Permission to make certain information available to a third party 2024

Who we are

Discovery Limited (registration number 1999/007789/06) acts as the holding company for:

- Discovery Health (Pty) Ltd (registration number 1997/013480/07), the administrator of your Scheme, Society or Fund and referred to as Discovery Health in this form.

Subsidiaries within the Discovery Group are authorised financial service providers. These companies all function as separate entities.

Your Scheme, Society or Fund refers to the Medical Scheme, Society or Fund you are a member of. Discovery Health (Pty) Ltd looks after the administration for the Scheme, Society or Fund.

Purpose of this form

By completing this form, you allow us to share your information with any third party you nominate. A third party is any person or entity that has a relationship with Discovery Limited; Discovery Health (Pty) Ltd; your Scheme, Society or Fund, administered by Discovery Health (Pty) Ltd; Please make sure you are using the most up to date form. Download the latest version of all forms from www.discovery.co.za under Medical Aid > Manage your health plan > Find important documents and certificates.

How to complete this form

- Please complete the form with black ink and print clearly.
- To avoid administrative delays, please make sure this form is completed in full.
- Forms that are incomplete or not signed will not be considered as valid consent and will not be processed.
- Provide a copy of your nominated third party's identity document or valid passport.
- Please **submit** your documents to consent@discovery.co.za.
- For more information about how and why we use your information, please view our Privacy Statement: https://www.discovery.co.za/corporate/privacy/
- Please specify the type of information that each third party may have access to and for how long the access should be valid. If you don't specify a date, we will assume the permission to be valid from the date of signature, in section 4 of this form, to continue until you revoke the permission in writing.

If we cannot identify your nominated third party, we cannot complete the request for this (applicable to section 2.5, 2.6 and 2.7).

When you sign this form, you confirm the information provided is true and correct.

1. About yourself (member)

Title	
Surname	
First name(s) (as per identity document)	
ID or passport number	
Country of issue	
Membership number	

2. About the third party (to whom we may give specified information)

2.1. **Your financial adviser** ☐

Your financial adviser is your appointed financial adviser, or your employer's appointed financial adviser, who is on record and works at your or your employer's appointed intermediary house. This financial adviser may change occasionally. This means the new financial adviser will have access to the information you make available. If you want to give permission to only a specific person, please complete the specific third party section of this form.

Financial Adviser number	
Surname	
First name(s) (as per identity document)	

2.2. Financial Adviser house ☐

An intermediary house is a group of financial advisers who conduct their business and give advice under one business name.

Financial Adviser house

Financial Adviser house name

2.3. **Your employer contact person** ☐

Your employer contact person is the contact person or representative where you work. This contact person or representative may change occasionally. This means a new contact person or representative may have access to the information you make available. Your permission only applies to the contact person at your current employer. If you change employers, this permission will end. If you want to give permission to only a specific person and not the employer contact person in general, please complete the specific third party section of this form.

Title

Surname

First name(s) (as per identity document)

ID or passport number | Country of issue

Third Party **Please tick the third party to which you want to make information available**

Make all of the below available ☐

	Financial Adviser	**Financial Adviser house**	**Employer contact person**	**Date from**	**Date to**
Biographical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

(Refer to table 1 on page 4 for examples of these types of information).

2.4. **Practice** ☐

BHF Practice number

Practice name

Practice details

Make all of the below available ☐

		Date from	**Date to**
Biographical information	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

(Refer to table 1 on page 4 for examples of these types of information).

**This information will be made available to the practice.*

2.5. **Specific third party 1** ☐

Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial service provider and administrator of medical schemes.

You give permission to make information available to the third party specified below.

Title

Surname

First name(s) (as per identity document)

ID or passport number | Country of issue

Contact number

Email address

2.6. **Specific third party 2** ☐

You give permission to make information available to the third party specified below.

Title

Surname

First name(s) (as per identity document)

ID number | Country of issue

Contact number

Email address

2.7. **Specific third party 3** ☐

You give permission to make information available to the third party specified below.

Title

Surname

First name(s) (as per identity document)

ID number | Country of issue

Contact number

Email address

3. About the information we may give to the specified third party

Third party | **Please tick the third party to which you want to make information available**

Make all of the below available ☐

	Specific third party 1	**Specific third party 2**	**Specific third party 3**	**Date from**	**Date to**
Biographical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	☐	☐	☐	D D M M Y Y Y Y	D D M M Y Y Y Y

Examples of the type of information we can make available to a third party are given in the table below:

Table 1

Examples of biographic information	Examples of benefit information	Examples of financial information	Examples of medical information
Membership number	Plan type	Medical scheme tax certificate and tax reports	Indicator of chronic condition
Date of birth	Medical Savings Account balance	Banking details	Prescribed Minimum Benefit chronic conditions details
ID number	Medical Savings Accounts choice: Scheme Rate or Cost	Total contribution and breakdown	Confirmation of claims paid (excluding amounts and origin of payments)
Postal and email address	Current Medical Savings Account spent		Claims transaction history
Physical address	Limits		Hospital procedures
Telephone numbers	Waiting period details		Procedure codes
	Self-payment Gap		Procedures done in doctors' rooms paid from Hospital Benefit
	Above Threshold Benefit		MedXpress medicine query

4. Terms and Conditions

4.1. This document gives Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society, or Fund permission to make certain information available to the named third party or third parties selected in this form and reserve the right to revoke this consent if there is a breach of any terms and conditions of this agreement or any rules by either of the parties.
4.2. You agree that by making this information available, Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society, or Fund are not responsible for any loss, whether direct, indirect or as a result of disclosing the information.
4.3. You agree that the named third parties receiving this information may not hold Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society, or Fund responsible for any claims that result from the wrongful use or disclosure of the information by the named third parties.
4.4. You agree that once you have given permission, Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society, or Fund may give all the information that falls under the selected type of information to the named third parties.
4.5. This permission will end on the dates specified in section 2 and 3 of this form or when your employer contract ends (if your relationship with Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society, or Fund is through your employer).
4.6. You agree that if you have not given an expiry date in section 3 of this form, the permission will only end on your specific instruction in writing (or when the purpose of the permission has been served). Any 3rd party consent expires on death.
4.7. Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society, or Fund will only share the personal, financial and medical information for you or your dependants or beneficiaries on your health plan or policies if it is requested by a third party to which you have already given consent for disclosure and the parties with which Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society, or Fund share the information agree to keep the information confidential. If Discovery Limited, Discovery Health (Pty) Ltd, the Scheme, Society or Fund wants to share your information for any other reason, we will do so only with your express consent.

Definitions

“Applicable law” includes all these:

- the Promotion of Access to Information Act 2 of 2000
- the Electronic Communications and Transactions Act 25 of 2002 (as amended)
- the Protection of Personal Information Act 4 of 2013
- the Consumer Protection Act 68 of 2008
- the Medical Schemes Act 131 of 1998 (as amended)
- the National Health Act 61 of 2003
- the Children’s Act 38 of 2005
- the Choice on Termination of Pregnancy Act 92 of 1996
- Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974 published as GNR 717, dated 4 August 2006 in the Government Gazette (“the Ethical Rules”)
- All applicable guidelines published in General Ethical Guidelines for the Health Care Professions as published by the Health Professions Council of South Africa (“the HPCSA guidelines”).

Acknowledgement
I acknowledge that -

- Medical information that healthcare providers send to Discovery Health (Pty) Ltd and the Scheme or Fund.
- Certain biographical details
- Chronic illness Benefit and health plan information
- All existing and newly diagnosed chronic conditions
- Discovery Health (Pty) Ltd (“Discovery Health”) has developed an application (“HealthID”) medical practitioners can use to access my

information recorded in my Electronic Health Record (EHR).

- The purpose of HealthID is to support and enable quality clinical care to members of the Schemes, Societies, or Funds administered by Discovery Health and to help reduce the administrative burden on medical practitioners accessing my information.
- All authorised medical practitioners who treat me from time to time can only request and access my information through HealthID if they have my consent.
- I can at any time change or revoke my consent by formally letting Discovery Health know of my decision. By giving my consent, I give Discovery Health permission to share my information with my authorised medical practitioners to assist in making informed clinical decisions.

I understand that once Discovery Health has shared my information with authorised medical practitioners, Discovery Health has no further control over this information and will not be accountable for its safeguarding. I also understand that the authorised medical practitioners have confirmed to Discovery Health that they will treat my information as confidential and in line with applicable laws. I note that Discovery Health will, as required by and in adhering to applicable laws, protect and maintain the confidentiality of my information.

Consent

4.8. By consenting, I agree to –
  4.8.1. My information being made available to authorised medical practitioners for the purposes outlined here
  4.8.2. Discovery Health receiving my information directly from any healthcare provider.
4.9. I am entitled to change or revoke my consent at any time.
When I revoke my consent, medical practitioners will no longer be able to access my information.
4.10. The consent I give (as set out in this form) is valid from the date and time when I give consent and will continue until I change or revoke my consent as explained in point 2.
4.11. I agree that by making this information available, Discovery Health will not be responsible for any loss or damage (whether direct or indirect) that may arise from the use of this information, other than where it is due to or attributable to grossly negligent or fraudulent conduct by Discovery Health.
4.12. I give permission for my authorised medical practitioners to provide Discovery Health and my Scheme, Society, or Fund with my diagnosis and other relevant clinical information to review applications for the Chronic Illness Benefit. For the Chronic Illness Benefit, I understand that –
  4.12.1. Funding from the Chronic Illness Benefit depends on meeting benefit entry requirements as determined by my scheme, society, or fund.
  4.12.2. It provides cover for disease modifying therapy only, which means that not all medicines for a listed condition are automatically covered or funded.
  4.12.3. By registering, I agree that my condition may be subject to disease management interventions and periodic review and that this requires giving both Discovery Health and my authorised medical practitioners access to my information.
  4.12.4. Funding for medicine will only be provided from when my Scheme, Society, or Fund receives and approves an application form that is completed in full.
  4.12.5. I may need to send an updated or new application form, if my Scheme, Society, or Fund asks for this.
4.13. I have had an opportunity to read (or have read to me) and I am aware of and fully understand all the terms, conditions and consequences of giving my consent.
4.14. I have had sufficient opportunity to ask questions about this consent form and have had these questions, if any, answered to my satisfaction by Discovery Health.
4.15. I have been made aware that the full terms and conditions can be accessed on www.discovery.co.za or by calling 0860 99 88 77 and that Discovery Health will provide me with a copy of this consent form on my request.

My signature below indicates my understanding of an agreement to comply with the terms of this consent form.

Signed at (town or city) ____________________ on D D M M Y Y Y Y

Please print name ____________________

Signature of person giving permission ____________________ Date D D M M Y Y Y Y

Please only sign if information is true, complete and correct.