

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

Full name and surname

ID number

Date of birth

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: to

Relationship to principal member/registered dependant

Full name and surname

ID number

Date of birth

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	
<input type="checkbox"/>	<input type="checkbox"/>	Personal information Personal details such as your ID number, home address and contact details, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Fund benefit information Benefits and limits, claims history, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Financial information Banking details, claims, contributions and amounts due to the Fund, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Medical information Personal medical history, diagnoses, treatment plans, chronic information, hospitalisations and authorisations, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Fund membership documents Claims statements, membership and tax certificates, etc.
<input type="checkbox"/>	<input type="checkbox"/>	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, 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, Momentum Health 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, Momentum Health 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, Momentum Health 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 Momentum Health 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, Momentum Health 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, Momentum Health 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, Momentum Health 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
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11/2024



WOOLTRU HEALTHCARE FUND

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