CONSENT FORM

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS.

It is imperative that all sections of this form be completed in full. Failing to do so will cause a delay in the processing of the request, as the incomplete form will be returned to the applicant.

Please email the completed form to **enquiries@wooltruhealthcarefund.co.za**.

If you require assistance in completing this form, please call:
0800 765 432 **Network Option** members
0802 228 922 **Saver Option** and **Comprehensive Option** members

1. FUND MEMBERSHIP INFORMATION

Membership number	
Benefit option	

2. PARTICULARS OF PERSON/ENTITY GIVING CONSENT

Principal member, registered dependant(s) or appointed third party/ies

Full name and surname			
ID number		Dependant code*	
Name of registered entity (if applicable)			
Designation/capacity of authorised representative named above			
Contact number			
Postal address			
		Postal code	
Email address			

* Dependant code of principal member or registered dependants, if applicable

3. TO WHOM YOUR INFORMATION MAY BE DISCLOSED

Please specify the details of the appointed party/ies to whom your information may be disclosed.

THIRD PARTY 1

Once-off consent ☐ Yes ☐ No Continuous consent ☐ Yes ☐ No

The time period for which consent will be valid: D D M M Y Y Y Y to D D M M Y Y Y Y

3. TO WHOM YOUR INFORMATION MAY BE DISCLOSED (CONTINUED)

Relationship to principal member/registered dependant

Full name and surname

ID number

Date of birth D D M M Y Y Y Y

Name of registered entity (if applicable)

Occupation/designation

Contact number

Postal address

Postal code

Email address

THIRD PARTY 2

Once-off consent ☐ Yes ☐ No Continuous consent ☐ Yes ☐ No

The time period for which consent will be valid: D D M M Y Y Y Y to D D M M Y Y Y Y

Relationship to principal member/registered dependant

Full name and surname

ID number

Date of birth D D M M Y Y Y Y

Name of registered entity (if applicable)

Occupation/designation

Contact number

Postal address

Postal code

Email address

4. INFORMATION THAT MAY BE DISCLOSED

Please indicate what information may be disclosed to the appointed party/ies referred to above. Please note that only information relating to the categories you select below will be disclosed.

THIRD PARTY 1	THIRD PARTY 2	
☐	☐	**Personal information** Personal details such as your ID number, home address and contact details, etc.
☐	☐	**Fund benefit information** Benefits and limits, claims history, etc.
☐	☐	**Financial information** Banking details, claims, contributions and amounts due to the Fund, etc.

4. INFORMATION THAT MAY BE DISCLOSED (CONTINUED)

THIRD PARTY 1	THIRD PARTY 2	
☐	☐	**Medical information** Personal medical history, diagnoses, treatment plans, chronic information, hospitalisations and authorisations, etc.
☐	☐	**Fund membership documents** Claims statements, membership and tax certificates, etc.
☐	☐	**All of the above**

5. CONSENT

Protection of Personal Information

Wooltru Healthcare Fund (the Fund) requests your consent to process and obtain your personal information from any other person for the purposes set out below. While your consent is voluntary, it is a requirement for your membership of the Fund.

The Fund and Momentum Health Solutions (MHS), the Fund's administrator, will maintain the confidentiality of your personal information and will comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing your personal information for the purposes of managing your membership of the Fund and in accordance with the Act. If you fail to provide the personal information required, or if you are not willing to agree to the processing of your personal information, then the Fund will not be able to offer you membership to the Fund.

By signing the declaration on page 4, you agree to the Fund, MHS and/or the Fund's service providers processing and disclosing your personal information as follows:

1. The collection, collation, processing, storing and disclosure of your personal information including health information, and that of all your dependants, **for the following purposes ONLY**:
   - membership to the Fund and in accordance with the Act
   - the management and administration of your Fund benefits
   - the provision of the Fund's managed care services to you and your dependants
   - the provision of relevant information to a contracted third party who requires this information to provide a healthcare service to you or any of your dependants on behalf of the Fund
   - for trends or risk analysis, peer review or participation in clinical studies, in which case your information will be provided on an anonymous basis.

2. The Fund, MHS and/or the Fund's service providers will only share your personal information or that of any of your dependants if it is requested by a third party to whom you have already given your consent for the disclosure of such information.

3. If we are required to share your information for any other reason, **we will only do so with your written permission, unless we are required to do so by law**.

4. When providing the Fund, MHS and/or the Fund's service providers with personal information about your dependants, you confirm that you have, where applicable, received appropriate permission to disclose such information.

5. You have the right to withdraw your consent to have your personal information processed provided that the lawfulness of the processing of your personal information before your withdrawal will not be affected.

6. You have the right to object on reasonable grounds relating to your particular situation, to the processing of your personal information unless processing is required by law. You have the right to request the Fund and/or MHS where necessary, to correct or delete your personal information that is inaccurate, irrelevant, excessive, outdated, incomplete, misleading or obtained unlawfully.

7. If you have a complaint relating to the processing of your personal information, you agree to refer it to the Fund and to the administrator to resolve it in terms of their internal complaints process first. If you are not satisfied with the outcome of the complaint, you may refer the complaint to the Information Regulator by telephone on **010 023 5200** or by email at **enquiries@inforegulator.org.za**.

8. Your personal information will be shared between the Fund, MHS and any contracted third parties both locally and outside the Republic of South Africa who require this information, for purposes related to your membership of the Fund.

6. DECLARATION

I, the undersigned, hereby:

- authorise Wooltru Healthcare Fund, MHS and/or the Fund's service providers to disclose the above information to the appointed party/ties as indicated on pages 1 and 2
- agree that neither Wooltru Healthcare Fund, MHS and/or the Fund's service providers shall be liable for any loss or damage whatsoever, including direct, indirect and consequential damage, that may arise from the disclosure of any information pursuant to this consent;
- agree that once consent is provided, all information as indicated herein may be disclosed to the appointed party/ies.

I declare that I have carefully read this application form, completed it in full, and confirm that all the information provided herein to be true and correct to the best of my knowledge.

Signature of person/entity/ appointed third party giving consent

Date D D M M Y Y Y Y

11/2023

WOOLTRU HEALTHCARE FUND

Postal address: PO Box 15403, Vlaeberg 8018
Telephone: **0800 765 432** (Network Option) | **0802 228 922** (Saver Option and Comprehensive Option)
Email: enquiries@wooltruhealthcarefund.co.za
Website: www.wooltruhealthcarefund.co.za