

SAB MEDICAL AID

Who we are

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.

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it digitally.
2. 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 Schemes for statistical purposes only. You are not compelled to provide this information.
3. Read and understand **the Privacy Statement and Terms and Conditions for membership (sections 9 and 10).**
4. Please sign sections **6, 9 and 10.**
5. Please make sure the principal applicant signs and dates any changes.
6. Please email the completed and signed form with any supporting documents to application@sabmas.co.za
7. Please attach a copy of each applicant's identity document. We also accept valid passports and unabridged birth certificates for children.
8. Please read sections 11 and 12 to understand who qualifies as a dependant and possible underwriting that may be applied.

- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will send you any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s (adult and child dependant/s).
- We will send you a welcome letter, SMS or an email to let you know when your application is fully and completely registered.
- You will then receive your welcome pack.

By signing this application, you confirm that you have read and understood the Terms and Conditions for membership and agree to them.

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

When do you want your cover to start?

D ₀	D ₁	M	M	Y	Y	Y	Y
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Title						Initials					
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Surname _____

First name(s) (as per identity document)	
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ID or passport number

Gender M ☐ F ☐ Date of birth

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

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

☐ PO Box	☐ Private Bag	Box number											
☐ Suite	☐ PostNet Suite	Number											
Suburb													
City										Postal code			

Physical address (If your post is delivered to your street address, please complete these details under physical address)

Unit/Suite number		Complex/Building					
Street number		Street name					
Suburb							
City			Postal code				

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

Title		Initials				
Surname						
First names (as per identity document)						
Previous/maiden name						
ID or passport number						
Gender	M ☐	F ☐	Date of birth			
Race	African ☐	Coloured ☐	Indian/Asian ☐	White ☐	Other ☐	Do not want to disclose ☐
<i>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.</i>						
Marital status	Married ☐	Single ☐	Divorced ☐	Widowed ☐		
Date of marriage to principal member (where applicable). Please attach a copy of an official certificate						
Telephone (H)			Telephone (W)			
Cellphone						
Email						

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. 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.

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.

Since when have you and your partner been in this relationship that is like a marriage

Signature of principal member		Date	
Signature of partner		Date	

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

Dependant 1

Title		Initials	
Surname			
First names (as in identity document)			
ID or passport number			

Gender M ☐ F ☐ Date of birth
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 or child. Where your child is not your biological child, please state your relationship, for example, adopted child or foster child. Please attach proof of this relationship to this application.)

If over 18 years provide cellphone number

If your dependant is 19 years or older:

Financially dependent on you? Yes ☐ No ☐ A registered student? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R .

Dependant 2

Title Initials

Surname

First names (as in identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth

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 or child. Where your child is not your biological child, please state your relationship, for example, adopted child or foster child. Please attach proof of this relationship to this application.)

If over 18 years provide cellphone number

If your dependant is 19 years or older:

Financially dependent on you? Yes ☐ No ☐ A registered student? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? R .

Dependent 3

Title Initials

Surname

First names (as in identity document)

ID or passport number

Gender M ☐ F ☐ Date of birth

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 or child. Where your child is not your biological child, please state your relationship, for example, adopted child or foster child. Please attach proof of this relationship to this application.)

If over 18 years provide cellphone number

If your dependant is 19 years or older:

Financially dependent on you? Yes ☐ No ☐ A registered student? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ Does your dependant earn an income? Yes ☐ No ☐

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How much does your dependant earn each month?

R .

4. Please select your Option

Comprehensive Option ☐ Essential Option ☐

MSA (Medical Savings Account) reimbursement (only applicable to Comprehensive Option)

Scheme Rate

Cost

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 60% of the lower of claimed or negotiated rate.

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

** 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.

5. Your employment details (to be completed by the employer)

Date HR received application		Name of employer	
Branch name		Branch number	
Employer or billing number		Employee number	
Date of employment		Employee's monthly salary R	
Department name			

If the employee is joining SAB Medical Aid more than 3 months after they were employed, please confirm if it is because of one of the following reasons

Employer warranty

1. Their spouse or partner resigned, was retrenched or is disabled	Yes ☐ No ☐	Date	
2. They were seconded	Yes ☐ No ☐	Date of return	
3. They are now offered medical aid due to their condition of employment	Yes ☐ No ☐	Date	

Authorised signature

Please do not sign an incomplete application form.

HR name and surname

Email

Designation

Date

EMPLOYER STAMP

6. Banking details for claims refund

Please give us the details you would like us to use to refund your claims. We cannot accept credit card account details.

Name of bank															
Branch name							Branch code			-			-		
Account number								Type of account	Cheque	☐	Savings	☐	Transmission	☐	
Account holder name															

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

Signature of account holder

Signature of principal member

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 Annexure A for the proof of bank account type required.

7. Previous medical scheme details

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

Were all your dependants on the same medical scheme/s Yes ☐ No ☐

If you and your dependant/s belonged to different medical schemes, please complete them below

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

8. Your health questions

Information on symptoms, conditions or disorders (must be completed for the principal member, spouse/partner and all dependant(s) and must include information on conditions even if covered or not on previous memberships). We use this information for lawful purposes only, for example, enabling us and our Administrator to process your application and to optimally administer your membership, to verify whether the information you provide on this application form is true and complete, to provide you with customised information relevant to your health status, to develop disease management programs for specific conditions, to review and enhance Scheme benefits, to improve the 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.

The Council for Medical Schemes has oversight over any irregular use of your or 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 you or any of your dependant/s relating to any condition that you disclose in this application except if you or 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 you 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 you or any dependant/s specified in this application at any time experienced, have been treated/investigated for, or are you currently suffering from any of the following symptoms, conditions or disorders? We have listed some examples of conditions, symptoms or disorders under each question. These are only examples and not the full list of conditions, symptoms or disorders.

Please take note that if you or 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 8.1 – 8.18 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 membership starts. This includes information about your health and the health of those you apply for. Please take note further that any indication of existing medical conditions on this application does not automatically enrol you/your dependant/s onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit www.sabmas.co.za

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

8.1. Tumours growths, cancerous, non-cancerous and disorders of the skin and breast

Yes ☐ No ☐

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

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.3. Gynaecological and Obstetric 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.5. Mental health

Yes ☐ No ☐

Example: mood disorders (like 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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, 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, any congenital conditions.

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.8. Brain and nerve conditions

Yes ☐ 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.11. Kidney or urinary conditions including current or past dialysisYes ☐ 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.12. Blood conditionsYes ☐ 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.13. Eye conditionsYes ☐ No ☐

Example: intra-ocular pressure, visual disturbances, night blindness, cataract, 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.14. 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.15. Male urogenital conditionsYes ☐ No ☐

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

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.16. Are you or any of your dependants expecting to have medical investigations or surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital/seen in casualty in the last 12 months?
Yes ☐ No ☐

Patient name	Symptoms/medical diagnosis	Date of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

8.17. 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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

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 of first diagnosis or first sign of symptoms	Date of last symptoms, consultations and/ or hospitalisation within the last 12 months	Medicine used for this condition and dose	Date of last treatment within the last 12 months

HIV and AIDS

If you, or one or more of your dependants, 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 (SABMAS) membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIV Programme. SABMAS may have waiting periods that apply in certain circumstances. This means there may be a set time period before SABMAS starts paying for any general or specific medical conditions. A 12-month condition specific waiting period or a three-month general waiting period may therefore apply to this condition or any related condition. If you do not let us know about you or your dependant's HIV status within 7 days of your membership being active, we may end your SABMAS membership.

9. 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

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10. 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.

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.

11. Member and dependant information

Members	Requirements
New members joining SAB Medical Aid within 90 days of employment	The member and dependants may join the Scheme and no underwriting will apply.
Members transferring from another medical scheme	- Voluntary transfer of members and dependants will not be subject to underwriting if you apply on 1 January of the new year. Proof of previous medical scheme cover must be provided. - Selective transferring of membership to SAB Medical Aid during the course of the year will be subject to underwriting. A three-month general waiting period may apply and/or a condition-specific waiting period from the previous medical scheme may be carried over.
Current employees of SAB Medical Aid joining the Scheme for the first time, but after 90 days of employment	The member and dependants' membership may be subject to underwriting. The underwriting may include a late joiner penalty, three-month general waiting period may apply and/or a condition-specific waiting period where applicable.

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 MM for family care and support. - Adult rates apply from the age of 26.

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Dependant Category	Requirements
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).

12. Waiting periods

- 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.
- 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
- Late joiner penalties may apply
 - 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.
 - 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

- Calculation of late joiner penalties are based on the number of years that the beneficiary has not had medical scheme coverage.
- 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.
- 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.

13. Annexure A: Third-party bank details

Banking details for a third party

A third party can be anyone, such as your spouse, aunt, uncle, friend, parent or adult child. Please attach the relevant proof of bank account if you give a third-party's bank account details for claim refunds or contribution debit orders.

Documents we need for a third-party bank account

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

Documents we need for a joint bank account

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

Documents we need for a company account

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

Documents we need for a trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, passport or driving licence of each of the trustees of the account
- A copy of the certificate of registration of the trust
- A copy of the trust resolution. The resolution must:
 1. Show the trustees
 2. Be dated and signed by an authorised person on behalf of the trust
 3. Contain the membership or policy numbers
- A copy of the principal member's ID, passport or driving licence
- If you are completing the request on behalf of the principal member, please include proof that you have the necessary authority to do so, for example a letter of authority or a letter of executorship.