Applying to become a member of Remedi in 2025 (with underwriting)

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

Thank you for applying to join Remedi. This document is an application form for membership.
It also contains the conditions of application. Please make sure you read and understand the Remedi terms and conditions.

Who we are

Remedi (referred to as 'the Scheme'), registration number 1430, is the medical scheme you are applying to become a member of, which is a not for profit organisation and is registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the conditions of application and Remedi terms and conditions (Section 10 and Section 11).
3. Sign Sections 7, 10 and 11.
4. Please make sure the main applicant signs and dates any changes.
5. Once completed, your employer contact must email the completed and signed form to **application@yourremedi.co.za**.
6. Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

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.
- We will activate your membership and send you or your employer a letter of confirmation when we are offering standard terms of acceptance (no waiting periods or late-joiner penalties). For any non-standard terms, we will issue a counter-offer letter which will indicate any conditions applicable to your membership (waiting periods and/or late-joiner penalties). You may accept the offer by signing and returning this letter for us to activate your membership.
- Provision is made in this form for you and your dependants to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information.
- We will send you or your employer, the counter offer letter and 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 or your employer a welcome letter, a notification or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form.
- You will then get a pack in the post.

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

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

When you sign this application, you confirm that you have read and understood the conditions (section 10 and 11 of this form) of application and Remedi terms and conditions.

1. About yourself (main applicant)

When do you want your cover to start? D D M M Y Y Y Y

Title | Initials

Surname

First names

Previous or maiden name

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

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

If your post is delivered to your street address, please complete these details under physical address.

Physical address

Unit/Suite number Complex name

Street number Street name

Suburb

City Postal code

Occupation Tax number

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

Title Initials

Surname

First names

Previous or maiden name

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

Tax number

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 the below section is not signed and dated by both parties, the application process will be stopped until the section is signed and dated by both parties.

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

Original hand signature required

Signature of partner Date D D M M Y Y Y Y

Original hand signature required
Please do not sign an incomplete application form

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

Dependant 1

Title | Initials

Surname

First names

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 main member (for example, mother, child. Please attach relevant proof as outlined in section 4.)

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A full-time student? Yes No

If yes, please confirm type of disability

Permanent Disability Temporary Disability

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

Dependant 2

Title | Initials

Surname

First names

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 main member (for example, mother, child. Please attach relevant proof as outlined in section 4.)

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A full-time student? Yes No

If yes, please confirm type of disability

Permanent Disability Temporary Disability

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

Dependant 3

Title | Initials

Surname

First names

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 main member (for example, mother, child. Please attach relevant proof as outlined in section 4.)

ID or passport number

If your dependant is 21 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A full-time student? Yes No

If yes, please confirm type of disability

Permanent Disability Temporary Disability

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

4. Dependant classification and proof required

Definition of dependant	Documents required
Spouse	ID and marriage certificate
Natural child	ID, birth certificate
Natural child with different surname to main member	ID, birth certificate, affidavit
Step child	ID, birth certificate, affidavit
Adopted child or foster child	ID, birth certificate, proof of adoption, court order
Mentally or physically disabled child (over 21)	ID, birth certificate, written confirmation from treating doctor of nature of disability, proof of state grant or pension
Traditional or polygamous spouse	ID, certificate of customary union
Parents or siblings of main member	ID, proof of income and an Application to register an additional adult dependant form
Common-law partner or same-gender partner	ID
Student	ID, proof of registration at tertiary institution and three months bank statements
Unemployed child (over 21)	ID, affidavit confirming unemployment and an Application to register an additional adult dependant form

Where the dependant is a common-law wife, husband or partner, a partnership declaration (Section 2) must be completed by both the main member and common-law wife, husband or partner.

5. Please select your Benefit Option

Remedi Standard ☐ Remedi Classic ☐ Remedi Comprehensive ☐

You have the right to ask for help in selecting a Benefit Option that suits your needs. By signing this application, you confirm that you are familiar with the conditions and benefits of the Option you have chosen.

Please complete the relevant income band below by inserting either a letter or upper most rand value.

Main member **R** ☐☐☐☐☐ Spouse or partner **R** ☐☐☐☐☐

Remedi Comprehensive

If you have selected Remedi Comprehensive, please note we pay benefits above the Remedi benefit relating to non-Prescribed Minimum Benefits from your Personal Medical Savings Account at cost, subject to your agreement and available benefit.
Please indicate if your Personal Medical Savings Account should be used to cover claims where the service provider has charged in excess of the benefit paid by Remedi:

Yes ☐ No ☐

Standard Option GP Selection

Please complete this if Remedi Standard is your benefit option. Please select a GP on the Scheme GP Network for your dependant. You also need to allocate a Second GP as per the Footnote inserted below the table. You may find the list of GPs to choose from by calling our Contact Centre on **0860 116 116**. If you experience any difficulties in making a selection, you may also reach out to your employer office for further assistance and/or guidance.

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant one**					
Dependant two**					
Dependant three**					
Dependant four**					
Dependant five **					

*If you live far away from where you work or you often need to work in different towns or province, you may need a second GP.
Please only choose a second GP if this applies to you.
** Please ensure that the dependant information you give above aligns with your membership and registered details as this form cannot be used to add dependants onto your membership. To add additional dependants or to change your dependants please reach out to your employer office or if you are a pensioner contact us on **0860 116 116**. If you have more than 5 dependants registered with the Scheme we will need you to contact us on **0860 116 116** to receive an additional form to complete

6. Your employment details

Name of employer ☐ Employer or billing number ☐☐☐☐☐☐☐☐☐

Membership: (tick the relevant block) Compulsory ☐ Non compulsory ☐

Employee number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Date of employment D D M M Y Y Y Y

Branch name ☐ Branch number ☐☐☐☐☐☐☐☐☐

Please make sure your employer completes this warranty. If this application form is not sent with an employer warranty, we cannot process the application form.

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. Remedi may bill us for the amount due for this member in the same way as it does for our other employees as members of Remedi.
3. The income band selected is in accordance with Remedi's rules and that if the spouse is also an employee, then the higher of the two income bands will be applied.

Employer's authorised signatories ☐ Employer's authorised signatories ☐

Original hand signature required **Original hand signature required**

Names ☐ Names ☐

Designation ☐ Designation ☐

7. Your banking details

Please give us the details you would like to use for your claim refunds.If we are paying a third party bank account, the main member must insert the ID number of the third party.
Please note: We cannot accept credit card account details.

Bank name

Account number

Branch code - -

Type of account Cheque Savings

Account holder

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

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

If the third party bank account is a joint account, company account or trust account please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required.

By signing below, you agree that once claims have been refunded into the bank account you have chosen, Remedi will not be responsible in any way for the amounts refunded, if these details are incorrect.

Signature of main applicant

Original hand signature required

8. 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.

Main applicant

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

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

Dependant 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	
				Yes No	

9. Your health questions

Treating healthcare professionals name

Practice number

Telephone

Email

Only the main applicant, spouse or partner and any adult dependant applying for cover needs to complete the section below

Have you or **any dependant/s** in this application **ever** experienced, been investigated, treated 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 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 9.1-9.18 below. Indication of existing medical conditions on this application does not automatically enroll you/your dependants onto the Scheme's Disease Management programme. For more information with regards to the Schemes disease management enrollment visit www.yourremedi.co.za

We may be able to use certain previous medical information for you and your dependants(if applicable) we have from previous policies. However, it is still your obligation to disclose any and all relevant information as required. By ticking this box you agree that we may utilize this information for the purposes noted below ☐

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

9.1 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, lump in breast, abnormal mammogram result, abscess, any autoimmune conditions, any congenital conditions or other skin conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.2 Heart and circulation conditions **Yes** ☐ **No** ☐

Example: chest pain, palpitations, shortness of breath, coronary heart disease, angina, heart attack, arrhythmia, high blood pressure (hypertension), cardiomyopathy, valvular heart disease or heart valve replacement, rheumatic fever, high cholesterol, previous heart surgery, stents, pacemaker, any autoimmune conditions, any congenital conditions, peripheral vascular disease, Deep Vein Thrombosis, Pulmonary embolus, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.3 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 first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.4 Are you or any of your dependants pregnant or undergoing treatment/investigation to fall pregnant or trying to conceive or difficulty falling pregnant? **Yes** ☐ **No** ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.5 Mental health Yes ☐ No ☐

Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, personality disorders, sleeping disorders (i.e. narcolepsy), eating disorders, Alzheimer's disease, dementia, attention deficit-hyperactivity disorder, drug and/or alcohol abuse or rehabilitation, suicide attempt, post traumatic stress disorders, counselling and any other psychological conditions, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.6 Metabolic or endocrine conditions Yes ☐ No ☐

Example: diabetes mellitus (high blood sugar),diabetes insipidus, thyroid disease, Addison's disease, Cushing's syndrome, metabolic syndrome, parathyroid disease, Paget's disease, osteoporosis, growth deficiency, metabolic disorders, Conn's syndrome, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.7 Abdominal conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, portal hypertension, liver disease, liver failure, pancreatitis, cystic fibrosis, gall bladder/stones, GORD (reflux), heartburn, oesophageal disease, hernias, gastritis, ulcers, malabsorption, 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 condition.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.8 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, vetriculo-peritoneal brain shunt (VP shunt used to drain fluid from the brain), intellectual disability, CVA, bleeding on the brain, constipation, any autoimmune conditions, any congenital condition.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.9 Breathing and respiratory conditions Yes ☐ 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 > 3 months any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

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

Example: arthritis (any form), ongoing/intermittent joint or muscular pain, ankylosing spondylitis, degenerative disc disease, scoliosis, kyphosis, spinal stenosis, gout, physical disability, prosthesis and internal insertion of surgical implants, amputation, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.11 Kidney or urinary conditions including current or past dialysis Yes ☐ No ☐

Example: kidney failure, kidney stones, recurrent urinary infections, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, urinary incontinence, neurogenic bladder (loss of bladder control or inability to empty the bladder), bladder infections, other bladder or kidney problems, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.12 Blood conditions Yes ☐ No ☐

Example: deep vein thrombosis, anaemia, polycythaemia vera, blood clotting/diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia haemochromatosis and other bleeding disorders, any autoimmune conditions, any congenital conditions, varicose veins.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.13 Eye conditions Yes ☐ 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, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.14 Ear, nose and throat (ENT) and dentistry conditions Yes ☐ No ☐

Example: otitis media (middle ear infection), otitis externa, (ear canal infection) hearing problems, hearing aid, cochlear implant, tonsillitis, adenoiditis, vertigo, deafness, sinus problem, nasal surgery, dental treatment or dental surgery, any autoimmune conditions, any congenital conditions.

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.15 Male urogenital conditions Yes ☐ No ☐

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

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.16 Are any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have they been admitted to hospital in the last 12 months? Yes ☐ No ☐

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.17 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, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

9.18 Have you or any of your dependants ever been diagnosed with or received treatment for, any condition/symptoms or any allergic reactions or side-effects, not mentioned in the questions above, in the last 12 months before this application? **Yes** **No**

Patient name	Symptoms/Medical diagnosis	Date first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medicine used for this condition and dosage	Date of last treatment taken

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 116 116** within seven working days from the date we activate your Remedi 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 *Care* Programme. Remedi may have waiting periods that apply in certain circumstances. This means there may be a set time period before Remedi 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 dependants HIV status within 7 days of your membership being active, we may end your Remedi membership.

10. Remedi Privacy Statement – how we will process and disclose your Personal Information and communicate with you

Please remove the privacy statement and replace with the following:
When you engage with Remedi, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants and beneficiaries, where applicable. To view and read our Privacy Statement, please follow this link:
https://www.yourremedi.co.za/wcm/medical-schemes/remedi/assets/legal/privacy-statement-for-remedi-medical-aid-scheme.pdf

Signature of main applicant

Please only sign if you have read and understand this statement

11. Terms and conditions applicable to Remedi

Who "we" are

Remedi, registration no 1430, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for Remedi, and an authorised financial services provider.

1. ***Scheme terms and conditions for membership***
   The terms and conditions of Remedi record your rights and responsibilities for your membership of the Remedi. They may change from time to time. You may ask us for a copy at any time.
   When you sign this application, you confirm that you have read and understood the terms and conditions and you agree that you and those you apply for will be bound by these and Scheme terms and conditions. Where applicable you also acknowledge and confirm that the broker you or your employer appointed, may communicate with us on this application and your membership of Remedi and give permission we share your medical information and other relevant personal information about you and your dependant/s.
   The information will be shared so that he or she can help us if necessary while we process your membership application.

2. ***Who you are applying for***
   You may apply to join Remedi on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Remedi terms and conditions. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. We might ask you to give us proof of financial responsibility. You may be called the principal member or main member in our future communications to you.

3. ***Acting for others***

You confirm you have the right to act for others

By signing this document, you confirm that:

- You have received permission from your spouse and any dependant/s over 18 to act for them in any matter relating to this application.
- You have the right to apply for membership and to act for those you apply for in any matter relating to this application.

4. ***Giving and getting information***

You must give true, correct and complete information

To consider your application for membership, we must learn more about you and those you apply for.
Information about you and those you apply for must be true, correct and complete. This includes the details you give 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 you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for information.

Your legal address

We will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

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

We may record telephone conversations with you and with those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

Remedi and Discovery Health (Pty) Ltd may get information about you from other relevant sources

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

Tell Remedi or Discovery Health (Pty) Ltd immediately if your information changes

You, your employer or your broker must tell us in writing if any of the information you gave in your 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. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When Remedi may cancel your membership/s

Remedi may cancel any memberships immediately, if you and those you apply for:

- Do not give us information that later turns out to be relevant to this 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 you apply for) between the day you sign this document and the day cover starts.

5. ***About becoming a member***

Remedi might not pay for certain expenses immediately after you become a member

Waiting periods may apply in certain circumstances to your membership. This means there may be a set time period before Remedi starts paying for any general or specific medical conditions. Please speak to your employer or us to find out if waiting periods apply to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from Remedi by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time

As the main member of Remedi, you are responsible for ensuring that your contributions and the contributions of those you apply for 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. If you pay your own contributions, you will be able to identify the debit order for your monthly contributions on your bank statement, the reference number REMEDICONT will be used.

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

Remedi 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.

You must repay any medical savings owing if you leave Remedi.

When you become a member, depending on the benefit option you chose, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the 'Medical Savings Account'. If you leave Remedi before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to Remedi during the specific year.

By signing this form, you agree that any money you owe to the Scheme may be deducted from any future claim payment amounts that are due to be paid to you. You will be able to identify the debit order for the money owing to the Scheme on your bank statement, the reference number REMEDICLAW will be used.

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

Signature of new main member _____

The main member must sign and date any changes
Please do not sign an incomplete application form
I confirm the information is accurate and complete

12. Third Party Bank details

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

THIRD PARTY ACCOUNT (e.g. spouse, aunt, uncle, friend, father, son)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, Passport or Driver's Licence
- A copy of the main member's ID, Passport or Driver's Licence

JOINT ACCOUNT

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

COMPANY ACCOUNT

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

TRUST ACCOUNT

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

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

13. Declaration

I hereby acknowledge that my membership will take effect as per the registered rules of Remedi. Any authorisations for procedures and treatment will be subject to the benefits available as per my revised membership details. I have read the Scheme's Benefit Brochure(s) and available communications on the Scheme website at **www.yourremedi.co.za** and familiarised myself with the benefits available to me and my family as per my chosen benefit option and understand that my membership is subject to the registered rules of Remedi which is also available on the Scheme website. I understand that any change in contributions will be payable and due to Remedi in line with the registered rules of Remedi.

If you can't physically sign this form, you must sign it digitally. We accept digital signatures from the following digital signature providers:

- SigniFlow
- DocuSign
- Quickly Sign
- Hellosign
- Santa
- mflow
- Smart Advise signaturesAdobe Sign with certificate