Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Applying to become a member of Bankmed in 2025

This document is a membership application form. It also contains some terms and conditions. Please make sure you read and understand these terms.

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, is the medical scheme to whom you are applying to become a member. 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) which takes 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. Alternatively, complete the form digitally.
2. Read and understand the terms and conditions as well as the Privacy Statement (section 10).
3. Please make sure the main applicant signs section 9 and 10 and dates any changes.
4. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.
5. Provision is made in this form for you and your dependant/s 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.

Please submit completed forms (signed and stamped by the employer/authorised company signatory) as follows:

ABSA Employees: E-mail **pmabsateam@bankmed.co.za**

FNB Employees: E-mail **pmfnbteam@bankmed.co.za**

SBSA Employees: E-mail **pmsbsateam@bankmed.co.za**

Employees of any other banks and/or non-banking officials: E-mail **application@bankmed.co.za**

Once you send us 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
- We will activate your membership and send you a letter of confirmation when we are offering standard terms of acceptance. Where you have waiting periods and/or late-joiner penalties, we will issue a letter which will indicate any conditions applicable to your membership. If you are a bank employee, we will activate your membership as a condition of employment. However, if you are adding a special dependant where any conditions are applicable, we will send you a counter-offer letter to sign and accept the terms and conditions before membership activation.
- We will send you a welcome letter, notification or an e-mail to let you know when your application has been fully and completely submitted. This date may differ from the date on which you sign the application form
- You will receive a message with a link to download your digital welcome pack

If you do not hear from us within seven days after sending us your application form, please contact us on **0800 BANKMED (0800 226 5633)**.

When you sign this application, you confirm that you have read and understood the terms and conditions as well as the Privacy Statement and agree to them.

I consent to my spouse/partner, and/or adult dependant (who is part of this application), acting on my behalf and providing my personal information, including health information, to Bankmed for the purpose of my application to join the Scheme. ☐

1. About yourself (main applicant)

Title | Initial(s)

Surname

First name(s) (as per identity document)

Gender M ☐ F ☐

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

This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.

ID or passport number | Date of birth D D M M Y Y Y Y

Occupation | Tax number

Where an e-mail address has been provided, electronic communication will be the default unless otherwise indicated.

Telephone (H) Telephone (W)

Cellphone

E-mail

Providing a valid e-mail address and cell phone number is mandatory for communication purposes.

Please indicate your gross monthly salary with a "x"

Income (R)	S1	S2	S3	S4	S5	S6	S7
	0 - 5 000	5 001 - 6 000	6 001 - 7 000	7 001 - 8 000	8 001 - 9 000	9 001 - 10 000	10 001+

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 Postal code

2. Regular dependant/s

Only to be completed if you are adding a spouse, domestic partner, civil union partner, a child or a dependant/s grandchild

Please notify Bankmed within 30 days of any event which alters the eligibility of your registered dependant/s, i.e. if you get divorced or if you and your domestic partner separate/are no longer living together**.**

- **If you are registering a spouse/civil union partner,** please attach a copy of your marriage certificate or proof of civil union
- **If you are registering a newborn baby,** please attach a copy of the birth certificate
- **If you are registering a domestic partner**, please complete and sign the Domestic Partner Declaration at the end of this section
- I**f you are registering a grandchild in respect of whom you are liable for family care and support,** please complete and sign the Grandchild Declaration at the end of this section

If you are registering a child or grandchild who is 27 years or older, you will need to demonstrate that you are liable for their family care and support in that they:

- are unable to support themselves and are financially dependent on you for family care and support **(please attach an affidavit setting out details of their monthly income and your regular contribution to their living expenses)**; or
- is dependent on you due to mental or physical disability **(please attach a medical report)**; or
- is a student at a registered tertiary institution and is financially dependent on you for family care and support **(please attach proof of registration or an affidavit)**

"Child" means your child, stepchild, legally adopted child, foster child, or a child who has been placed (or is in the process of being placed) in your custody or in the custody of your partner/spouse. Proof of dependence must be supplied each year for children (including grandchildren) who are 27 years or older. Adult contribution rates apply from the time a dependent child (or grandchild) turns 23.

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

This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.

Initial/s	Surname	Full name/s	Date of birth (DD/MM/YYYY)	Gender	Monthly income (compulsory)	Relationship (e.g. spouse, partner, grandchild)	ID number or passport number (attach copy)

Domestic partnership declaration - only to be completed if you are registering a domestic partner

I, _____ (your name and surname) declare that I have established a domestic partnership with _____ (your domestic partner's name and surname) and that we have been living together since _____ (date). I declare that we intend to continue living together indefinitely, and I undertake to inform Bankmed within 30 days in the event of termination of this domestic partnership.

Signed by me _____ (your signature) on this _____ day of _____ (month) _____ (year).

Grandchild declaration - only to be completed if you are registering a grandchild who is dependent on you for family care and support

I, _____ (your name and surname) declare that any grandchild included in this application is financially dependent on me for family care and support.

Signed by me _____ (your signature) on this _____ day of _____ (month) _____ (year).

3. Special dependant/s

Only to be completed if you are adding a parent, parent-in-law, parent of a civil union partner or a brother/sister who is dependent on you for family care and support

PLEASE DO NOT cancel the existing membership of a special dependant with their current medical scheme (if applicable) before you have received confirmation that they qualify as your dependant on Bankmed.
Please complete and sign the Special Dependant Declaration at the end of this section, regarding your special dependant/s.

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

This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.

Initial/s	Surname	Full name/s	Date of birth (DD/MM/YYYY)	Gender	Monthly income (compulsory)	Relationship to Principal Member (e.g. spouse, partner, grandchild)	ID number or passport number (attach copy)

- Nephews and nieces are not eligible as dependant/s, unless they are in your foster care or legal guardianship exists (attach proof)
- Grandparents do not qualify as dependant/s

Special dependant declaration – only to be completed if you are registering special dependant/s

I, _____ (your name and surname) declare that any special dependant indicated in the table above is unable to support themselves financially and that they are dependent on me for family care and support.

I declare that their income as declared in this application form is a true and accurate reflection of their regular monthly income from all sources.

I undertake to notify Bankmed in writing should any special dependant as registered on Bankmed, no longer be financially dependent on me for family care and support.

I accept that dependant membership of a special dependant will terminate in the event the requirements for registration as a special dependant are no longer being satisfied.

Signed by me _____ (your signature) on this _____ day of _____ (month) _____ (year).

I am aware that Bankmed reserves the right to impose waiting periods on any special dependant included in this application.

A three-month general and/or 12-month condition-specific waiting period (nine months in respect of an existing pregnancy) may be imposed if:

- the beneficiary was without medical scheme cover for three months or more, immediately preceding this application to join Bankmed
- the beneficiary was on a previous medical scheme for less than two years and applied to join Bankmed within three months of ending membership of the previous scheme (12-month condition-specific waiting period only)
- the beneficiary was on a previous medical scheme for two or more years and applied to join Bankmed within three months of ending membership of the previous scheme (three-month general waiting period only)

Bankmed will notify me in writing within one month of registration, should any of these waiting periods apply to me and/or any of my registered dependant/s, based on the information provided in this application.

I am aware that a penalty may be added to the monthly contribution payable to Bankmed in respect of any special dependant as per this application form, who is 35 years or older at the time of this application and was not registered as a member or dependant on a registered medical scheme on 1 April 2001 and/or has (at any time) been without medical scheme cover for a period of three or more consecutive months since 1 April 2001.

Bankmed will notify me in writing within one month of registration, of any penalties that may apply, based on the information provided in this application.

Full name

Signature

Date D D M M Y Y Y Y

Original hand signature required

4. Please select your Plan

Bankmed Plan: Essential Plan ☐ Basic Plan ☐ Core Saver Plan ☐ Traditional Plan ☐ Comprehensive Plan ☐ Plus Plan ☐

Visit: **http://instagib.co.za/2265633/calculator/questions/basic-information** to find a Plan suitable for you and your family's needs.

You have the right to request assistance in selecting a 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.
Should you select a Plan with a Medical Savings Account (Core Saver, Comprehensive or Plus Plan), the "above tariff" portions are not automatically funded from your available Medical Savings Account. Should you wish for "above tariff" portions to be paid from your Medical Savings Account, please mark with an "X".

Yes ☐ No ☐

If you wish to receive unlimited GP visits, you must nominate a primary and secondary GP. Please place their information below. (This should be completed by Basic and Essential Plan members only):

	Name	**Primary GP name**	**Practice number**
Principal member			
Spouse or partner			
Dependant/s 1			
Dependant/s 2			
Dependant/s 3			

5. About your employer

Please ask your employer to complete this section.

Cover start date D D M M Y Y Y Y

Name of employer

Employer or billing number

Applicant's employee number

Date of employment D D M M Y Y Y Y

Branch name

Branch number

Physical address

Unit/Suite number

Complex name

Street number

Street name

Suburb

City

Post code

Telephone

Employer e-mail address

Personnel officer

Signature of Personnel Officer Payroll Stamp

Designation

Date D D M M Y Y Y Y

6. Your banking details

6.1 Your contributions

Should you be paying your contributions in full or in part, please complete this section:

Please note: we cannot accept credit card account details.

Bank name

Branch name

Branch code - -

Account number

Type of account Cheque Savings

Account holder

Account holder contact

Account holder e-mail address

If third party bank details, please insert the third party ID number

If the third party bank account is a Joint account Company account Trust account

Please provide proof of bank account. Refer to Section 11 at the back of the application form for the proof of bank account required.

As part of Payment Association of South Africa (PASA) debit order mandate requirements, you are required to supply the account holder's residential address, e-mail 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 our system. If you wish to update any contact details please visit **www.bankmed.co.za**.

Account holder's signature

Date D D M M Y Y Y Y

6.2 Your claims refund

May we use the same account from which contributions are deducted in order to refund your claims? Yes No

If you do not wish to use the same banking details for your contributions and claims refunds, please provide us with the details you wish to use:

Please note: we cannot accept credit card account details.

Bank name

Branch name | Branch code - -

Account number | Type of account Cheque Savings

Account holder

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

If third party bank details, please insert the third party ID number

By signing this application, you agree that once claims have been refunded into the selected bank account, Bankmed will not be responsible in any way for the amounts refunded.

7. Previous medical scheme details

Are your dependant/s currently on another medical scheme? Yes No

If you have ticked "Yes", have they given notice of termination to their current medical scheme? Yes No

If "Yes", please attach a certificate of membership from that medical scheme reflecting the end date of membership. We cannot finalise this application without this.

If "No", please give the required notice to the current medical scheme before submitting this application, and attach a certificate of membership from that medical scheme indicating the end date of membership. We cannot finalise this application without this.

Please give us the details of all registered medical schemes to which you previously belonged. We will use this information to determine whether we need to apply any waiting periods, late-joiner penalty fees or both. Kindly supply us with proof in the form of a membership certificate.

Main applicant:

Dependant/s 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	

If all dependant/s were on the same medical scheme(s) as completed above, please tick here to confirm this

If any of your regular dependant/s applying for cover belonged to different medical schemes, please add their details below:

Dependant/s 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	

If any of your special dependant/s applying for cover belonged to different medical schemes, please add their details below:

Special dependant/s 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	

8. Your health questions

The spouse or partner and all dependant/s applying for cover need to complete section 8.

Have you or **any dependant** in this application ever experienced/investigated, been treated for, or are currently suffering from any of the following symptoms, conditions or disorders? (Examples of conditions, symptoms or disorders are listed 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 symptom, disorder or condition not listed in the questions below, you should highlight and provide full details thereof in response to question 8.18 below. Indication of existing medical conditions on this application does not automatically enroll you/your dependant/s onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit www.bankmed.co.za. Should you be moving from a Discovery-administered medical scheme and currently registered for chronic medication, you need to re-apply with Bankmed. Bankmed is a separate legal entity and benefits are not transferable between medical schemes.

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

Example: disorders of the skin, skin lesions, breast disease, non-cancerous tumours, cancerous tumours, cancer of any organ, fibrocystic breast disease, fibroadenoma, lump in breast, abnormal mammogram result, abscess, any autoimmune conditions, any congenital conditions 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 and any other psychological conditions, 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

8.6 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, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, Crohn's disease, ulcerative colitis, diverticulitis, 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

8.8 Brain and nerve conditions

Yes ☐ No ☐

Example: stroke, epilepsy, seizures multiple sclerosis, motor neuron disease, myasthenia gravis, other chronic headaches, 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, Down's syndrome.

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: ventilator, oxygen therapy, CPAP, asthma, chronic obstructive pulmonary disease, bronchiectasis, tuberculosis, bronchitis or emphysema, cystic fibrosis, sarcoidosis, pneumonia, interstitial lung disease / chronic cough > 3 months, any autoimmune conditions, any congenital conditions.

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, 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	Medication 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, keratoconus (cross linkage), corneal ulcer, uveitis, glaucoma, squint, ptosis, retinopathy, macular degeneration, cornea transplant, intra-ocular pressure, visual disturbances, night blindness, 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 any one of your dependants are HIV-positive, its crucial to call us on **0800 226 5633** within seven working days from the date we activate your Bankmed membership. We treat this information with the utmost confidentiality. Registering on the HIV Care Programme is strongly recommended if you or any of your dependants are HIV-positive. Bankmed may impose waiting periods in certain situations, meaning there's a specific timeframe before Bankmed starts covering expenses related to general or specific medical conditions. Consequently, a 12-month condition-specific waiting period or a three-month general waiting period may be applicable to this condition or any related condition. Failure to inform us about you or your dependant's HIV status within seven days of activating your membership could lead to your membership being suspended or cancelled.

9. Bankmed Privacy Statement

When you engage with Bankmed Medical 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.bankmed.co.za/wcm/medical-schemes/bankmed/assets/bankmed-privacy-statement.pdf

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

Please do not sign an incomplete application form

10. Bankmed terms and conditions

1. ***Rules for membership***

1.1. ***Who "we" are***

Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme. Balance (referred to as 'Balance') is the health management and wellness programme developed specifically for Bankmed and its members. Discovery Vitality (referred to as 'Vitality') is a separate company (registration number 1999/07736/07) which carries out business as a Wellness Programme and is appointed by Bankmed to administer Balance.

1.2. ***Rules for membership***

The Bankmed Rules records your rights and responsibilities pertaining to your membership of Bankmed. They may change from time to time.

You may ask us for a copy at any time or you may access them on the website **www.bankmed.co.za**. When you sign this application, you confirm that you have read and understood the Rules and you agree that you and, those for whom you apply, will be bound by them.

Where applicable, you also acknowledge and confirm that the financial adviser whom you or your employer appointed, may communicate with us regarding this application and your membership with Bankmed. You give permission for us to 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 they may contact us if necessary while we process your membership application.

Please speak to your financial adviser or one of our consultants should there be anything you do not understand.

1.3. ***Who you may apply for***

You may apply to join Bankmed on your own or together with your dependants i.e. your spouse, your partner and people who are financially dependent on you, as defined in the Bankmed Rules. For anyone to be treated as financially dependent for this application, you must be responsible for providing financially for that dependant. We might ask you to provide us with proof of financial responsibility. You will be referred to as the Principal Member or Main Member in our future communications to you.

1.4. ***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 for whom you are applying in any matter relating to this application.

You have obtained consent from your spouse and any dependant/s aged 18 years or older to act on their behalf in any matters pertaining to this application.

If you are signing on behalf of a minor (person younger than 18 years) that you are a competent person and authorised to sign on their behalf.

1.5. ***Providing and obtaining information***

You must provide true, correct and complete information

To consider your application for membership, Bankmed must learn more about you and those for whom you apply. This information must be true, correct and complete. This includes the details you provide in this application form and in future dealings with us. It is important that you inform us of any medical condition, symptom or illness relating to you or those for whom you are applying, even if you do not consider it to be relevant to your application. We may ask for more information about those for whom you are applying if they are 18 years of age and older.

Your legal address

We will send documents to you at the address you selected as the communication channel at which you prefer to be contacted. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have provided, or at any other address you have supplied. It is your responsibility to ensure we have the correct address for you.

Bankmed and Discovery Health (Pty) Ltd may record telephone calls

We may record telephone conversations with you and with those for whom you are applying. The recordings and all information we obtain therein will be processed and retained as required by law.

We may obtain information about you from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments, consider a claim for medical expenses, profile and analyse risk or to investigate fraud, waste and/or abuse (including by medical practitioners, contracted service providers), you agree that we may obtain information about you and those for whom you are applying from other relevant sources. These include any entity that is part of Bankmed, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you provide on this application and in respect of any matter pertaining to or that arises during your membership of Bankmed, is true, correct, and complete. You give your permission that we may obtain any information that is relevant to your application and membership from your employer.

Inform us immediately if your information changes

You, your employer, or your financial adviser must inform us in writing, should any of the information you have provided in your application for membership change between the day you sign this document and the day on which your membership commences. This includes information regarding your health and the health of those for whom you apply. We require advance notice of any administrative changes such as cancellation of membership, as we cannot accept backdated changes.

When Bankmed may suspend or terminate your membership/s

Bankmed may suspend or terminate any memberships immediately, should the member or dependant/s on the membership be found guilty of abuse of privilege of the Scheme. It is very important for the member and dependant/s to provide true, correct and complete information on the application form and in their dealings with the Scheme.

1.6. ***Becoming a member***

Bankmed might not pay for certain expenses immediately after you become a member. Bankmed may have waiting periods that apply in certain circumstances. This means there may be a set time period before Bankmed begins paying for any general or specific medical conditions. Please speak to one of our consultants to find out if waiting periods apply to your membership and the memberships of those for whom you are applying.

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 for whom you are applying must resign from your current medical schemes when you receive notice from Bankmed by letter, e-mail, WhatsApp or SMS confirming that you and those for whom you have applied have been accepted.

You must ensure contributions are paid on time

As the main Bankmed member, you are responsible for ensuring that your contributions and the contributions of those for whom you are applying, are paid on time every month to avoid suspension of benefits. If you pay your own contribution, you will be able to identify the debit order for your monthly contributions on your bank statement by the reference “BANKMEDCON.” The Scheme has the right to amend monthly contributions and benefits from time to time and suspend/terminate membership if the contributions are in arrears.

1.7. ***Repaying money owed to the Scheme***

Bankmed has the right at any time to collect from you any amount that you owe to the Scheme. We will notify you should there be any such amount owed to the Scheme.

You must repay any medical savings owing should you leave Bankmed

Once you become a member, depending on the Plan you choose, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the 'Medical Savings Account'. Should you leave Bankmed before the year is up, you must repay the portion of your medical savings you have utilised should it amount to more than you have paid back to Bankmed over the year. Debit orders for collection of money owing to the Scheme will reflect on your bank statement as "BANKMEDCLA".

Account holder's signature

Date D D M M Y Y Y Y

11. Third Party Bank details

Please attach the relevant proof of bank account if you providing a third party bank account for claims refund.

THIRD PARTY ACCOUNT (e.g. spouse, aunt, uncle, friend, father, 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 Driver's Licence
- A copy of the main members ID, Passport or Driver's Licence

JOINT ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the joint

COMPANY ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of the signatories who have authority to sign on behalf of the company
- A letter of authority stating that the account can be used including the details of the signatory and stating the membership details for which the bank account will be used. The letter must be dated, signed by an authorized person on behalf of the company and it must contain the membership or policy number(s)
- A copy of the company's certificate of registration
- A copy of the main members ID, Passport or Driver's Licence

TRUST ACCOUNT

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the trustees of the account
- A copy of the Trust's certificate of registration
- A copy of the Trust resolution, the resolution must be dated, signed by an authorised person on behalf of the Trust and it must contain the membership or policy number(s)
- A copy of the main members ID, Passport or Driver's Licence

If you are completing the request on behalf of the main member, please include proof that you have obtained the necessary authority (example, Letter of Authority or Letter of Executorship).