ENGEN Medical Benefit Fund

Administered by Discovery Health

Contact details
Tel: 0800 001 615 • PO Box 652509, Benmore 2010 • www.engenmed.co.za

Permission to make certain information available to a third party

By completing this form, you allow us to share your information with any third party you nominate. A third party is any person or entity that has a relationship with Engen Medical Benefit Fund , including its administrator (Discovery Health (Pty) Ltd), as well as those entities who do not have a direct relationship with Engen Medical Benefit Fund.

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a non-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, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly and remember to sign the form.
2. To avoid administrative delays, please make sure this form is completed in full.
3. Please sign the form.
4. Provide a copy of your nominated third party's identity document or valid passport.
5. Incomplete forms will not be considered as valid consent.
6. Fax the completed and signed form to **011 539 5217** or email it to **consent@engenmed.co.za**
7. Please specify the type of information that each third party may have access to and for how long the access should be valid. If you don't specify a date, we will assume the permission to be valid from the date of signature, in section 3 of this form, to continue until you revoke the permission in writing.
8. For more information about how and why we use your information, please view our **Privacy Statement**.

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

If your nominated third party has not previously given Discovery Health a copy of their identity document, please submit it with this form.

If we cannot identify your nominated third party, we cannot complete the request for this (applicable to section 2.3, 2.4 and 2.5).

1. About yourself (member)

Membership number

ID or passport number

Member's name

Member's surname

2. About the third party (to whom we may give specified information)

2.1. Your employer contact person

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

Title

Surname

First name(s) (as per identity document)

ID or passport number

Please note that this form expires on 31/03/2025. Up to date forms are available on www.engenmed.co.za

EMBPMC001

2.2. Your doctor

BHF Practice number

Doctor's first name and surname

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

Your doctor

Make all of the below available			
Biographical information		D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information		D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information		D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information (Including Health Record containing pathology and radiology results and may include HIV-related information)		D D M M Y Y Y Y	D D M M Y Y Y Y

(Refer to table 1 on page 4 for examples of these types of information).

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

2.3. Specific third party 1

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

Title

Surname

First name(s) (as per identity document)

ID or passport number

Email

Contact number

2.4. Specific third party 2

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

Title

Surname

First name(s) (as per identity document)

ID or passport number

Email

Contact number

2.5. Specific third party 3

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

Title

Surname

First name(s) (as per identity document)

ID or passport number

Email

Contact number

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

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

Third party **Please tick the third party to which you want to make information available**

Make all of the below available ☐

	Specific third party 1	Specific third party 2	Specific third party 3	**Date from**	**Date to**
Biographical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

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

Table 1			
Examples of biographic information	**Examples of benefit information**	**Examples of financial information**	**Examples of medical information**
Membership number	Benefits	Fund tax certificate and tax reports	Indicator of chronic condition
Date of birth	Medical Savings Account balance	Banking details	Prescribed Minimum Benefit chronic conditions details
ID number	Medical Savings Accounts choice: Scheme Rate or Cost	Total contribution and breakdown	Confirmation of claims paid (excluding amounts and origin of payments)
Postal and email address	Current Medical Savings Account spent		Claims transaction history
Physical address	Limits		Hospital procedures
Telephone numbers	Waiting period details		Procedure codes
			Procedures done in doctors' rooms paid from Hospital Benefit
			MedXpress medicine query
			Doctors only
			Health Record (including pathology and radiology results and may include HIV-related information)

4. Terms and conditions

4.1. This document provides permission to Engen Medical Benefit Fund, and its outsourced service providers, including the administrator, to make certain information available to the named third party or third parties selected in this form and reserves right to revoke this consent if there is a breach of any terms and conditions of this agreement or any rules by either of the parties.

4.2. You agree that by making this information available, Engen Medical Benefit Fund, and its outsourced service providers, including the administrator are not responsible for any loss, whether direct, indirect or as a result of disclosing the information.

4.3. You agree that the named third parties receiving this information may not hold Engen Medical Benefit Fund, and its outsourced service providers, including the administrator responsible for any claims that result from the wrongful use or disclosure of the information by the named third parties.

4.4. You agree that once you have provided permission, Engen Medical Benefit Fund, and its outsourced service providers, including the administrator may give all the information that falls under the selected type of information to the named third parties.

4.5. This permission will end on the dates specified in section 2 and 3 of this form or when your employer contract ends. You agree that should you not have given an expiry date in section 2 and 3 of this form, the permission will only end on your specific instruction in writing (or when the purpose of the permission has been served). Any 3rd party consent expires on death.

4.6. Engen Medical Benefit Fund, and its outsourced service providers, including the administrator will only share the personal, financial and medical information for you or your beneficiaries should it be requested by a third party to which you have already provided consent for disclosure and the parties with which Engen Medical Benefit Fund, and its outsourced service providers, including the administrator share the information agree to keep the information confidential. Should Engen Medical Benefit Fund, and its outsourced service providers, including the administrator wish to share your information for any other reason, we will do so only with your express consent

Engen Medical Benefit Fund, registration number 1572, is registered by the Council for Medical Schemes and administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. Discovery Health (Pty) Ltd is an authorised financial services provider.

5. Consent to use the Engen Medical Benefit Fund Electronic Health Record application. * (refer to 2.2)

Definitions

"Applicable law" includes all these:

- the Promotion of Access to Information Act 2 of 2000
- the Electronic Communications and Transactions Act 25 of 2002 (as amended)
- the Protection of Personal Information Act 4 of 2013
- the Consumer Protection Act 68 of 2008
- the Medical Schemes Act 131 of 1998 (as amended)
- the National Health Act 61 of 2003
- the Children's Act 38 of 2005
- the Choice on Termination of Pregnancy Act 92 of 1996
- Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974 published as GNR 717, dated 4 August 2006 in the Government Gazette ("the Ethical Rules")
- All applicable guidelines published in General Ethical Guidelines for the Health Care Professions as published by the Health Professions Council of South Africa ("the HPCSA guidelines").
  "Electronic Health Record" (or EHR) is a regularly updated summary of all information (also referred to as "my information") that is accessible and made available through the Engen Medical Benefit Fund Electronic Health Record application.
  "My information" refers to all personal, other and possibly sensitive medical, clinical or claim information (recorded in the EHR) and includes:
- All existing and newly diagnosed chronic conditions
- Chronic Illness Benefit and Health Plan information
- Certain biographical details
- Medical information that healthcare providers send to the Fund and its administrator
- All results, including pathology and radiology (if any), which may also include information about HIV or AIDS, sexually transmitted diseases and pregnancy or its termination.

Acknowledgement

I acknowledge that –

- Engen Medical Benefit Fund's administrator has developed an application ("Electronic Health Record") medical practitioners can use to access my information recorded in my Electronic Health Record (EHR).
- The purpose of Electronic Health Record is to support and enable quality clinical care to members and to help reduce the administrative burden on medical practitioners accessing my information.
- Only medical practitioners who have subscribed to and are authorised to use my Electronic Health Record and its features ("authorised medical practitioners") can access my information.
- All authorised medical practitioners who treat me from time to time may only request and access my information through the EHR if they have my consent.
- Once I have granted consent, any authorised medical practitioners who I may consult from time to time and who have my consent may access all my information recorded in my EHR including details of consultations with other medical practitioners I may have consulted before.
- I may at any time change or revoke my consent by formally letting Engen Medical Benefit Fund know of my decision. In this case, Electronic Health Record will grant authorised medical practitioners access to my information only up to the date I change or revoke my consent and will not make my information available to any authorised medical practitioners from then on. By granting my consent, I provide Engen Medical Benefit permission to share my information (through my EHR) with my authorised medical practitioners to assist in making informed clinical decisions.

I understand that once Engen Medical Benefit Fund has shared my information with authorised medical practitioners, Engen Medical Benefit Fund has no further control over this information and will not be accountable for its safeguarding. I also understand that the authorised medical practitioners have confirmed to the Fund's administrator that they will treat my information as confidential and in line with applicable laws.

I note that Engen Medical Benefit Fund will, as required by and in adhering to applicable laws, protect and maintain the confidentiality of my information.

Consent

5.1. By consenting, I agree to –

  5.1.1. My information being made available to authorised medical practitioners through Electronic Health Record for the purposes outlined here.

  5.1.2. Engen Medical Benefit Fund's administrator receiving my information directly from any healthcare provider and making this available through my Electronic Health Record.

5.2. I am entitled to change or revoke my consent at any time. When I revoke my consent, medical practitioners will no longer be able to access my information.

5.3. The consent I provide (as set out in this form) is valid from the date and time when I give consent and will continue until I change or revoke my consent as explained in point 2.

5.4. I agree that by making this information available, the Fund's administrator will not be responsible for any loss or damage (whether direct or indirect) that may arise from the use of this information, other than where it is due to or attributable to grossly negligent or fraudulent conduct by the Fund and / or its administrator.

5.5. I provide permission for my authorised medical practitioners to provide the Fund and the administrator with my diagnosis and other relevant clinical information to review applications for the Chronic Illness Benefit. For the Chronic Illness Benefit, I understand that –

  5.5.1. Funding from the Chronic Illness Benefit depends on meeting benefit entry requirements as determined by Engen Medical Benefit Fund.

5.5.2. It provides cover for disease modifying therapy only, which means that not all medicines for a listed condition are automatically covered or funded.
5.5.3. By registering, I agree that my condition may be subject to disease management interventions and periodic review and that this requires giving both Engen Medical Benefit Fund and my authorised medical practitioners access to my information.
5.5.4. Funding for medication will only be provided from when Engen Medical Benefit Fundreceives and approves an application form that is completed in full.
5.5.5. I may need to send an updated or new application form, if Engen Medical Benefit Fundasks for this.

5.6. I have had an opportunity to read (or have read to me) and I am aware of and fully understand all the terms, conditions and consequences of providing my consent.
5.7. I have had sufficient opportunity to ask questions about this consent form and have had these questions, if any, answered to my satisfaction by Engen Medical Benefit Fund Medical Benefit Fund and/or its administrator.
5.8. I have been made aware that the full terms and conditions can be accessed on www.engenmed.co.za or by calling 0800 001 615 and that Engen Medical Benefit Fund will provide me with a copy of this consent form on my request.
5.9. My consent to all the terms and conditions of Electronic Health Record is provided of my own free will without any undue influence from any person whatsoever.

I indicate my full understanding and agreement to consent to use Engen Medical Benefit Fund Electronic Health Record.

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

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

Name ______

Signature of person providing permission ______