and radiology results. This may include information related to HIV and AIDS.

I understand that once Discovery Health (Pty) Ltd and the Scheme have handed my records to the healthcare professional, they have no further control over this information and that they will not be accountable for the safeguarding of this information. I understand that the healthcare professional has confirmed to Discovery Health (Pty) Ltd and the Scheme that he/she will treat my health records as confidential and in line with the relevant legislation.

I agree that by making this information available, Discovery Health (Pty) Ltd and the Scheme are not responsible for any loss (whether direct or indirect) that may arise from the use of this information.
I agree that I may not hold Discovery Health (Pty) Ltd or the Scheme responsible for any loss that may result from the incorrect use or disclosure of the information by my healthcare professional.

I give permission for my doctor to give Discovery Health (Pty) Ltd my diagnosis and other relevant clinical information required to review my application for the Chronic Illness Benefit.

Pathology records

1 I acknowledge and understand that –
  - 1.1 Discovery Health (Pty) Ltd, hereinafter referred to as "Discovery Health", has developed an application. With this application, medical practitioners who have subscribed to and are authorised to use the application ("authorised medical practitioners") can access the pathology reports of members of the medical schemes administered by Discovery Health from time to time.
  - 1.2 The purpose of the HealthID System is to improve the quality of clinical care to members and reduce the administrative burden on medical practitioners regarding accessing pathology reports;
  - 1.3 All authorised medical practitioners who may treat me from time to time can request and access my pathology records via the HealthID system.
  - 1.4 I am a member and, therefore, any authorised medical practitioner who I may consult from time to time and who is authorised to use the HealthID System, can have access to all my pathology reports, including those requested by other medical practitioners with whom I may have consulted from time to time.

2 By signing below, I consent to –
  - 2.1 My pathology reports being provided by the pathology laboratory in question to Discovery Health and the authorised medical practitioners.
  - 2.2 Discovery Health receiving my pathology results directly from the pathology laboratory in order to store these results in the HealthID system.

3 I am entitled to change or revoke my consent at any time, in which case my pathology information will no longer be disclosed as described above. All my pathology reports that may be available via HealthID will be erased and will no longer be available via HealthID or via another means to the authorised medical practitioner or any medical scheme administered by Discovery Health.

4 The consent given by me as set out in this document, is valid from the date and time of my signature below and will continue until such time as the consent is removed or changed, as described in point 3 above.

Chronic Illness Benefit application

I give permission for my healthcare professional to provide Discovery Health Scheme (Pty) Ltd with my diagnosis and other relevant clinical information required to review my application for the Chronic Illness Benefit.
I understand that:

1. Funding from the Chronic Illness Benefit is subject to meeting benefit entry requirements as determined by Discovery Health (Pty) Ltd.
2. The Chronic Illness Benefit provides cover for disease-modifying therapy only, which means that not all medicines for a listed condition are automatically covered by the Chronic Illness Benefit.
3. By registering for the Chronic Illness Benefit, I agree that my condition may be subject to disease management interventions and periodic review. For this purpose both Discovery Health (Pty) Ltd and my provider need access to my medical records.
4. Funding for medicine from the Chronic Illness Benefit will only be provided from the fund when Discovery Health (Pty) Ltd receives an application form that is completed in full.
5. I may need to send an updated or new application form, if the Chronic Illness Benefit department asks for this.

I consent to Discovery Health (Pty) Ltd disclosing, from time to time, information supplied to Discovery Health (Pty) Ltd (including general or medical information that is relevant to my application) to my healthcare provider, to administer my Chronic Illness Benefit.

Consent to use the Discovery HealthID application

I may choose to change or revoke my consent at any time. If this happens, my health information may not be disclosed to my healthcare professional any longer. I will inform Discovery Health (Pty) Ltd of this change or revocation in writing. The results displayed will reflect the change or removal of my consent. If consent is withdrawn entirely, all results will be removed from the display.

Consent is valid from the date and time of my signature and will continue until such time as consent is removed or changed.

I have had an opportunity to receive and read (or have read to me) and I fully comprehend the terms, conditions and consequences of this consent form. I have:
– Been made aware of all the terms printed in bold by the Scheme;
– Have had sufficient opportunity to ask questions about this consent form and have had these questions, if any, answered to my satisfaction by the Scheme.

My consent to the terms of this consent form is provided of my own free will without any undue influence from any person whatsoever. Discovery Health has undertaken to provide me with a signed copy upon my request. The full terms and conditions can be accessed on the website (www.discovery.co.za) or through Discovery's call centre on 0860 99 88 77.

My signature below indicates my understanding of and agreement to comply with the terms of this consent form.

Signed at (town or city) _____ on Y Y Y Y M M D D

Please print name _____

Signature of person giving permission _____