OMSMAF
OLD MUTUAL STAFF MEDICAL AID FUND

Administered by Universal Healthcare (Pty) Ltd
Universal House, 15 Tambach Road, Sunninghill Park, Sandton, 2191
PO Box 1411, Rivonia, 2128, South Africa
Tel +27 (11) 208 1000, Fax +27 (11) 208 1128
www.universal.co.za

Application for Membership

(for employees joining **after 90 days** from employment start date)

Please note that this form may contain sensitive and confidential information.
Submit this form directly to Universal Healthcare and not via your Human Resources or Line Manager together with a copy of your ID or Passport.

This form is issued without admission of liability and must be signed by the member.
Email your completed form to membership@omsmaf.co.za or call 0860 100 076 for assistance.

Please complete in BLOCK LETTERS

A. APPLICANT'S DETAILS

Identity number: Title:

Member name(s):

Surname:

Date of birth: (DD/MM/YYYY) Gender: Male Female

Marital status:

Contact number: H Cell:

W Alternative Cell:

E-mail address: Alternative Email:

Postal address: Code

Home address: Code

Where should your membership card be sent?

Your postal address Walk-in-centre for you to collect (Mutualpark only)

B. MEDICAL PLAN

Hospital Plan

Network Plan** *(not suitable for members in Namibia or outlying countries)*

Network SELECT Plan*** *(not suitable for members in Namibia or outlying countries)*

Savings Plan

Traditional Plan

Traditional SELECT Plan* *(not suitable for members in Namibia or outlying countries)*

Traditional Plus Plan

C. EMPLOYMENT DETAILS

Staff code (Not Sales code) Date of permanent employment: (DD/MM/YYYY)

Office Staff PFA Staff Business Unit:

Job title:

Income bracket: R0-R5 870 R5 871 - R8 800 R8 801 - R11 740 R11 741 - R15 680

R15 681 - R23 240 R23 241+

Medical scheme start date: (DD/MM/YYYY)

D. BANKING DETAILS FOR PAYMENT OF REFUNDS

Account holder's name:

Bank's name:

Branch code: Account type: ☐ Current ☐ Savings

Account number:

I hereby authorise you to pay any medical scheme benefit that may be due to me to the above-mentioned bank account or any other bank account which I might change to in future.

E. DEPENDANT INFORMATION

1.
Title: Initials: Identity/Passport number:
Surname:
Name(s):
Date of birth: (DD/MM/YYYY) Gender: ☐ Male ☐ Female
Relationship: Spouse ☐ Son ☐ Daughter ☐ Other

2.
Title: Initials: Identity/Passport number:
Surname:
Name(s):
Date of birth: (DD/MM/YYYY) Gender: ☐ Male ☐ Female
Relationship: Spouse ☐ Son ☐ Daughter ☐ Other

3.
Title: Initials: Identity/Passport number:
Surname:
Name(s):
Date of birth: (DD/MM/YYYY) Gender: ☐ Male ☐ Female
Relationship: Spouse ☐ Son ☐ Daughter ☐ Other

4.
Title: Initials: Identity/Passport number:
Surname:
Name(s):
Date of birth: (DD/MM/YYYY) Gender: ☐ Male ☐ Female
Relationship: Spouse ☐ Son ☐ Daughter ☐ Other

5.
Title: Initials: Identity/Passport number:
Surname:
Name(s):
Date of birth: (DD/MM/YYYY) Gender: ☐ Male ☐ Female
Relationship: Spouse ☐ Son ☐ Daughter ☐ Other

Please note that the Fund requires that you submit the following accompanying documentation as proof if:

• Your and your spouse's surnames differ:	Copy of marriage certificate or other appropriate proof if married according to religious or traditional rights.
• If your child dependant(s) surname(s) differs:	Copy of birth certificate/affidavit and proof of adoption (if applicable)
• If a child has been placed in your custody:	Copy of birth certificate and court order
• For a Partner	Completed and signed Affidavit: Domestic Partnership Refer below to Affidavit Form: Registered Dependants
• For Indigent parents/siblings/grand children/ great-grand child/great-grand parents	Completed and signed Affidavit Proof of Dependency Refer below to Affidavit Form: Registered Dependants
• Over-age dependant children (21-30)	Completed and signed Affidavit Proof of Dependency Refer below to Affidavit Form: Registered Dependants

F. PREVIOUS MEDICAL SCHEME HISTORY

Are your dependant/s currently on another medical scheme? Yes ☐ No ☐

If you have ticked "Yes", have they given notice of termination to their current medical scheme? Yes ☐ No ☐

If "Yes", please attach a certificate of membership from that medical scheme reflecting the end date of membership. We cannot finalise this application without this.

If "No", please give the required notice to the current medical scheme before submitting this application, and attach a certificate of membership from that medical scheme indicating the end date of membership. We cannot finalise this application without this.

Please give us the details of all registered medical schemes to which you previously belonged. We will use this information to determine whether we need to apply any waiting periods, late-joiner penalty fees or both. Kindly supply us with proof in the form of a membership certificate.

In South Africa, medical schemes can impose late-joiner penalties on individuals who join a medical scheme after the age of 35; those who have never been medical scheme members, or those who have not belonged to a medical scheme for a specified period of time since April 2001.

Applicant

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

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

If any of your dependant/s applying for cover belonged to different medical schemes, please add their details below:

Dependant/s 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 ☐	

If any of your special dependant/s applying for cover belonged to different medical schemes, please add their details below:

Dependant/s 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 ☐	

G. MEDICAL DETAILS (Please note that this section is only required if you are joining AFTER 90 days from your employment start date)

PLEASE SAFEGUARD ALL INFORMATION ABOUT ANY MEDICAL CONDITIONS AND ONLY DISCLOSE THIS TO THE MEDICAL SCHEME ADMINISTRATOR AND NOT YOUR HR OR LINE MANAGER.

Failure to disclose information is fraudulent and may result in membership not being granted or termination of membership without refund of contributions paid.

Have you or any of your dependants sought any advice, been diagnosed with or been treated for any conditions in the last 12 months? If yes, please provide details. ☐ Yes ☐ No

If you or any of your dependants are living with HIV/ AIDS and would prefer not to disclose the HIV/ AIDS status on this form in the interest of confidentiality, then please call HIV and AIDS Management Programme on 0860 378 800 to register.

Should this space be insufficient, please attach a separate sheet.

Name of beneficiary			
Diagnosis		Date (DD/MM/YYYY)	
Name of medication and dosage			
Are you currently receiving treatment?	☐ Yes ☐ No		
Have you been hospitalised?	☐ Yes ☐ No		
Name and contact number of treating Family Practitioner, Dentist or Specialist			

Name of beneficiary			
Diagnosis		Date (DD/MM/YYYY)	
Name of medication and dosage			
Are you currently receiving treatment?	☐ Yes ☐ No		
Have you been hospitalised?	☐ Yes ☐ No		
Name and contact number of treating Family Practitioner, Dentist or Specialist			

Name of beneficiary			
Diagnosis		Date (DD/MM/YYYY)	
Name of medication and dosage			
Are you currently receiving treatment?	☐ Yes ☐ No		
Have you been hospitalised?	☐ Yes ☐ No		
Name and contact number of treating Family Practitioner, Dentist or Specialist			

Name of beneficiary			
Diagnosis		Date (DD/MM/YYYY)	
Name of medication and dosage			
Are you currently receiving treatment?	☐ Yes ☐ No		
Have you been hospitalised?	☐ Yes ☐ No		
Name and contact number of treating Family Practitioner, Dentist or Specialist			

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? ☐ Yes ☐ No

Have you been hospitalised? ☐ Yes ☐ No

Name and contact number of treating Family Practitioner, Dentist or Specialist

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? ☐ Yes ☐ No

Have you been hospitalised? ☐ Yes ☐ No

Name and contact number of treating Family Practitioner, Dentist or Specialist

Name of beneficiary

Diagnosis

Date (DD/MM/YYYY)

Name of medication and dosage

Are you currently receiving treatment? ☐ Yes ☐ No

Have you been hospitalised? ☐ Yes ☐ No

Name and contact number of treating Family Practitioner, Dentist or Specialist

H. DECLARATION BY THE APPLICANT

I, the undersigned, hereby make application to be admitted as a member of the Fund. If admitted, I agree to abide by the Rules of the Fund. I declare that any false statement in the above application or the non-disclosure of any material information will render my membership null and void, and that any monies paid to the Fund shall be forfeited to the Fund.

I warrant that all the answers given in this application are true, correct and complete in every respect.

I undertake to disclose to the Fund any material alteration to the facts disclosed in this application and any change in my state of health or that of my dependants which may occur between the date of signature of the application by me and the date of receiving written acceptance of this application, (in the form of an underwriting acceptance letter or a certificate of membership) and that such notification shall give the Fund the right to reconsider the application and to process new terms of acceptance. I am also aware that my membership shall not commence unless the Fund notifies me in writing. I accept that the failure to make such disclosure will render my membership null and void, benefits may be reversed and any monies paid to the Fund shall be forfeited to the Fund.

Accepting that I am thereby curtailing my right of privacy, but to facilitate the assessment of the risk and the consideration of any claim for benefits in respect of the membership, I hereby authorise any healthcare provider and any other person who may be in possession of any information concerning my health or that of any of my dependants to disclose the information to the Fund or its authorised representative and its contracted third parties. A photostat copy or facsimile of this authorisation shall be considered as effective and valid as the original.

I am aware of the fact that on joining the Fund during the course of the benefit year, the maximum benefits to which I may be entitled, shall be adjusted in proportion to the period of membership calculated from the date of admission to the end of the particular benefit year.

On termination of membership of the Fund, I agree that any amounts due by me may be offset against any amount due to me by the Fund. If I resign from the Fund during a benefit year and have used the annual Personal Medical Savings Account (PMSA) benefit to such an extent that there is an outstanding debt to the Fund, this debt will become fully due on the date of termination of my membership. I hereby authorise my employer to deduct from my salary and pay the Fund all amounts that may be due by me to the Fund directly or on my behalf.

On resignation of membership of the Fund, I agree that any amount due to the Fund by me may be deducted from any monies due to me by my employer group. Where OMSMAF is unable to deduct any outstanding monies from my employer, I authorise the Fund to debit the outstanding money from the following bank account: _____.

I acknowledge that if collection via debit order is unsuccessful, or if the debit order is returned, that the Fund will immediately proceed with the above.

I confirm that I am familiar with the conditions and benefits of the Fund.

I declare that neither I nor my nominated dependants are covered by any other medical scheme.

I declare that I will inform the Fund of any change of income including additional income. Income changes are effective on date of notification.

I undertake to cancel my membership with the Fund or that of my nominated dependants immediately upon becoming a member or a dependant of another medical scheme.

I accept the terms and conditions as set out in the section below “PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION”.

Signed at _____ on the _____ day of _____

Signature of applicant

Annexure

INFORMATION

All permanent employees must belong to the Fund, unless they belong to their spouse's or partner's employer-preferred medical scheme (in which case they need to submit proof of such membership by uploading their certificate of membership on Workday each year). Active members who retire from Old Mutual may continue to belong to the Fund as pensioner continuation members. To qualify, they must have been a member of the Fund at retirement.

You have an opportunity to review and change your choice of Plan at the start of the new benefit year on 1 April each year. Once you have selected a Plan for the benefit year, you will not be allowed to change your Plan during the benefit year. Please refer to your Member Guide for a comparison of the benefits offered by the Fund, as well as detailed information about the benefits and the administration of the Fund.

The Fund offers medical scheme benefits to qualifying members and their dependants. There are clear guidelines as to who qualifies to receive benefits, especially relating to dependants and you will need to provide certain documentation to prove their dependency on you. Your monthly contribution will increase as the number of your dependants increase, or child dependants turn 21 years old and/or if your monthly income increases. Please refer to the contribution tables in your Member Guide.

Contributions: All contributions in respect of new members shall be due from the first day of the month during which employment commences or date of admission, except when the date on which employment commences (with simultaneous admission) is the 15th or later of a month, in which case the contributions shall be due from the first day of the following month. Benefits shall commence from the date of registration.

The 2023/2024 benefit year will run from the 1st of April 2023 to the 31st of March 2024, a 12-month benefit year. If a person joins the Fund during the benefit year they will receive pro rata benefits. The same applies if there is a movement in membership for example the addition or removal of a dependent, benefits will be adjusted and prorated accordingly.

Medical scheme contributions are paid in arrears.

- If your membership is terminated up to and including the 14th of the month, no contribution will be due for that particular month and you will be entitled to benefits until your last day of employment.
- If your membership is terminated on the 15th or later of a month, the full contribution will be due and you will be entitled to benefits until the end of the month.

Waiting Periods

- No waiting period will apply for new employees who apply to join the Fund within 90 days of first becoming an employee of Old Mutual or within 90 days of their return to employment after a period of unpaid leave or secondment.
- No waiting period will apply to a dependant whose application is submitted within 30 days after they become eligible to join the Fund as a dependant.
- If you join the Fund by means of the Employer's auto-enrollment process and you wish to add dependants, no waiting period will apply to such a dependant if you add them within 30 days of your join date.
- No waiting period will apply to an employee who undergoes a life-changing event and applies to join the Scheme within 90 days from the life-changing event taking place. A life-changing event is defined as divorce, marriage, retrenchment, a spouse's or partner's change of employment, or death. Proof of such an event needs to be provided.

When will waiting periods apply?

- If you have never been a member or dependant of a medical scheme or were not covered for a period of more than 90 days immediately before applying to the Fund, the Fund may impose the general waiting period and the condition-specific waiting period (if the beneficiary suffers from a pre-existing condition). In this case the waiting periods will also apply to Prescribed Minimum Benefits.
- If you have been a member or dependant of a medical scheme for less than 24 months and you apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), a condition-specific waiting period will apply. If the beneficiary suffers from a pre-existing condition, the Fund may also impose any unexpired balances imposed by the previous scheme. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits.
- If you have been a beneficiary of a medical scheme for more than 24 months and apply for membership or registration as a dependant within three months of termination from the previous medical scheme (other than due to a change of employment), the general waiting period will apply. In this case you and your beneficiaries will be entitled to Prescribed Minimum Benefits.
- An adopted child is considered the child of the adopted parents. We should apply the same as above.

What is a waiting period?

This is the period during which you will not be covered for any medical expenses incurred, even though you may be making contributions to the Fund. There are two types of waiting periods:

Condition-specific waiting period: A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made. This will also apply to Prescribed Minimum Benefits (PMB).

General waiting period: A period during which a beneficiary is not entitled to claim any benefits. This will also apply to PMB.

What is a Late Joiner Penalty (LJP)?

An LJP will be applied to any dependant over the age of 35 except the member, who has not been on a medical scheme before.

- Dependants' LJPs are, for example, calculated as follows: A dependant is 65 years and has had 5 years' previous medical scheme cover. Then we take 65 (age) – 35 = 30 (without medical scheme cover) – 5 (previous cover) = 25 years without medical scheme cover, therefore the LJP will be 75%.

Years without medical scheme cover	Late joiner penalty (LJP) payable
1 – 4 years	5% of contribution
5 – 14 years	25% of contribution
15 – 24 years	50% of contribution
25 years and more	75% of contribution

- On receipt of the member's application form, the administrator will impose LJPs and waiting periods as per the approved Fund Rules.

In South Africa, medical schemes can impose late-joiner penalties on individuals who join a medical scheme after the age of 35; those who have never been medical scheme members, or those who have not belonged to a medical scheme for a specified period of time since April 2001

- It is important to provide all supporting documents, such as membership certificates of all previous medical schemes (indicating the membership end date) to the Fund as soon as possible, to ensure that LJPs, if applicable, are not calculated incorrectly. (If you are unable to provide proof of cover, the Fund will accept an affidavit.) Any LJP is only adjusted from the 1st of the next month after proof of previous membership is received and there will be no refunds or backdating.
- Condition of employment: If a member and his dependants join within 90 days, no waiting periods will apply to the member and his/her dependants. but LJP's could apply to dependants over the age of 35.
- Please take note that LJPs are implemented for life and do not expire.
- Also note that the participating companies do NOT subsidise this late joiner penalty.

Recovery of overspent PMSA balances

If you resign from the Fund during a benefit year and you have used the annual Personal Medical Savings Account (PMSA) benefit to such an extent that there is a debt, this debt will become fully due on the date of termination of membership. This practice is supported by the Rules of the Fund.

The Fund will notify you in writing and telephonically of any outstanding debt when you resign from the Fund. Such communication will be delivered to your last known contact details either via electronic media or post. This outstanding debt will become fully due on notification of your resignation. The Fund will attempt to collect any outstanding debt from your payroll department.

The Fund will transfer all unsettled accounts to its Debt Recovery Service Provider within 90 days of resignation from the Fund. Unsettled accounts will incur recovery costs once handed over to the Debt Recovery Service Provider.

PROTECTION OF PERSONAL AND HEALTH INFORMATION (POPI)

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.

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 your 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.

OMSMAF
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Tel +27 (11) 208 1000, Fax +27 (11) 208 1128
www.universal.co.za

Affidavit Form: Registered Dependants

A Commissioner of Oaths must sign this affidavit.

Member Name:	
Member Surname:	
Member ID / Passport Number:	
Membership Number:	
Dependant Name:	
Dependant Surname:	
Dependant ID / Passport Number:	

Tick and complete ONLY the column relevant to your dependant:

☐ Dependant child over age 30

I confirm that the dependant specified above is **financially dependant*** on me.

The dependant is:
(Please tick)

☐ Employed

OR

☐ Not employed.

Earns R_____
(gross income) per month from all sources.

☐ Parent / Parent-in-law / Grandparent

I confirm that the dependant specified above is **financially dependant*** on me

(Please tick)

☐ Parent
☐ Grandparent / Parent in-law

The dependant is:
(Please tick)

☐ Employed

OR

☐ Not employed.

Earns R_____
(gross income) per month from all sources.

☐ Dependant

I confirm that the dependant specified above is **financially dependant*** on me and is my or my spouse's/partner's:

(Please tick)

☐ Niece
☐ Nephew
☐ Grandchild
☐ Biological child with different surname
☐ Other (please stipulate relationship to you)

_____

The dependant is:
(Please tick)

☐ Employed and earns
R_____
(gross income) per month.

OR

☐ Not employed.

☐ Partner (Domestic Partnership)

I confirm that the dependant specified above is my **partner****.

****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 dependant rates, regardless of age.**

***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.**

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

STAMP

PROTECTION OF YOUR PERSONAL AND HEALTH INFORMATION (POPI)

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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.

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 your 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.