



Broker House: AON South Africa (Pty) Ltd  
 Broker Code: Aon  
 Tel NO: 0860 100 404

I	D	/	P	A	S	S	P	O	R	T
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Broker Code:

www.umvuzohealth.co.za

Alenti Office Park, Building D, 457 Witherite Road, The Willows, Pretoria, 0040  
 P.O. Box 1463, Faerie Glen, 0043. **T:** +27 (0) 12 845 0000 **F:** +27 (0) 86 670 0242  
**Call Centre:** 0861 083 084

## MEMBER APPLICATION FORM

### A. DETAILS OF MAIN MEMBER Race - A = African / Black, I = Indian / Asian, W = White, C = Coloured • Gender - F = Female, M = Male

Company name	Employee no	
Paypoint	Operations/Shaft	
Date of permanent employment	<input type="text"/>	Medical aid start date
Option: (mark with an "X")	Ultra Affordable <input type="checkbox"/>	Standard <input type="checkbox"/>
	Supreme <input type="checkbox"/>	Extreme <input type="checkbox"/>
		Activator** <input type="checkbox"/>

If **Ultra Affordable** is selected **AND** income is below threshold, kindly attach payslip to this application form.

Main member name	Surname	I	D	/	P	A	S	S	P	O	R	T
Date of birth	<input type="text"/>	Gender	Race	Email								
Postal / Physical address		Cell 1										
	Code	Cell 2										

### B. DETAILS OF BENEFICIARIES

#### Spouse/Life Partner

Name	Surname	I	D	/	P	A	S	S	P	O	R	T	Gender	Race	Relationship
Email		Date of birth	<input type="text"/>	Cell											
Name	Surname	I	D	/	P	A	S	S	P	O	R	T	Gender	Race	Relationship
Email		Date of birth	<input type="text"/>	Cell											

#### Adult dependants (≥21)

Name	Surname	I	D	/	P	A	S	S	P	O	R	T	Gender	Race	Relationship
Email		Date of birth	<input type="text"/>	Cell											
Name	Surname	I	D	/	P	A	S	S	P	O	R	T	Gender	Race	Relationship
Email		Date of birth	<input type="text"/>	Cell											

#### Child dependants (<21)

Name	Surname	I	D	/	P	A	S	S	P	O	R	T	Gender
Date of birth	<input type="text"/>	Race	Relationship										
Name	Surname	I	D	/	P	A	S	S	P	O	R	T	Gender
Date of birth	<input type="text"/>	Race	Relationship										

### C. BANK DETAILS (FOR REFUND PURPOSES ONLY)

Bank name		Account number	
Branch name		Branch code	
		Account type (mark with an "X")	Cheque <input type="checkbox"/> Savings <input type="checkbox"/>

**D. PROTECTION OF PERSONAL INFORMATION**

1. The privacy and security of your personal information (which includes the personal information of your dependants) are important to Umvuzo Health Medical Scheme. The Scheme will only process personal information, which includes collecting, using, storing, sharing, analysing, automated and manual processing of such information, in accordance with its Privacy Policy, available at <https://www.umvuzohealth.co.za> and if the processing is permitted by law, for a legitimate interest or otherwise with your consent, if necessary.
2. Umvuzo Health Medical Scheme may require additional personal information about you and your dependants to assess your eligibility for Scheme membership, apply underwriting as permitted by the Medical Schemes Act 131, 1998 and the Umvuzo Health Medical Scheme registered rules to perform the contract between the principal member and the Scheme.
3. All conversations between you or any of your dependants and Umvuzo Health Medical Scheme, its agents or contracted parties, will be recorded and all information obtained through these conversations will form part of the records of Umvuzo Health Medical Scheme.
4. By signing this form, you authorise Umvuzo and/or its agents to obtain any information that they may require concerning you or any of your dependants (such as health information) for any purpose directly related to the medical scheme membership or which is authorised in terms of the Medical Schemes Act, the Scheme Rules or any other legislation, from any person who holds such information (such as healthcare practitioners).
5. By signing this form, you guarantee that to the extent that it may be required by law, you have the necessary authority or permission from your dependants to provide the consent, permissions and personal information on their behalf as set out in this document and as may be required from time to time by Umvuzo Health Medical Scheme.

**E. MEMBER'S UNDERTAKING**

I \_\_\_\_\_

(full name and surname) hereby declare that:

**The contents** of this document have been explained to me in a language that I understand and that all my questions have been answered satisfactorily.

**All information supplied** on this application form is, to the best of my knowledge and belief, true, correct and complete, and that I will advise the Scheme as soon as any of the information changes.

**I have read** the Privacy Policy of Umvuzo Health Medical Scheme and that I fully understand my/our rights in respect of my/our personal information processed by the Scheme, how the Scheme will process my/our information and with whom it will be shared.

**I provide** the consent below out of my own free will without any undue influence from any person whatsoever.

**I have familiarised** myself with the rules, benefits and networks of the Scheme and subject myself to them.

**I understand** that I must get authorisation to visit a specialist, go to hospital, get a scan and make use of an emergency visit or any other service as specifically detailed by the scheme.

**I understand** the medicine benefit of my selected Option and the fact that benefits can be driven by medicine formularies/lists, protocols and Scheme rules and that any medicine outside these parameters will be for my own account.

**I hereby undertake** to comply with the management of benefits by the Authorisation Centre and the guidelines they follow and to co-operate to the best of my ability with their processes and procedures.

**I grant permission** to any health care provider, person or party who may be in possession of information concerning my health or that of my dependants, to divulge such information to Umvuzo Health or its duly contracted agents upon request, also after my death.

**I understand** my premium must be payed on or before the 3rd day of each month and to pay my share of accounts.

**I hereby authorise** Umvuzo Health to recover such payments from my employer, whom I authorise to deduct the amount from my salary or if I resign, from my pension and or any other money due to me and to pay this over to Umvuzo Health.

The above mechanisms may be used to cover any incurred cost should I resign from my job or terminate my Umvuzo Health Medical Scheme membership prior to such cost being recovered.

**Upon signing this document**, I understand that I am entering into a binding agreement with Umvuzo Health Medical Scheme and that it is my responsibility to make sure that all the beneficiaries listed on this application, as well as any beneficiaries I add in future, are fully informed about all aspects of my agreement with Umvuzo Health Medical Scheme.

**I hereby accept** the appointment that my representatives made on my behalf with regards to Healthcare Consultants and/or Brokers. I will specifically inform the Scheme in writing should I wish to revoke the appointment of the Healthcare Consultant and / or Broker.

\_\_\_\_\_  
Signature of applicant (main member)

**Broker House: AON South Africa (Pty) Ltd**  
**Broker Code: Aon**  
**Tel NO: 0860 100 404**

\_\_\_\_\_  
Name & signature of witness/broker (if applicable)

Date	Y	Y	Y	Y	M	M	D	D
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Date	Y	Y	Y	Y	M	M	D	D
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\_\_\_\_\_  
Signature of employer

\_\_\_\_\_  
Employer stamp as verification

**APPLICATION REQUIREMENT:** To ensure your application is processed, please complete and sign the Medical Conditions Disclosure form on page 3 and 4. All fields marked with \* is mandatory.

**MEDICAL CONDITIONS DISCLOSURE FORM**

APPLICATION REQUIREMENT: To ensure your application's speedy processing, please fill out all fields marked with an asterisk \*.

Company name *	Paypoint/Branch	
Name *	Surname *	I D / P A S S P O R T
Contact numbers *	Email *	

Have you or your dependants suffered from any of the following conditions and/or injuries? (mark with an "X")

<b>MAIN MEMBER</b>	<b>Spouse</b>	<b>Adult dependant</b>
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Brain illness / disease  
 Serious ear conditions  
 Serious throat conditions  
 Skin conditions  
 Liver conditions  
 Kidney conditions  
 Reproductive conditions  
 Mental illness  
 Serious eye conditions  
 Serious nose conditions  
 Lung conditions  
 Heart illness / disease  
 Back problems  
 Gastro-intestinal conditions  
 Bone / Injury conditions  
 Any joint replacement surgeries

Brain illness / disease  
 Serious ear conditions  
 Serious throat conditions  
 Skin conditions  
 Liver conditions  
 Kidney conditions  
 Reproductive conditions  
 Mental illness  
 Serious eye conditions  
 Serious nose conditions  
 Lung conditions  
 Heart illness / disease  
 Back problems  
 Gastro-intestinal conditions  
 Bone / Injury conditions  
 Any joint replacement surgeries

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

Are you currently pregnant?  Yes  No Weeks

**PAST MEDICAL HISTORY (mark with an "X")**

Previous operation	<input type="checkbox"/>	Previously hospitalised	<input type="checkbox"/>
Sugar Diabetes	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Cancer treatment / diagnosis	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>
HIV	<input type="checkbox"/>	Chronic medicine	<input type="checkbox"/>

**DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Mark with Y/N)**

Vehicle accident	<input type="checkbox"/>	Road accident fund	<input type="checkbox"/>	Injury on duty	<input type="checkbox"/>
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If you marked Yes (Y) on any of the above please indicate the date of the incident

	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> D
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Name	Surname
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Contact	Male	<input type="checkbox"/>
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Email	Female	<input type="checkbox"/>
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Are you currently pregnant?  Yes  No Weeks

**PAST MEDICAL HISTORY (mark with an "X")**

Previous operation	<input type="checkbox"/>	Previously hospitalised	<input type="checkbox"/>
Sugar Diabetes	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Cancer treatment / diagnosis	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>
HIV	<input type="checkbox"/>	Chronic medicine	<input type="checkbox"/>

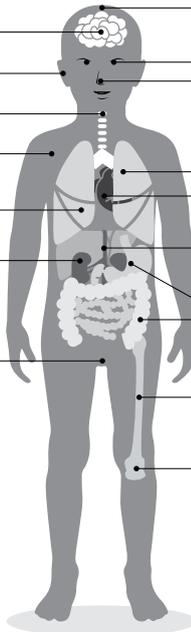
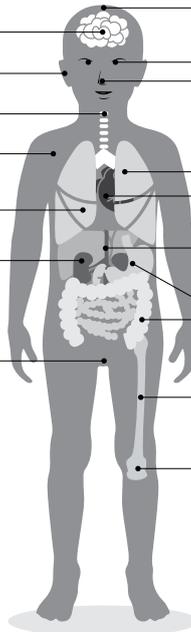
**DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Mark with Y/N)**

Vehicle accident	<input type="checkbox"/>	Road accident fund	<input type="checkbox"/>	Injury on duty	<input type="checkbox"/>
------------------	--------------------------	--------------------	--------------------------	----------------	--------------------------

If you marked Yes (Y) on any of the above please indicate the date of the incident

	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> Y	<input type="checkbox"/> M	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> D
--	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------	----------------------------

Initial	<input type="checkbox"/>
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Adult dependant <input type="checkbox"/> Child dependant <input type="checkbox"/> Gender <input type="checkbox"/>	Adult dependant <input type="checkbox"/> Child dependant <input type="checkbox"/> Gender <input type="checkbox"/>
 <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Brain illness / disease <input type="checkbox"/></p> <p>Serious ear conditions <input type="checkbox"/></p> <p>Serious throat conditions <input type="checkbox"/></p> <p>Skin conditions <input type="checkbox"/></p> <p>Liver conditions <input type="checkbox"/></p> <p>Kidney conditions <input type="checkbox"/></p> <p>Reproductive conditions <input type="checkbox"/></p> </div> <div style="width: 45%;"> <p>Mental illness <input type="checkbox"/></p> <p>Serious eye conditions <input type="checkbox"/></p> <p>Serious nose conditions <input type="checkbox"/></p> <p>Lung conditions <input type="checkbox"/></p> <p>Heart illness / disease <input type="checkbox"/></p> <p>Back problems <input type="checkbox"/></p> <p>Gastro-intestinal conditions <input type="checkbox"/></p> <p>Bone / Injury conditions <input type="checkbox"/></p> <p>Any joint replacement surgeries <input type="checkbox"/></p> </div> </div>	 <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Brain illness / disease <input type="checkbox"/></p> <p>Serious ear conditions <input type="checkbox"/></p> <p>Serious throat conditions <input type="checkbox"/></p> <p>Skin conditions <input type="checkbox"/></p> <p>Liver conditions <input type="checkbox"/></p> <p>Kidney conditions <input type="checkbox"/></p> <p>Reproductive conditions <input type="checkbox"/></p> </div> <div style="width: 45%;"> <p>Mental illness <input type="checkbox"/></p> <p>Serious eye conditions <input type="checkbox"/></p> <p>Serious nose conditions <input type="checkbox"/></p> <p>Lung conditions <input type="checkbox"/></p> <p>Heart illness / disease <input type="checkbox"/></p> <p>Back problems <input type="checkbox"/></p> <p>Gastro-intestinal conditions <input type="checkbox"/></p> <p>Bone / Injury conditions <input type="checkbox"/></p> <p>Any joint replacement surgeries <input type="checkbox"/></p> </div> </div>
Name <input type="text"/> Surname <input type="text"/> Contact number <input type="text"/> Email <input type="text"/>	Name <input type="text"/> Surname <input type="text"/> Contact number <input type="text"/> Email <input type="text"/>
Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Weeks <input type="text"/>	Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Weeks <input type="text"/>
PAST MEDICAL HISTORY (mark with an "X")	
Previous operation <input type="checkbox"/> Previously hospitalised <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer treatment / diagnosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> Chronic medication <input type="checkbox"/>	Previous operation <input type="checkbox"/> Previously hospitalised <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer treatment / diagnosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> High blood pressure <input type="checkbox"/> Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> Chronic medication <input type="checkbox"/>
DO OR DID YOU HAVE AN INCIDENT OR CLAIM RELATED TO? (Mark with Y/N)	
Vehicle accident <input type="checkbox"/> Road accident fund <input type="checkbox"/> Injury on duty <input type="checkbox"/>	Vehicle accident <input type="checkbox"/> Road accident fund <input type="checkbox"/> Injury on duty <input type="checkbox"/>
If you marked Yes (Y) on any of the above please indicate the date of the incident <input type="text"/>	If you marked Yes (Y) on any of the above please indicate the date of the incident <input type="text"/>

**THE IMPORTANCE OF DISCLOSING YOUR HEALTH STATUS**

 <p>In terms of the <b>registered Scheme Rules</b> you have a duty to <b>disclose any material information on request</b>. This includes the <b>duty</b> to fill out the above <b>health history</b> form <b>openly and honestly</b>.</p>  <p>By <b>disclosing your health status</b> in detail, we can ensure that the <b>clinical and financial risk</b> of you as <b>our member</b> and the medical scheme are <b>well managed</b>.</p>  <p>In terms of Section 29 of the <b>Medical Schemes Act</b>, failure to <b>disclose material information</b> gives Umvuzo Health Medical Scheme will take such steps as may be the right to <b>cancel or suspend</b> a member's membership or that of any of <b>his/her dependants</b>.</p>	 <p><b>Full disclosure</b> of any health issues is vital in forging and maintaining a <b>good relationship with your medical scheme</b>.</p>  <p><b>Disclosure will assist</b> you and your dependants in <b>gaining access to medical care and funding</b> - but <b>non-disclosure</b> can lead to <b>medical care and funding being refused</b>.</p>  <p>In order to manage risk effectively, the <b>Scheme holistically manages each individual member's unique healthcare funding needs</b> and disclosing your health status, allows us to manage your health more effectively.</p>
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The Scheme and its contracted providers will only collect personal information consistent with the purpose for which it is required and will only process personal information in a manner that is adequate, relevant and not excessive in the context of the purpose for which it is processed. Umvuzo Health Medical Scheme will take such steps as may be required to ensure that it complies with any law in respect of transfer, storage, security and use of the personal information.

I confirm that the above information is a true and correct record. I agree to notify the Scheme and its contracted providers should there be any change in my health or medical requirements.

Member signature \*  Date \*

Email to: [disclosure@umvuzohealth.co.za](mailto:disclosure@umvuzohealth.co.za)



# Benefits of appointing Aon South Africa Healthcare as your intermediary

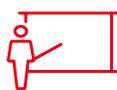
Across Aon, we are united in our passion to provide you with the insights and support to make Better Decisions around all aspects of your holistic wellbeing, medical scheme, gap cover and primary care insurance. We have a team of professional, fully accredited advisors to assist you with all your medical schemes, Gap cover and Primary care enquiries.

## Our philosophy is to:



### Guide:

our members in selecting the medical scheme, Gap cover insurance or Primary care options aligned to their needs.



### Educate:

our members with ongoing training throughout the year, end of year medical schemes and Gap cover benefits and rate changes.



### Protect:

the rights of members by applying the Medical Scheme Act and scheme rules when resolving disputes with the medical schemes on behalf of the members.

## Catalogue of services and technological platform accessible to our members

- **Microsites:** Provides you with access to voice recorded Induction, Year-end launch highlight presentations, brochures, COVID-19 updates, various application forms.
- **Aon Resolution Centre:** Professional assistance with your Medical scheme, Gap cover or Primary care claim resolution, comparison or benefit explanation.
- **Year-end renewal communications:** Access to the following:
  - **Alert** - Provides high level summary of benefits and rates changes launched by medical scheme, Gap cover insurance as well as Primary care providers.
  - **Member letter** - Provides comprehensive information in relation to the benefits and rates changes implemented by Medical scheme, Gap cover or Primary care provider.
  - **Guidance letter** - Aon generates guidance letters for members that are under or over insured. The purpose of the guidance letter is to guide a member on selecting an appropriate option aligned to his/her needs.
- **Client Assistance Programme** - We are delighted to offer you access to a range of essential services at absolutely no charge. The Aon Client Wellbeing Programme is a telephonic, online, and structured e-mail support program (excluding in-person or video sessions). The following services are available through our third- party service provider, LifeAssist:
  - Structured Telephonic Counselling
  - Telephonic Trauma Support
  - Financial Wellbeing Coaching
  - Legal Advisory Services
  - Health and Wellness Services (professional advice from a dietician and a biokineticist)
- **General Updates:**
  - Ad-hoc updates pertaining to Medical schemes industry and providers specific updates.

## Cost of appointing Aon

We are pleased to inform you that there is no additional fee charged by Aon when you appoint Aon Healthcare as your Healthcare intermediary. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme whether you have appointed Aon as broker or not. This monthly commission is 3% of the contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus value added tax (VAT). In terms of Primary Care Insurance products, we earn maximum 3%. Gap Cover Insurance products, we earn commission on a sliding scale from 5% up to 20% depending on policy holder's monthly contributions.

## For more information, contact Aon South Africa:

0860 100 404 | [arc@aon.co.za](mailto:arc@aon.co.za) | [www.aon.co.za](http://www.aon.co.za)

## Connect with us

We focus on communication and engagement, across insurance retirement and health, to advise and deliver solutions that create great client impact. We partner with our client and seek solutions for their most important people and HR challenges. We have an established presence on social media to engage with our audiences on all matters related to risk and people.

For more information from Aon Employee Benefits on healthcare, retirement benefits and a wide range of topics feel free to go to [www.aon.co.za](http://www.aon.co.za)

<http://www.facebook.com/Aonhealthcare>  
Click "Like" on our page (Aon healthcare)

[http://twitter.com/Aon\\_SouthAfrica](http://twitter.com/Aon_SouthAfrica)  
Click "follow" on our profile

## Aon Employee Benefits - Healthcare

Aon South Africa Pty Ltd, an Authorised Financial Service Provider, FSP # 20555.

<http://www.aon.co.za/disclaimer>

On all services provided, Aon's Terms & Conditions of Business, as amended from time to time, are applicable and can be found at <http://www.aon.co.za/terms-of-trade> or will be sent to you upon request.

[Privacy Notice](#)

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## Disclaimer:

The Benefits and contributions are subject to approval by the council for medical schemes. Although care is taken to represent the rates and benefits correctly, errors and omissions could occur. In case of any conflict, the rules of the affected medical scheme prevail. Any decisions regarding your medical scheme portfolio should be made in conjunction with your Aon Employee Benefits consultant or manager. While Aon has taken reasonable steps to ensure that the information contained in this report is relevant, accurate and current, no warranties of any kind, whether express or implied, including but not limited to the accuracy, completeness, relevance or fitness for a particular purpose are given and Aon expressly disclaims any liability for any loss or damage that may arise from the use of this report. This report is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you received this report in error, you should not disseminate, distribute or copy this report and you should notify Aon if you are not the intended recipient and destroy the report. The report is copyright of Aon SA (Pty) Ltd. You may not, except with our express written permission, distribute or commercially exploit the report. Aon hereby authorizes you to copy the report for non-commercial use within your organization only.

## POPIA

Protection of Personal Information Act 4 of 2013 (POPIA), Medical Schemes are requesting a signed Broker Appointment letter to make certain information available to Aon South Africa (Pty) Ltd.



## Acknowledgement of appointment

I acknowledge and appoint Aon South Africa (Pty) Ltd as my financial advisor for all matters related to my medical scheme membership.

My ID: \_\_\_\_\_ and membership number: \_\_\_\_\_

Signed at (Town or City): \_\_\_\_\_ on yy/mm/dd: \_\_\_\_\_

I have been informed that there is no additional fee charged by Aon for providing you with healthcare intermediary services. Aon earns monthly commission which is already included in the monthly contribution you pay over to the medical scheme. Monthly commission is part of your total monthly contributions paid to the scheme. This monthly commission is 3% of the monthly contribution to a maximum amount payable (as disclosed on the Brokers Statutory Notice) to brokers in terms of Section 65 of the Medical Schemes Act, 131 of 1998, plus Value Added Tax (VAT).

**Permission to process my personal information as well as personal information of all dependents included on my membership application form and I consent to Aon South Africa (Pty) Ltd accessing information listed on the table below.**

I give consent for the disclosure of information about me.

Membership number: \_\_\_\_\_ ID or passport number: \_\_\_\_\_

Title: \_\_\_\_\_ Initials: \_\_\_\_\_ Surname: \_\_\_\_\_

First name(s) (as per identity document): \_\_\_\_\_

The following information should be made available to my appointed financial advisor as is necessary:

Personal examples	Benefit examples	Financial examples	Medical examples
<ul style="list-style-type: none"> <li>* Name and Surname</li> <li>* Membership number</li> <li>* Date of birth</li> <li>* ID number</li> <li>* Postal Address</li> <li>* Physical address</li> <li>* E-mail Address</li> <li>* Telephone numbers</li> <li>* Cellular Number</li> <li>* Number of dependents</li> </ul>	<ul style="list-style-type: none"> <li>* Plan type</li> <li>* Medical Savings Account (MSA)</li> <li>* Balance Medical Scheme benefits</li> <li>* Spent for the year Accumulated</li> <li>* Medical scheme Savings Account</li> <li>* Medical Savings Carry over from previous year</li> <li>* MSA reimbursement, Scheme Rate or cost</li> <li>* Self-payment Gap</li> <li>* Above Threshold Benefit</li> <li>* Waiting period details</li> <li>* Late joiner penalty indicator</li> <li>* Wellness benefits</li> </ul>	<ul style="list-style-type: none"> <li>* Total Contribution</li> <li>* Contribution breakdown</li> </ul>	<ul style="list-style-type: none"> <li>* Chronic Indicator/ confirmation (Yes/No)</li> <li>* In Hospital Indicator/ confirmation (Yes/No)</li> <li>* Confirmation of claims paid and from what benefit</li> <li>* Claims transaction history</li> <li>* Procedures done in doctor's rooms paid from Hospital Benefit</li> </ul>



By signing this letter of appointment , I confirm that I have fully read and understood the contents of this document and provide my express consent for Aon South Africa (Pty) Ltd (“Aon”) to process my Personal Information including but not limited to special personal information, as well as that of my beneficiaries and where necessary including my minor children (as defined in the Protection of Personal Information Act no 4 of 2013) for the purposes set out herein and which Personal Information may be shared and or disclosed with any party including but not limited to service providers who Aon (in it’s reasonable discretion) has an obligation or requirement to share or disclose my Personal Information and that of my beneficiaries and where necessary my minor children in compliance with its obligations in law or contract.

Signed at (Town or City): \_\_\_\_\_ on yy/mm/dd: \_\_\_\_\_

Signature: \_\_\_\_\_