Medical Aid Scheme

Administered by Discovery Health

Contact details
Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

Applying to become a member of TFG Medical Aid Scheme in 2025 (with underwriting)

For TFG office use

Employee number	
Cost centre code	
Branch code	

Thank you for deciding to apply to join TFG Medical Aid Scheme. This document is an application form for membership.

It also contains terms and conditions for membership. Please make sure you read and understand these rules.

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

How to complete this form

Please go through these steps:

1. Please use one letter per block, complete in black ink and print clearly.
2. Read and understand the terms and conditions for membership (section 10). View the Scheme legal page and Privacy Statement here.
3. Sign sections 6, 9 and 10.
4. Please make sure the main applicant signs and dates any changes.
5. All requests relating to you application to become a member of TFGMAS must be submitted by logging a ticket via **https://synergy@tfg.co.za/**.
6. 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.
7. 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.
- 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, 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.

If you have any questions, please let us know. Once we have assessed your application, we will let you know what will happen next.

When you sign this application, you confirm that you have read and understood the terms and conditions (section 10 of this form) for membership as well as the Privacy Statement and agree to them.

1. About Yourself (main applicant)

Cover start date D 0 D 1 M M Y Y Y Y

Title Initials

Surname

First name/s (as per identity document)

Previous or maiden name

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.

Via email, you will receive your communication quicker and there is less of an impact on the environment.

Preferred language: English Afrikaans

Occupation Tax number

ID or passport number

Telephone (H) Telephone (W)

Cellphone

Email

Physical address:

Suite or unit number Complex name

Street number Street name

Suburb Postal code

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

Title Initials

Surname

First name(s) (as per identity document)

Previous or maiden name

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.

ID or passport number

Telephone (H) Telephone (W)

Cellphone Tax number

Email

Partnership declaration

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

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

Dependant 1

Title Initials

Surname

First name/s (as per identity document)

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.

ID or passport number

Please answer all questions.

Is your dependant:

Your child? Yes No *A student? Yes No

*Disabled? Yes No *A special dependant? Yes No

What is your dependant's marital status?

If your dependant is none of the above, please explain his or her relationship to you (for example: nephew, niece):

Does your dependant earn an income? Yes No

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

Dependant 2

Title Initials

Surname

First name/s (as per identity document)

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.

ID or passport number

Please answer all questions.

Is your dependant:

Your child? Yes No *A student? Yes No

*Disabled? Yes No *A special dependant? Yes No

What is your dependant's marital status?

If your dependant is none of the above, please explain his or her relationship to you (for example: nephew, niece):

Does your dependant earn an income? Yes No

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

Dependent 3

Title Initials

Surname

First name/s (as per identity document)

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.

ID or passport number

Please answer all questions.

Is your dependant:

Your child? Yes No *A student? Yes No

*Disabled? Yes No *A special dependant? Yes No

What is your dependant's marital status?

If your dependant is none of the above, please explain his or her relationship to you (for example: nephew, niece):

Does your dependant earn an income? Yes No

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

*If your dependant is a student or a disabled child, please send us the following:

- If student, proof of enrolment at an academic institution
- If disabled, your medical proof of disability
- If special dependant, please provide proof of financial dependence. An affidavit is required from the main member confirming financial dependence, as well as proof of your dependant's income. Please also provide proof that the dependant resides at the same residence as the main member.

4. Please select your health plan

TFG Health TFG Health Plus

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

Your gross monthly salary? **R** .

Your spouse's gross monthly salary? **R** .

*Please attach your spouse's payslip as proof of income. If your spouse is unemployed, please attach an affidavit to this effect.

Income verification may be conducted to determine whether you are registered on the correct income band. Income is considered as: The higher of the main member or registered spouse or partner's earnings, commission and rewards from employment; interest from investments; income from leasing of assets or property; distributions received from a trust, pension and/or provident fund; receipt of any financial assistance received from any statutory social assistance programme.

Choosing you and your dependant/s healthcare professional

If you have selected TFG Health, you need to choose a GP from the KeyCare Network for you and your dependant/s. Please fill in the details of the GP you have chosen for you and your dependant/s.

	Name	GP name	Practice number
Main applicant			
Spouse or partner			
Dependant 1**			
Dependant 2**			
Dependant 3**			

5. Employment details (to be completed by TFG Payroll only)

Name of employer: THE FOSCHINI GROUP

Employer number: 3 7 1 6 9 3 8

Employee number

Date of employment: D D M M Y Y Y Y

Branch number

Branch name

Cost centre number

Date of promotion (if applicable): D D M M Y Y Y Y

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. TFG Medical Aid Scheme may bill us for the amount due for this member in the same way as it does for our other employees with TFG Medical Aid Scheme.

Employer's authorised signatory

Original hand signature required

Name

Designation

If you have more than three dependants, please complete an application to add dependants to TFG Medical Aid Scheme.

6. Your claims refund banking details

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

Bank name

Branch name

Branch code - -

Account number

Type of account Cheque Savings

Account holder

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

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

After third party ID number, please insert the following: 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 this application, you agree that once claims have been refunded into the bank account you have chosen, the TFG Medical Aid Scheme will not be responsible in any way for the amounts refunded. Please make sure that we have your correct bank account details.

Signature of account holder

Original hand signature required

7. Previous medical scheme details

Please give us the details of all registered South African medical scheme that you previously belonged to. We will use this information to determine if we need to apply any late-joiner penalty fee. Please give us proof in the form of a membership certificate.

Main applicant

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

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

If any of your dependants applying for cover belonged to different medical schemes, please complete below:

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

8. Your health questions

A. Only the main applicant, spouse or partner and any adult dependant applying for cover needs to complete section 8.A.

Have you or any dependant/s in this application ever experienced/investigated, been 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 8.18 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.tfgmedicalaidscheme.co.za

We may be able to use certain previous medical information for you and your dependants(if applicable) we have from previous policies. By ticking this box you agree that we may utilize this information for the purposes noted below. ☐

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

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

TFG Medical Aid Scheme, registration number 1578, is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. Discovery Health (Pty) Ltd is an authorised financial services provider.

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 and peripheral vascular disease, Deep Vein Thrombosis, Pulmonary embolus, varicose veins.

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

8.3 Gynaecological and obstetrics conditions Yes ☐ No ☐

Example: abnormal pap smear results, abnormal menstrual bleeding, endometriosis, miscarriage, polycystic ovarian syndrome, infertility, ectopic pregnancy, missed periods, ovarian cyst, any autoimmune conditions, any congenital conditions.

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

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

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

8.5 Mental health conditions Yes ☐ No ☐

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

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

8.6 Metabolic or endocrine conditions Yes ☐ No ☐

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

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

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, constipation, hernias, gastritis, ulcers,coeliac disease, obesity, overweight, unintentional weight loss, incontinence, abdominal pain, colo-rectal symptoms/conditions, malabsorption, Crohn's disease, ulcerative colitis, diverticulitis, any autoimmune conditions, any congenital conditions.

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

8.8 Brain and nerve conditions Yes ☐ No ☐

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

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

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, any autoimmune conditions, interstitial lung disease/chronic cough > 3months any congenital conditions.

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

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

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

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

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

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

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

8.12 Blood conditions Yes ☐ No ☐

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

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

8.13 Eye conditions Yes ☐ 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 first diagnosed/symptoms	Date of last symptoms, consultations and/or hospitalisation	Medication used for this condition and dosage	Date of last treatment

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

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

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

8.15 Male urogenital conditions Yes ☐ No ☐

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

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

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

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

8.17 Have any of your dependant/s received medical advice or treatment for symptoms not diagnosed by a medical professional, in the last 12 months before this application? Yes ☐ No ☐

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

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

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

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 123 077** within seven working days from the date we activate your TFG Medical Aid Scheme 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*. TFG Medical Aid Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before TFG Medical Aid Scheme 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 TFG Medical Aid Scheme membership.

9. Privacy Statement for TFG Medical Aid Scheme administered by Discovery Health (Pty) Ltd

Privacy Statement

When you engage with TFG Medical Aid Scheme, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants and beneficiaries, where applicable. To view and read our Privacy Statement, please follow this link:
https://www.tfgmedicalaidscheme.co.za/wcm/medical-schemes/tfg/assets/legal/privacy-statement.pdf

Signature of main member

By signing this Privacy Statement, You acknowledge that You have read, understood and accepted all the terms and conditions contained in this Privacy Statement.

10. Terms and conditions applicable to TFG Medical Aid Scheme ("TFGMAS")

1. ***Who "we" are***
   TFGMAS, registration no 1578, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd, registration number 1997/013480/07, the administrator and managed care organisation for TFGMAS, and an authorised financial services provider.

2. **Scheme terms and conditions for membership**
   The rules of TFGMAS record your rights and responsibilities for your membership of TFGMAS. 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 rules.

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

4. ***Acting for others***
   You confirm you have the right to act for others
   By signing this document, you confirm that:

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

5. ***Giving and getting information***
   You must give true, correct and complete information
   To consider your application for membership, TFGMAS 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 more information about themselves.

   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.

   TFGMAS 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.

   TFGMAS and Discovery Health (Pty) Ltd may get information about you from other relevant sources
   To consider your application for membership, conduct underwriting 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). You agree that we can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Limited, medical practitioners, 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 TFGMAS, 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 TFGMAS or Discovery Health (Pty) Ltd immediately if your information changes
   You or your employer 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 back dated changes may not be accepted.

   When TFGMAS may cancel your membership/s
   TFGMAS 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.

6. ***About becoming a member***
   TFGMAS might not pay for certain expenses immediately after you become a member
   TFGMAS may have waiting periods that apply in certain circumstances. This means there may be a set time period before the TFGMAS starts paying claims for any general or specific medical conditions. Please speak to 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 TFGMAS 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 TFGMAS, 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. TFGMAS 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 TFG CONT will be used.

7. ***Repaying money owed to TFGMAS***
TFGMAS 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 TFGMAS.

By signing this form, you agree that any money you owe to TFGMAS 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 TFG CLAWBK will be used.

Signature of new main member

Date D D M M Y Y Y Y

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

11. Banking details for a third party - Annexure A

Please attach the relevant proof of bank account if you give a third party's bank account details for claim refunds and / contribution debit orders.

Documents we need for a third-party bank account

(A third party can be anyone, such as your spouse, aunt, uncle, friend, father or son.)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (accountholder) ID, passport or driving licence
- A copy of the main 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 persons who have authority to sign on behalf of the company
- A letter of authority. The letter must:
  - State that the account can be used
  - State the membership details (including the membership or policy numbers) for which the bank account will be used
  - Include the details of the signatory
  - 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 main 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:
  - Show the trustees
  - Be dated and signed by an authorised person on behalf of the trust
  - Contain the membership or policy numbers
- A copy of the main member's ID, passport or driving licence

If you are completing the request on behalf of the main member, please include proof that you have the necessary authority to do so, for example, a letter of authority or a letter of executorship.