

Affidavit Form: Registered Dependants

A Commissioner of Oaths must sign this affidavit.

Main Member Name:	<input type="text"/>
Main Member Surname:	<input type="text"/>
Main Member ID / Passport Number:	<input type="text"/>
Membership Number:	<input type="text"/>
Dependant Name:	<input type="text"/>
Dependant Surname:	<input type="text"/>
Dependant ID / Passport Number:	<input type="text"/>

Tick and complete **ONLY** the column relevant to your dependant:

Dependant child over age 30	Parent / Parent-in-law / Grandparent	Dependant	Partner (Domestic Partnership)
<p>I confirm that the dependant specified above is financially dependant* on me.</p> <p>The dependant is: (Please tick)</p> <p><input type="checkbox"/> Employed</p> <p>OR</p> <p><input type="checkbox"/> Not employed.</p> <p>Earns R _____ (gross income) per month from all sources.</p>	<p>I confirm that the dependant specified above is financially dependant* on me</p> <p>(Please tick)</p> <p><input type="checkbox"/> Parent <input type="checkbox"/> Grandparent</p> <p>The dependant is: (Please tick)</p> <p><input type="checkbox"/> Employed</p> <p>OR</p> <p><input type="checkbox"/> Not employed.</p> <p>Earns R _____ (gross income) per month from all sources.</p>	<p>I confirm that the dependant specified above is financially dependant* on me and is my or my spouse's/partner's:</p> <p>(Please tick)</p> <p><input type="checkbox"/> Legally adopted child <input type="checkbox"/> Grandchild <input type="checkbox"/> Biological child with different surname <input type="checkbox"/> Other (please stipulate relationship to you)</p> <p>_____</p> <p>The dependant is: (Please tick)</p> <p><input type="checkbox"/> Employed and earns R _____ (gross income) per month.</p> <p>OR</p> <p><input type="checkbox"/> Not employed.</p>	<p>I confirm that the dependant specified above is my partner**. Our life partnership took effect as at (please provide the date of this union)</p> <p>_____</p> <p style="background-color: #e0f0e0; padding: 5px;">**A partner is a person with whom you have a committed and serious relationship, similar to a marriage, based on objective criteria of a shared and common household, irrespective of the gender of either party. Such a dependant will pay adult rates, regardless of age.</p>
<p>*The term 'FINANCIALLY DEPENDANT' shall mean in relation to a dependant other than the member's spouse or partner, a dependant who is not in receipt of a regular remuneration and the member is liable for family care and support.</p>			

I, the undersigned, hereby warrant that all information given in this declaration is true, correct and complete in every respect.
 I accept the terms and conditions as set out in the section below "PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION"

Member's signature:

Date:
(DD/MM/YYYY)

A Commissioner of Oaths must complete this section.

I certify that the Deponent signed this declaration in my presence at (PLACE)

on this the (DATE) and has acknowledged

- a. That he/she knows and understands the contents of this declaration;
- b. That he/she has no objection to taking the prescribed oath;
- c. Considers the prescribed oath to be binding on his conscience; and

Uttered the words "I swear that the contents of this declaration are true, so help me God/I truly affirm that the contents of the declaration are true

Commissioner Name:

Signature: Commissioner of Oaths



PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION

This Section explains how Old Mutual Staff Medical Aid Fund (the Fund) collects, uses, shares and processes your personal information that you give to the Fund, and this information may include your health and benefit information ("Personal Information"), in terms of the Protection of Personal Information Act, 4 of 2013 ("POPI").

It is important that you read and understand the terms of this Section carefully before accepting these terms and conditions. The acceptance of these terms and conditions is voluntary, but in order to activate your Fund membership, these terms and conditions must be accepted by yourself and your dependants. If you do not accept these terms and conditions, we will not be able to provide you with the full range of our medical scheme services.

It is also important to note that when you accept these terms and conditions, you provide the Fund with your consent and the consent of your dependants, registered on your membership, to activate your personal health record and enrol you on any managed healthcare programmes for you and your dependants' healthcare benefit.

Terms and Conditions:

1. The Fund collects, uses, processes, retains and shares your and your dependants' personal information for the purpose of providing medical scheme benefits and managed healthcare services to you and your dependants. This includes the collecting and sharing of your and your dependants' personal information with our third-party healthcare partners, facilities and associated partners of the Fund, who are essential to the membership process.
2. The personal information of you and your dependants may also be shared with emergency service providers, including hospital facilities, in medical emergency situations that may result in serious bodily impairment, dysfunction or death.
3. The Fund, its administrator and its managed care organisation will keep all personal information of you and your dependants given to us in this application or collected from other sources, confidential and will only provide the personal information to additional third parties not involved in the administration of your membership or healthcare needs, with your consent.
4. You confirm that when you provide us with your personal information and that of your dependants, you have the appropriate permission to disclose their personal information to us for the purposes of receiving medical scheme benefits and related

- services. In the event of you providing personal information and consent on behalf of a minor dependant person younger than 18 years old, or adult dependant unable to provide their own consent, or any person registered as a dependant on your membership, you confirm that you are authorised to do so on their behalf.
5. You agree to us processing (which shall include collecting, collating, processing, storing, disclosing and retaining) your and your dependants' personal information):
 - a. for the administration of your benefit option;
 - b. for providing managed healthcare services to you or any dependant/s based on your benefit option;
 - c. for providing relevant information to a contracted third party who requires this information to provide a healthcare service to you or any dependant/s on your benefit option;
 - d. for academic research conducted by the Fund, contracted third parties of the Fund, its marketing agents, affiliates and partners;
 - e. for any managed healthcare programme or initiative that will benefit you or your dependants in managing any healthcare condition and optimise your medical scheme benefits; and
6. You acknowledge that your personal information may be stored in a secure web-based facility, where we endeavour to ensure that your personal information is kept confidential at all times.
7. You acknowledge that you have the right to contact the Fund at any time to update, correct or delete your personal information. You and your dependants can update or correct your information at any time by logging on to www.omsmaf.co.za.
8. You have the right to object to the processing of your personal information at any time and revoke any consent you have given for yourself or your dependants. Please contact the Fund to do so.
9. You have the right to request a copy of the personal information we hold about you. Please contact us to find out how to request your personal information.
10. Please note that these terms and conditions may be changed from time to time; please check the OMSMAF website for an updated version.
11. Should you believe that we have used your personal information in a way that is against POPI or without your consent, please contact us immediately to resolve the problem.