

Application to add dependants 2026



Contact details
Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is the medical scheme that you are a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Provision is made in this form for your dependant/s to provide information relating to their race. This information is required by the Council for Medical Schemes for statistical purposes only. You are not compelled to provide this information.
3. Please make sure the principal member signs and dates any changes.
4. Please email this completed and signed form with any supporting documents to email application@sabmas.co.za
5. Please attach a copy of each applicant's identity document. We also accept valid passports and unabridged birth certificates for children.
6. Please read sections 10 and 11 to understand who qualifies as a dependant, what supporting documentation is required, as well as the possible underwriting that may be applied.

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

If any details are missing or if we need more information for underwriting purposes, we will contact you.

If you do not hear from us seven days after sending us your application form, please contact us on **0860 100 345**.

Cover start date

D	0	D	1	M	M	Y	Y	Y	Y
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1. Principal Member details

Membership number	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																				
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2. Adding a spouse or partner (if applying for cover)

Only complete this section if you are adding a spouse or partner.

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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.

Date of marriage to principal member (where applicable). Please attach a copy of an official certificate.	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y																																		
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Addition of spouse to an existing membership

If addition of spouse or partner to an existing membership is:

- Due to legal and registered marriage within the 90 days, an official marriage certificate must accompany this application form to avoid underwriting.
- For a spouse married for a period of more than 90 days, full underwriting will apply.
- As a result of a long-standing relationship or in terms of common-law practice, the partnership declaration must be completed and signed.

Partnership declaration

If you are not legally married and you cannot give us a marriage certificate, you have to complete the following section in full. We declare we are in a long-term, committed relationship that is like a marriage and that we live together at the same residence. We understand that by signing this declaration, we agree to tell the Scheme about any change to the status of our relationship or any change to our living arrangements, such as separation. We further understand that if the information we give about our relationship or residency is false in any way, the Scheme reserves the right to end both our memberships. If both parties have not signed and dated the below section, we will halt the application process until we receive the section signed and dated by both parties.

How long have you and your partner been in a relationship that is like a marriage?

Signature of principal member

Date

D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y

Signature of partner

Date

D	D	M	M	Y	Y	Y	Y
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Please do not sign an incomplete application form

3. Adding your dependants (if applying for cover for them)

Dependant 1

Title

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Initials

--	--	--	--

Surname

First name(s) (as per identity document)

ID or passport number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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.

Relationship to principal 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 over 18 years provide cellphone number

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If your dependant is 19 years and older, are they:

Financially dependent on you?

Yes

☐

No

☐

Is your dependant disabled?

Yes

☐

No

☐

Is your dependant a registered student?

Yes

☐

No

☐

Does your dependant earn an income?

Yes

☐

No

☐

How much does your dependant earn each month?

R

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Dependant 2

Title

--	--	--	--

Initials

--	--	--	--

Surname

First name(s) (as per identity document)

ID or passport number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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.

Relationship to principal 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 over 18 years provide cellphone number

If your dependant is 19 years and older, are they:

Financially dependent on you?

Yes ☐

No ☐

Is your dependant disabled?

Yes ☐

No ☐

Is your dependant a registered student?

Yes ☐

No ☐

Does your dependant earn an income?

Yes ☐

No ☐

How much does your dependant earn each month?

R

Dependant 3

Title

Initials

Surname

First name(s) (as per identity document)

ID or passport number

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.

Telephone (H)

Telephone (W)

Cellphone

Email

Relationship to principal 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 over 18 years provide cellphone number

If your dependant is 19 years and older, are they:

Financially dependent on you?

Yes ☐

No ☐

Is your dependant disabled?

Yes ☐

No ☐

Is your dependant a registered student?

Yes ☐

No ☐

Does your dependant earn an income?

Yes ☐

No ☐

How much does your dependant earn each month?

R

4. Your employer warranty (to be completed by the employer)

Please ensure your employer completes this warranty if you are part of an employer group.

- We warrant that the member detailed in section 1 of this application form is an employee of our organisation.
- SAB Medical Aid may bill us for the amount due for this dependant in the same way as it does for our other employees with SAB Medical Aid.

SIGNATURE/COMPANY STAMP

HR Name and Surname

Email

Designation

Date

5. Selecting your GP (Essential Option only)

Please complete this if you have selected the Essential Option. Members on the Essential Option will need to nominate two chosen GPs. To make sure you are still able to get the treatment you need, you will be able to see a doctor, who is not your chosen GP, three times a year. Thereafter, the fourth consultation onwards funds at sixty percent of the lower of claimed or negotiated rate.

	Name	Primary GP name	Practice number	Secondary GP name	Practice number
Spouse or partner**					
Dependant**					
Dependant**					

** Please make sure that the dependant information you give above is the same as the dependant information in section 2 and 3 of this form.

6. Previous medical scheme details

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. Please give us proof in the form of a membership certificate.

If all dependants were on the same medical scheme as completed above, please tick here to confirm this ☐

If any of your dependants applying for cover belonged to different medical schemes, please provide the relevant information:

Dependant name	Scheme name	Start date	Are you still a member	End date if you have already registered	Reason for leaving
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		
			Yes ☐ No ☐		

7. Your health questions

Information on symptoms, conditions or disorders (must be completed for the , spouse/partner and all dependant/s and must include information on conditions even if covered or not on previous memberships). 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 customized 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 modeling, to assist the Scheme to better assess and mitigate its risk (which includes whether to impose a waiting period on your membership) and any other relevant uses. Please note that the Council for Medical Schemes has oversight over any irregular use of your dependant/s health information.

Please also note that the Medical Schemes Act restricts the ability of the Scheme to impose waiting periods. A condition specific waiting period cannot be imposed on your dependant/s relating to any condition that you disclose in this application except your dependant/s received or were recommended any medical advice, diagnosis, care or treatment in respect of such a condition within a 12 month period ending on the date on which this application is considered to be fully and properly made. Information disclosed by you relating to health conditions prior to the preceding 12 months can serve as a basis for the Scheme requiring that your dependant/s undergo a medical examination, at the Scheme's cost. Should that medical examination reveal a current health condition, waiting periods may apply in respect of such current condition.

Below we require you to advise us about whether any dependant/s specified in this application at any time experienced, have been treated/investigated for, or are your dependant/s 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 any of your dependant/s 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 7.1 – 7.18 below.

Please also note that you must tell us in writing if any of the information you gave, in this application for membership, changes between the day you sign this document and the day your dependant/s' membership starts. This includes information about your dependant/s' health. Please take note further that any indication of existing medical conditions on this application does not automatically enrol your dependant/s onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrolment visit www.sabmas.co.za.

Please answer ALL questions by ticking "Yes" or "No". If you answered 'Yes', please provide full details in the sections provided.

SABAAD001

7.1. Tumours, growths, cancerous, non-cancerous and disorders of the skin and breastYes ☐ No ☐

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.2. Heart and circulation conditionsYes ☐ 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, peripheral vascular disease, deep vein thrombosis, pulmonary embolus, any autoimmune conditions, and any congenital conditions, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.3. Gynaecological and Obstetric conditionsYes ☐ 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.4. Are any of your dependant/s 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.5. Mental healthYes ☐ No ☐

Example: mood disorders (like depression and 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 and any other psychological conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

SABAAD001

7.6. Metabolic or endocrine conditionsYes ☐ 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.7. Abdominal conditionsYes ☐ No ☐

Example: hepatitis, cirrhosis, portal hypertension, alcoholic 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, Irritable Bowel Syndrome (IBS), Hemorrhoids, long standing constipation/diarrhea, ascites (fluid in the abdomen), any autoimmune conditions, and any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.8. Brain and nerve conditionsYes ☐ No ☐

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.9. Breathing and respiratory conditionsYes ☐ 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 > 3months, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

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

Example: arthritis (any form), ongoing joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, injury, fractures, 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

SABAAD001

7.11. Kidney or urinary conditions including current or past dialysisYes ☐ No ☐

Example: kidney and/or renal 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.12. Blood conditionsYes ☐ No ☐

Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), polycythaemia vera, blood clotting diseases, any autoimmune conditions, any congenital conditions, leukaemia, lymphoma, pulmonary embolus, haemophilia, haemochromatosis and other bleeding disorders.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.13. Eye conditionsYes ☐ 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.14. Ear, nose and throat (ENT) and dentistry conditionsYes ☐ 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.15. Male urogenital conditionsYes ☐ 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.16. Are any of your dependants expecting to have medical investigations or surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital/seen in casualty in the last 12 months?

Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.17. Have any of your dependants received or not yet received medical advice or treatment for symptoms, not yet 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

7.18. Have any of your dependant/s 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, consultation and/or hospitalisation within the last 12 months	Medicine used for this condition and dosage	Date of last treatment within the last 12 months

HIV and AIDS

You do not need to disclose the HIV status of your dependant/s on this form if you do not feel comfortable doing so. However, if one or more of your dependant/s are HIV positive, you or they must call us on **0860 002 133** within seven working days from the date we activate your SAB Medical Aid Scheme membership. We treat this information in the strictest confidence. A 12-month condition specific waiting period may apply to this condition and any related conditions. If you do not let us know about your HIV status within 7 days of your membership being active, we may end your SAB Medical Aid Scheme membership.

8. Privacy Statement applicable to SAB Medical Aid Scheme membership 2026

When you engage with SAB Medical Aid, 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, children, and other dependant/s, collectively "your dependant/s", where applicable. To view and read our Privacy Statement, please follow this link: <https://www.sabmas.co.za/assets/medical-schemes/sabmas/legal/privacystatement-and-rules.pdf>

Signature of principal member

Date

9. Terms and conditions applicable to SAB Medical Aid Scheme membership 2026

Definitions

1. Who "we" are

The Scheme refers to SAB Medical Aid Scheme (SABMAS), registration number 1209, registered with the Council for Medical Schemes. Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed healthcare organisation for SABMAS.

2. Scheme rules for membership

The Terms and Conditions record your rights and responsibilities for your membership of SABMAS. They may change from time to time. You may ask us for a copy at any time or view these rules on www.sabmas.co.za. When you sign this application, you confirm that you have read and understood the Terms and Conditions and you agree that you, and those for whom you apply, will be bound by these and the Scheme rules. Where applicable you also acknowledge and confirm you, or your employer appointed contact, may communicate with us on this application and your membership to SABMAS. The information will be shared so that he or she may contact us if necessary while we process your membership application. Please speak to your employer if there is anything you do not understand.

SABAAD001

3. Acting for others

You confirm you have the right to act for others and/or:

- You have the right to act for those on your membership in any matter relating to membership;
- You have received permission from your spouse/partner and any dependant(s) over 18 to act for them in any matter relating to their membership
- In the event that you are signing on behalf of a minor (person younger than 18 years old) that you are a competent person and authorised to sign on their behalf

4. Giving and getting information

4.1. You must give true, correct and complete information

To consider your application for membership, SABMAS 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 tell us about any medical condition, symptom or illness relating to you or those for whom you are applying, even if you do not consider it relevant to your application. We may ask for more information about those for whom you are applying if they are 18 years of age or older.

4.2. Your legal address

The Scheme or Administrator 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 given us. It is your responsibility to make sure we have the correct address for you.

4.3. The Scheme and the Administrator may record telephone calls

The Scheme and the Administrator may record telephone conversations with you and with those for whom you are applying. The recordings and all information we get during the recordings will be processed and kept as required by law.

4.4. The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including healthcare professionals, contracted service providers, credit bureaus or industry regulatory bodies ("relevant sources") and further process such information to conduct risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse. We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct and complete. You give your permission that the Scheme and Administrator may get any information that is relevant to your application and your membership from your employer.

4.5. Tell the Scheme or Administrator immediately if your information changes

You or your employer must inform us in writing should any of the information you have provided, in your application for membership, changes between the day you sign this document and the day your membership commences. This includes information regarding your health and the health of those for whom you apply. If at any stage you become a direct paying member, we require advance notice of any administrative changes, such as cancellation of membership, as we cannot accept backdated changes.

5. When the Scheme may cancel your membership/s

The Scheme may cancel your membership if you and those on your membership:

- Do not give us information that later turns out to be relevant to your application;
- Give us any information that is not true, correct and complete;
- Do not tell us about any relevant changes (including about your health and the health of those on your membership);
- Providing false information may lead to criminal charges being brought against you. You will have to pay any amount owing to the Scheme because of this cancellation.

6. The Scheme might not pay for certain expenses

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. Please speak to your employer or one of our consultants to find out if waiting periods apply to your membership and the memberships of those for whom you are applying.

7. Resign from your current medical aid when accepted

It is illegal to be a member of more than one medical aid at the same time. You and those for whom you are applying must resign from your current medical aid when you receive notice from SABMAS by letter, email or SMS informing you that you and those for whom you have applied have been accepted.

8. You must ensure contributions are paid on time

As the principal member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those on your membership are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time with prior notification.

9. Repaying money owed to the Scheme

SAB Medical Aid 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.

10. Dependant information

Dependant Information

Please take note of additional requirements and eligibility criteria for the various dependant categories listed below:

Dependant Category	Requirements
Spouse	- Please include a copy of the marriage certificate when submitting this form. - Waiting periods and/or late joiner penalties will not apply to a spouse joining SAB Medical Aid within three months of marriage.
Fiancé/Fiancée/Partner	- A fiancé/fiancée/partner may qualify as a dependant if the member can demonstrate to the Scheme's satisfaction that he/she is in a committed and serious relationship with the member, akin to a marriage. - Please include an affidavit confirming mutual interdependency for financial assistance/family support. - Proof of shared finances such as jointly owned property/lease agreements/insurance beneficiaries. If: - Customary marriage: Customary marriage certificate or civil union certificate. - Traditional marriage: Traditional marriage certificate or civil union certificate. - Partner: Partnership declaration.
Child	Biological child/ren with a different surname - Please include an affidavit and an unabridged birth certificate or affidavit to confirm relationship to the principal member. Adopted child/ren - Please include proof of adoption. *Stepchild/ren - Please include an affidavit confirming the relationship to the principal member and an abridged birth certificate, the biological parent must be on the policy. Child aged 19 or older (excluding a differently abled child) - In order for a child older than 18 to qualify as a dependant, the member must demonstrate that the child is dependent on him/her for family care and support, in form of an affidavit and is not employed. - Adult rates apply from the age of 21. - If your dependant is unemployed, please provide proof and extent of financial dependency (an affidavit will suffice). Disabled child aged 19 or older - Please include a doctor's report confirming the nature and extent of the learning difficulty/physical disability (must be within the current year). - Affidavit from principal member and dependant confirming the dependant is not employed and is dependent on the principal member for family care and support. - Adult rates apply from the age of 26.
Grandchild	- The mother/father of the child must be a registered dependant on the medical scheme. - An affidavit and court order providing legal guardianship of grandparents registered is required when the parents of the child are not registered on the member's medical scheme. - Affidavit from Principal member and dependant confirming the dependant is not employed and is dependent on the Principal member for family care and support. - If grandchild is older than 19, in addition to above, we require an Affidavit from the principal member and dependent confirming the dependent is not permanently employed and is dependent on the principal member for family care and support.
Parent/parent-in-law	- The Principal member's spouse must be a registered dependant on the medical scheme for a parent-in-law to qualify as or remain a dependant. - An affidavit from the member and the dependant confirming the dependent is not employed/does not have a bank account and dependent on the principal member for family care and support. - Proof of income, three month's bank statement and tax returns for both parents (where applicable).

11. Waiting periods

1. Applicants who had previous cover and have applied to the medical scheme within 90 days of resigning from their previous scheme, must provide a membership certificate.
2. The following type of waiting periods may apply:
 - General waiting periods (all benefits) - three months
 - Condition-specific waiting period - if applicable, 12 months for any pre-existing conditions
3. Late joiner penalties may apply
 - 3.1. Medical schemes may apply contribution penalties to a late joiner (beneficiaries over the age of 35) and such penalties must be applied only to the risk portion of the contribution related to the member or any adult dependants.
 - 3.2. Contribution penalties shall not exceed the following bands:

Penalty Bands	Maximum Penalty
1 - 4 years	5% x contribution
5 - 14 years	25% x contribution
15 - 24 years	50% x contribution
25 + years	75% x contribution

- 3.3. Calculation of late joiner penalties are based on the number of years that the beneficiary has not had medical scheme coverage.
4. This rule does not apply to any member or dependant who has been involuntarily transferred. This includes members who are disabled due to trauma, divorced, retrenched, relocated, dismissed and other reasons reviewed on an adhoc basis by SAB Medical Aid. Underwriting will apply if the application is considered anti-selection or a voluntary transfer.
5. Should you wish to apply with no underwriting, you may opt to join from 1 January of the new year. Proof of previous medical scheme cover is required. If you join within this window period and did not have previous cover, you will receive a mandatory three-month general waiting period. However, they will have access to Prescribed Minimum Benefits (PMB) during this time.