Real value speaks for itself

Keyhealth MEDICAL SCHEME

PO Box 14145, Lyttelton, 0140 | Client Service Centre: 0860 671 050 | Application submissions: newbusiness@keyhealthmedical.co.za

APPLICATION FOR MEMBERSHIP

Instructions

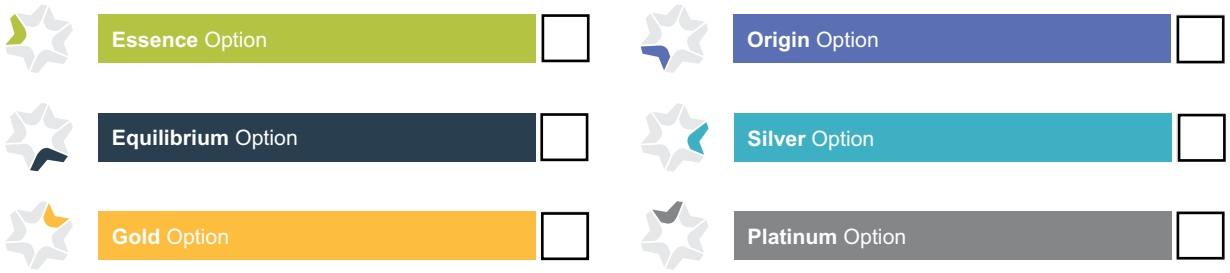
1. Please complete every section below in full. If not applicable, please write N/A in the appropriate field.
2. A copy of the Principal Member and all Dependants' identity documents/birth certificates must be attached.
3. Any incomplete or illegible information will result in further enquiries, which could delay your application for membership.
4. Membership is subject to the conditions, exclusions or limitations of benefits in accordance with the Medical Schemes Act and/or Scheme Rules.
5. Since the Scheme's contract is with the Principal Member, the application form is to be completed by and signed on behalf of all the Dependants, by the Principal Member.
6. Applicants may not make use of medical services, to be paid for by the Scheme, until such time as WRITTEN CONFIRMATION OF MEMBERSHIP has been received.

Applicant

PRIVATE MEMBER ☐ LOCAL GOVERNMENT EMPLOYEE ☐

Section 1: Option Choice

Important note: The Principal Member may make an option change only as from 1 January of each year



I request the Scheme to register me and my dependants from 0 1 – M M – 2 0 Y Y

Section 2: Principal Member Personal Details (attach copy of ID / Passport)

Title | Initials | First name

Surname

ID number (Y Y M M D D) | Gender: Male ☐ Female ☐

Race: African/Black (A) ☐ Coloured (C) ☐ White (W) ☐ Indian/Asian (I) ☐ Unknown (U) ☐

Passport number | Marital status

Residential address

Postal code

Postal address (if different)

Postal code

Telephone - home (code - number) | Cellphone number

Telephone - work (code - number) | Fax - work (code - number)

E-mail address

Language preference: English ☐ Afrikaans ☐

Section 2.1: Spouse / Partner and Dependants Personal Details

First name	Surname	ID No./Passport No.	Race	Gender (M/F)	Relationship to Principal Member
			A C W I U		

Contact details (if applicable	E-mail address (if applicable)	Country of origin/residence

First name	Surname	ID No./Passport No.	Race	Gender (M/F)	Relationship to Principal Member
			A C W I U		

Contact details (if applicable	E-mail address (if applicable)	Country of origin/residence

First name	Surname	ID No./Passport No.	Race	Gender (M/F)	Relationship to Principal Member
			A C W I U		

Contact details (if applicable	E-mail address (if applicable)	Country of origin/residence

First name	Surname	ID No./Passport No.	Race	Gender (M/F)	Relationship to Principal Member
			A C W I U		

Contact details (if applicable	E-mail address (if applicable)	Country of origin/residence

Is any of your dependants under the age of 27years studying full-time? Yes ☐ No ☐

If yes, please attach proof of registration with an academic institution.

Section 3: Financial Advisor / Broker

Name

Broker Code Accreditation Number

Telephone number (code - number)

Email Address

I,____, (Principal Member) appoint the abovementioned broker.

I declare that I am aware of the appointment and that I:

- ☐ will give my broker access to my/our membership information with the scheme in order to be of service to me
- ☐ was made voluntary by me and can be cancelled by me at any time
- ☐ Broker commission will be payable in accordance with the amount as determined annually by the Minister of Health in the Government Gazette, or 3% plus value-added tax (VAT) of the contributions payable in respect of that member, whichever is the lesser.
- ☐ will entitle me to receive certain services from my broker and that the broker explained these services to my satisfaction.

Principal Member Signature **Date** D D – M M – 2 0 Y Y

Financial Advisor Signature **Date** D D – M M – 2 0 Y Y

Please note: The broker appointment cannot be backdated.

Section 4: Private members Method of Contribution Payments

Method of payment | Debit order ☐ | Electronic Funds Transfer (EFT) ☐

***Please note that no credit card banking details will be accepted**

Section 4.1: Contribution Collection and Claims Reimbursements

Please indicate the choice of monthly debit order deduction date: **02** ☐ **26** ☐ **Last day of month** ☐

Please note - Local Government Employees only complete the **claims reimbursements** section.

☐ Use this account for **contribution collections** and **claims reimbursements**

☐ Use this account for **contribution collections** only

Name of account holder _____

Name of financial institution _____

Bank Branch code | | | | | | | | |

Type of Account | Cheque ☐ | Transmission ☐ | Savings ☐

Bank account number | | | | | | | | | | | | | |

***Please note that no credit card banking details will be accepted**

Account Holder Signature

Date D D – M M – 2 0 Y Y

☐ Use this account for **claims reimbursements** only

Name of account holder _____

Name of financial institution _____

Bank Branch code | | | | | | | | |

Type of Account | Cheque ☐ | Transmission ☐ | Savings ☐

Bank account number | | | | | | | | | | | | | |

***Please note that no credit card banking details will be accepted**

Account Holder Signature

Date D D – M M – 2 0 Y Y

Assignment: I hereby acknowledge that the party hereby authorise to effect the drawing(s) against my account may not cede or assign any of its rights to any third party without my consent and that I may not delegate any of my obligations in terms of ths contract/authority to any third party without prior written consent of the authorised party.

Note: Attach a copy of a recent stamped bank statement or an official bank letter from the bank to verify the banking details.

Account Holder Signature

Date D D – M M – 2 0 Y Y

If a company account is to be debited:

- I warrant that the Principal Member, referred to in this application, is an employee of the organisation.
- KeyHealth may bill the employer for the amount due for this member in the same manner as for other members that the organisation employs.

Name

Position in company

Authorised signatory

Date D D – M M – 2 0 Y Y

Section 5: Banking Details for Payment of Contributions

Bank account holder	**KeyHealth Medical Scheme**
Name of financial institution	**ABSA**
Account number	**6 000 000 12**
Account type	**Cheque**
Branch code	**632005**
Reference	**Kindly use your membership number as reference**

Please send proof of payment to proofofpayment@keyhealthmedical.co.za

Section 6: Employer Information - To be completed by employer

Local Government Employees: Employer Information - To be completed by employer / HR

Company Name

Existing group number

Employee number

Business telephone number
(code - number)

Date of employment D D – M M – Y Y Y Y

Principal Member's occupation

SIGNATURE AND STAMP OF EMPLOYER

DESIGNATION

Date D D – M M – **2 0** Y Y

Section 7: Previous Medical Scheme Information

Please provide below the details of all previous and current medical scheme membership and attach the relevant membership certificates. General and/or condition-specific waiting periods and/or late joiner penalties may be imposed.

A late joiner penalty may be imposed on a Beneficiary aged 35 and over, who was not a Beneficiary of one or more recognised medical scheme(s), before 1 April 2001 and without a break in coverage exceeding 90 (ninety) days. The penalty is for the duration of membership.

Please list previous medical scheme details for Spouse/Partner/Dependants separately, if different from the principal member.

If the space provided below is insufficient, please submit additional information with this application.

Name of member	Name of scheme	Member number	Date joined	Date terminated / or current

1. Are you changing your medical scheme due to a change in your employment, if yes please provide proof of change of employment and certificate of membership. (Closed Schemes members only) Yes ☐ No ☐

2. Have you, your Spouse / Partner or any of your Dependants ever had a waiting period, pre-existing condition, exclusion or a late joiner penalty? If Yes, please attach previous membership certificate(s) (if available). Yes ☐ No ☐

Section 7.1: Medical Details Questionnaire

This section is extremely important. It is essential to declare all pre-existing conditions/illnesses/symptoms/treatment and/or advice received/medication use (acute and/or chronic), no matter how insignificant they may seem. Disclosure is not limited to the conditions cited below.

A twelve (12) month condition-specific waiting period may be imposed to any pre-existing conditions/illnesses/symptoms/treatment and/or advice received/medication use (acute and/or chronic) declared, subject to the requirements of the Medical Schemes Act No. 131 of 1998. Failure to disclose pre-existing conditions/illnesses/symptoms//treatment and/or advice received/medication use (acute and/or chronic) could limit and/or exclude certain benefits or result in termination of your membership.

Should there be any change in state of health or illness suffered by yourself or any of your registered dependants from the date of signing this application form and the date of inception on the Scheme, notification of such change must be provided to the Scheme in writing with full details of such condition/ailment.

The Scheme may, within the first twelve (12) months of membership initiate a possible non-disclosure investigation for any major medical services (e.g. hospitalisation, radiology investigations, including emergencies).

All questions must be answered with either 'Yes' or 'No'. If the answer to any question is 'Yes', please provide full details. If more space is required, please include additional pages.

7.1.1 Have you or any of your dependants suffered from a chronic illness (for example but not limited to: raised cholesterol, heart problems, chest pain, high or low blood pressure, diabetes, asthma, headaches, depression, anxiety, bi-polar mood disorders, learning disability or behavioural challenges, epilepsy, convulsions, and/or thyroid disorder)?
If yes, provide details. Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

Section 7.1: Medical Details Questionnaire (Continued)

7.1.2 Have you or any of your dependants suffered from any gastro-intestinal disorders (for example but not limited to: gastro-oesophageal reflux disease, hernia, heartburn, stomach or duodenal disorders, ulcers, Crohn's disease, ulcerative colitis, diverticulitis, spastic colon and/or irritable bowel syndrome)?
If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.3 Have you or any of your dependants suffered from muscle, bone, joints, skin, tissue or nerve illnesses or disorders (for example but not limited to: back and neck-related conditions - including injury, knee or hip or any joint problems, pain, arthritis, gout, multiple sclerosis, motor neuron disease, osteoporosis, Rheumatoid Arthritis, Systemic Lupus Erythematosus (SLE), dermatitis, skin lesions)?
If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.4 Have you or any of your dependants suffered from urinary or genital disorders (for example but not limited to: kidney and/or urinary stones/infections, prostate, prostatitis)?
If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.5 Have you or any of your dependants suffered from eye, ear, nose, mouth (teeth or gums) or throat disorders (for example but not limited to: glaucoma, cataracts, sinusitis, visual disorders, deafness, blindness, rhinitis, orthodontics).
If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.6 Have you or any of your dependants suffered from Cancer (any, either benign or malignant) or Blood disorders (for example but not limited to: anaemia, iron deficiency)?
If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.7 Female reproductive system: Have any female member/dependants sought advice or been treatment and/or experienced symptoms, for example but not limited to: endometriosis, ovarian cysts, polycystic ovary syndrome (PCOS), fibroids, urinary tract infection (UTI)? Is any female member/dependant currently pregnant, planning pregnancy within in the next 12 months, suspecting pregnancy has an irregular menstrual cycle / abnormal, menstrual bleeding (irrespective of severity) or had a missed menstrual cycle?
If YES, please confirm the last date of their menstrual cycle.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.8 Have you or any of your dependants have any surgery, admission to hospital (including, but not limited to: pacemakers, VP shunts, joint replacements), had radiology investigations (for example but not limited to: MRI/CT scans), scopes (for example but not limited to: gastroscopy/colonoscopy)?
If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

Section 7.1: Medical Details Questionnaire (Continued)

7.1.9 Are you or any of your dependants planning any radiology investigations (for example but not limited to: MRI/CT scans), scopes (for example but not limited to: gastroscopy/colonoscopy), medical advice or planning any hospitalisation or surgery within the next 12 months?
If yes, provide detail

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.10 Is there any other condition or symptom(s) not listed above, for which medical advice, diagnosis, care or treatment has been recommended or received, or could potentially result in a medical claim (including Paraplegia, Quadriplegia, congenital disorders, and premature births)?
If yes, provide details.

Yes ☐ No ☐

Name of applicant	Condition and date diagnosed	Name of medication	Current treatment and/or medication	Date of last treatment/symptoms	Attending doctor

7.1.11 Experienced any symptom(s) (for example but not limited to: abdominal pain, pain, discomfort) or using any type of medication (acute or chronic), how insignificant if might seem, that has not yet been treated or diagnosed?
If yes, provide details.

Yes ☐ No ☐

Section 7.2: GP Nomination - Essence Option Only

Members on the Essence Option are required to nominate a General Practitioner (GP) in respect of the treatment of chronic conditions.
Please note that a GP nomination is required for each beneficiary. Request Dr information for all visits with the past 12 months.

First name of Beneficiary	Surname, if different from Principal Member	GP Name	Practice Name	Practice number
1.				
2.				
3.				
4.				
5.				
6.				

Section 7.3: HIV/Aids

If you and/or any of your Dependants are living with HIV/Aids and would prefer not to disclose your and/or their HIV-status on this form due to confidentiality, you may wait until you have received your membership number; please then dial 0860 50 60 80 to notify the Scheme that you and/or any of your Dependants are living with HIV/Aids. This information must be disclosed to KeyHealth within 7 days of your official entry onto KeyHealth.

The Scheme may impose waiting period(s) to pre-existing conditions.

Failure to disclose a pre-existing condition as stipulated, could limit and/or exclude certain benefits or result in termination of membership.

Section 8: Declarations

Section 8.1: Medical Scheme Declaration

KeyHealth Medical Scheme confirms that:

8.1.1 The Medical Scheme will collect personal information about you and your dependants, for the duration of and after termination of your membership to KeyHealth, as permitted in terms of the Medical Schemes Act or any other relevant legislation. Personal information includes the information provided by you on this application as well as information collected from service providers who have treated or attended to you and your dependants, your broker, your employer and any other source from which KeyHealth may lawfully collect such personal information. Your personal information will be kept confidential at all times;

8.1.2 Member information (personal and health information) will not be used for purposes of related company business nor sold for commercial purposes;

8.1.3 The Medical Scheme has data security measures in place including anti-virus security, prevention of unauthorized access to members detail, eliminating unauthorized e-mails, web-mails and access controls for signing on to the computer system;

8.1.4 The Medical Scheme has granted access to your personal information, to employees of KeyHealth and it's contracted service providers as may be necessary to perform their functions and duties. In the event of a breach in confidentiality, the Medical Scheme assumes responsibility and the breach will be managed according to the Scheme's internal protocols or contractual arrangements, as may be applicable, or as may be required in terms of the law;

8.1.5 All KeyHealth employees and it's contracted third parties, who have access to beneficiary information for the purposes of data transfer and management, Scheme administration and managed care arrangements, are bound by internal confidentiality agreements;

8.1.6 The Medical Scheme and its contracted third parties will process, which includes the collection and storage of your personal/medical health/diagnosis/procedure information as provided for in the Rules of the Scheme, this application and the law, only for the following purposes:

- 8.1.6.1 Processing your application for membership and the administration thereof;
- 8.1.6.2 Collection of contributions and other money owed to KeyHealth;
- 8.1.6.3 Determining member entitlement to benefits;
- 8.1.6.4 Assessment and payment/re-imbursement of claims;
- 8.1.6.5 Risk assessment and management practices - including, but not limited to hospital risk management, disease risk management and medicine risk management;
- 8.1.6.6 Investigating and reporting of suspicious behaviour or fraudulent conduct to appropriate persons and bodies;
- 8.1.6.7 Communication of information relevant to your membership, including KeyHealth's products and services;
- 8.1.6.8 Communication of relevant personal information to healthcare service providers to enable you or your dependants to access benefits in terms of the Rules;
- 8.1.6.9 Systems testing, maintenance and development;
- 8.1.6.10 Reporting to authorised persons and authorities, e.g. the Board of Trustees and the Council for Medical Schemes;
- 8.1.6.11 Historical, statistical and research purposes;
- 8.1.6.12 Compliance with any relevant legislation; and
- 8.1.6.13 Any other lawful purpose which directly relates to your membership of KeyHealth or which is authorised in terms of the law or the Rules.

8.1.7 You may object to the processing of your personal information contemplated in 8.1.6 above in the manner prescribed in terms of the Protection of Personal Information Act, 2013 (Act 4 of 2013) unless the Medical Scheme is authorised to such information in terms of other applicable legislation;

8.1.8 The Medical Scheme will share relevant personal information, including health information, of your dependants with you as the principal member to ensure the efficient administration of your membership and benefits;

8.1.9 The Medical Scheme will only disclose your personal information to your employer (if part of an employer group), your broker or other third parties or grant access to such information in accordance with the law or otherwise with your or your dependants' consent as may be appropriate;

8.1.10 The Medical Scheme will only share your personal information with third parties outside of the borders of the Republic of South Africa if it is necessary for the provision of healthcare and other services to you and your dependants in terms of the Rules, subject to the provisions of relevant legislation;

Section 8.2: Financial Declaration

8.2.1 I hereby instruct and authorise the Scheme to draw against my bank indicated in this application form (or any other bank or branch to which I may transfer my account) the amount necessary for payment of my monthly contribution due in respect of the abovementioned membership on the selected deduction date as indicated in Section 3.1 each and every month and continuing until termination of our agreement or until cancelled by me in writing. All such withdrawals from my bank account by the Scheme shall be treated as though they had been signed by me personally.

8.2.2 I understand that the withdrawals hereby authorised will be processed through a computerised system provided by the South African Banks and I also understand that details of each withdrawal will be printed on my bank statement or on an accompanying voucher.

8.2.3 I agree to pay any bank charges relating to this debit order instruction.

8.2.4 This authority may be cancelled by me giving you thirty days notice in writing, but I understand that I shall not be entitled to any refund of amounts which you have withdrawn while this authority was in force, if such amounts were legally owing to you. Receipt of this instruction by you shall be regarded as receipt thereof by my bank (whichever it is or will be).

Section 8.3: Declaration by Principal Member

PLEASE NOTE

8.3.1 Acceptance of this application is at the discretion of the Scheme and shall be subjected to such conditions as the Scheme may determine in its rules from time to time.

8.3.2 The Scheme reserves the right to call for such additional information on the income, where applicable, and health of the applicant and/or Dependants.

8.3.3 With specific reference to and acknowledgement of the detail contained in the Medical Details section, failure to disclose pertinent information or to supply false information could lead to the termination of membership or such other measures as the Scheme may determine in its sole discretion, and the applicant's attention is specifically drawn to Article 66 of the Medical Scheme Act, Act No. 131 of 1998.

8.3.4 **I understand** what a nondisclosure is and that a nondisclosure investigation may be initiated within the first 12 months of membership at any time, even in the event of certain "emergency admissions or treatment" that may be related to a pre-existing condition, symptom or illness that was not disclosed on my application form.

Section 8.3: Declaration by Principal Member (Continued)

8.3.4.1. I declare that

8.3.4.1.1. the contents of this application, and any other documents which may be required in support thereof, are true, correct and complete, whether recorded in writing by me or by any intermediary on my behalf and should there be any change in state of health or illness suffered by myself or any of my registered dependants from the date of signing this application form and the date of inception on the Scheme, notification of such change will be provided to the Scheme in writing with full details of such condition/ailment;

8.3.4.1.2. none of the applicants are registered with another medical scheme;

8.3.4.1.3. I expressly authorise any healthcare service provider or person who has attended to me or my dependants in the past or who will attend to us in the future or who may be in possession of information about us, including our health status, treatment received or anticipated as well as any other relevant health information, to disclose such information to the Scheme, or its contracted service providers, on request, also after the death or termination of membership of any of us. I expressly grant the Scheme the right to access our personal information as and when necessary;

8.3.4.1.4. I expressly authorise the Scheme, to the extent that it may be required by law, to process, which includes the collection, usage and storage of, our personal information, comprising amongst others our demographic, health and biometric information, contact details as well as information related to any suspected fraudulent behaviour by me or any of my dependants, and which information has been supplied by us to the Scheme or which the Scheme may lawfully collect from any third party, for the purposes specified above;

8.3.4.1.5. I consent to the recording of all conversations between myself or any of my dependants and the Scheme or any of its contracted service providers and agree that all information so obtained as well as all other information about us may form part of the records of the Scheme, which records may be retained for as long as it is required in terms of the Rules or applicable legislation, for historical, statistical or research purposes, subject to the requirements of the law, or for any other lawful purpose;

8.3.4.1.6 I understand that my dependants and I must ensure that the Scheme is at all times in possession of accurate and up-to-date information about my dependants and I as it may impact on the assessment of our application for membership, underwriting, the administration of our membership, the calculation of contributions, the processing of claims, payment of benefits, communication by the Scheme with us, and other purposes relevant to our membership as stipulated above;

8.3.4.1.7. I understand that my dependants and I may have access to our personal information held by the Scheme and may request that the Scheme correct any inaccurate information subject to the provisions of applicable legislation;

8.3.4.1.8 I understand that should any of my dependants or I have any concern about the processing of our personal information, we may raise the matter with the Information Officer. I also understand that once the Information Regulator has been established we may also lodge a complaint with this Regulator."

8.3.4.1.9 I authorise the Scheme to deal with my dependants and I electronically and treat electronic communication (such as e-mail, fax, telephone, or communication through the Scheme's digital app) as being the same as written authority and confirmation. I agree further that, where I choose to use electronic methods to transact with the Scheme, we will carry the risk of such use;

8.3.4.1.10 I guarantee that, to the extent that it may be required by law, I have the necessary authority from my dependants to provide the consent and permissions contained in this application and to receive communication from the Scheme on their behalf regarding any matter related to their membership and medical scheme cover, including relevant health information.

8.3.4.2. further accept that

8.3.4.2.1. my statements and answers in this application form shall form the basis of the proposed membership;

8.3.4.2.2. if I omit any pertinent information or make any false statement in my application, the Scheme may decline the application, or if membership has already been granted, terminate my or my dependants' membership, or impose such appropriate sanctions as it may determine in its sole discretion;

8.3.4.2.3. I will be responsible for all monthly contributions for the applicants and for any other amounts legally due to the Scheme, which may be incurred by them, and that such amounts may be recovered from me retrospectively;

8.3.4.2.4. I will be responsible for informing the Scheme of any changes to any of my dependants and their income, where applicable, within 30 days and for obtaining confirmation of those changes, in writing, from the Scheme.

8.3.4.2.5. All conversations between myself and the Scheme or its contracted parties may be recorded.

8.3.4.2.6. The terms and conditions issued in respect of this application are valid for 30 days from the signature date.

8.3.4.3. authorise

8.3.4.3.1. the Scheme to obtain, process and disclose any personal or medical information as it relates to myself or my dependants (adults and/or minors) in order to consider and process this application for membership, and, during my period of membership, to obtain as it may require, disclose and utilise any information concerning my own and my dependants medical history;

8.3.4.3.2. the Scheme to share membership information with the employer, where I or my dependants are a member of an employer group. This will be limited to information that is relevant to our application or information that is required for the ongoing servicing of our membership, but will not include any health information unless I or my dependants have given permission to do so;"

8.3.4.3.3. where applicable, my employer to pay to the Scheme any portion of the monthly contribution due by me, by deduction from my salary, and any amount in arrears by way of double deduction from my salary, until fully recovered;

8.3.4.3.4. the Scheme to register me and my dependants' membership.

8.3.4.4. state that

8.3.4.4.1. I am familiar with the conditions and benefits of the option selected, notwithstanding representation by any other party;

8.3.4.4.2. I undertake and agree that my dependants and I shall abide by the latest Rules of the Scheme as amended from time to time.

8.3.4.4.3. I am of sound mind, memory and understanding.

8.3.4.4.4. I understand that the Scheme may impose general and/or conditions specific waiting periods, as provided for in the Medical Schemes Act 131 of 1998;

8.3.4.4.5. I fully understand the implications of moving from one scheme to another;

8.3.4.4.6. Admission to the Scheme is not subject to the services of a broker being employed;

8.3.4.4.7. I understand the role of my broker (if applicable).

Declaration of understanding:
I hereby declare that by signing this document I declare that I have read and understand the content of the application and all the terms and conditions.

This authorisation will remain valid until cancelled in terms of the Rules of the Scheme.

Signature of Principal Member		**Print Name and Surname of Principal Member**	

Date D D – M M – 2 0 Y Y