sasolmed

Contact details
Tel: 0860 002 134 • PO Box 652509, Benmore 2010 • sasolmed.co.za

Applying to become a member of Sasolmed 2026

Who we are

Sasolmed (referred to as 'the Scheme'), registration 1234, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the Administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health takes care of the administration of your membership for the Scheme.

How to complete this form

1. Use one letter per block, complete in black ink and print clearly. Alternatively, complete it electronically by typing in the fields below
2. Principal applicant to ensure sections 6, 7 and 9 are signed.
3. Hand the completed form to your Payroll and Benefits Centre team by no later than the 5th of the month
   Applications will not be processed by the Payroll and Benefits Centre team, unless all supporting documentation has been received
4. Provision is made in this form for you and your dependant/s to provide information relating to your race. This information is required by the Council for Medical Scheme for statistical purposes only. You are not compelled to provide this information

Once you send us your application form, here is what will happen:

- If any details are missing or if we need more information for underwriting purposes, we will contact you
- We will send you or your employer, the counter offer letter and any outstanding underwriting requirements where we cannot offer standard terms of acceptance for both you and your dependant/s. You may accept the offer by signing and returning this letter for us to activate your membership
- We will send you a welcome letter, SMS or an email to let you know when your application is considered to have been fully and completely made. This date may differ from the date on which you sign the application form

If you do not hear from us seven days after sending us your application form, please contact us on **0860 002 134.**

When you sign this application, you confirm that you have read and understood the Terms and Conditions (Section 9 of this form) for membership as well as the Privacy Statement and agree to them.

I consent to my spouse and/or adult dependant acting on my behalf and providing my personal information, including health information, to Discovery Health for the purpose of my application to join Sasolmed. Yes ☐ No ☐

1. About yourself (principal member)

Title | Initials

Surname

First name(s)
(as per identity document)

ID or passport number | Control number

Gender M ☐ F ☐ | Date of birth D D M M Y Y Y Y

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

Date of birth D D M M Y Y Y Y

Telephone (H) | Telephone (W)

Cellphone

Email

Postal address (Post collected from post box, suite or private bag)

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb

City | Postal code

Residential address:

Unit/Suite number | Complex name

Street number | Street name

Suburb

City | Postal code

Tax number

2. About your spouse or partner (only complete if applying for cover)

Title | Initials

Surname

First name(s)
(as per identity document)

ID or passport number

Gender M F

Race African Coloured Indian/Asian White Other Do not want to disclose

Date of birth D D M M Y Y Y Y

Telephone (H) | Telephone (W)

Cellphone

Tax number

Email

3. About your dependant/s (only complete if applying for cover)

Dependant 1

Title | Initials

Surname

First name(s)
(as per identity document)

ID or passport number

Gender M F

Race African Coloured Indian/Asian White Other Do not want to disclose

Date of birth D D M M Y Y Y Y

Relationship to principal member (for example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If over 18 years provide cellphone number

If your dependant is 23 years and older, are they:

Married? Yes No | Financially dependent on you? Yes No

Disabled? Yes No | A student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

Dependant 2

Title | Initials

Surname

First name(s)
(as per identity document)

ID or passport number

Gender M F

Race African Coloured Indian/Asian White Other Do not want to disclose

Date of birth D D M M Y Y Y Y

Relationship to principal member (for example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If over 18 years provide cellphone number

If your dependant is 23 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

Dependant 3

Title Initials

Surname

First name(s)
(as per identity document)

ID or passport number

Gender M F

Race African Coloured Indian/Asian White Other Do not want to disclose

Date of birth D D M M Y Y Y Y

Relationship to principal member (for example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If over 18 years provide cellphone number

If your dependant is 23 years and older, are they:

Married? Yes No Financially dependent on you? Yes No

Disabled? Yes No A student? Yes No

Does your dependant earn an income? Yes No

How much does your dependant earn each month? **R**

Dependant 4

Title Initials

Surname

First name(s)
(as per identity document)

ID or passport number

Gender M F

Race African Coloured Indian/Asian White Other Do not want to disclose

Date of birth D D M M Y Y Y Y

Relationship to principal member (for example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If over 18 years provide cellphone number

If your dependant is 23 years and older, are they:

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? **R**

Dependant 5

Title Initials

Surname

First name(s)
(as per identity document)

ID or passport number

Gender M ☐ F ☐

Race African ☐ Coloured ☐ Indian/Asian ☐ White ☐ Other ☐ Do not want to disclose ☐

Date of birth D D M M Y Y Y Y

Relationship to principal member (for example, mother, child etc. Where your child is not your biological child, please state relationship, i.e. adopted child, foster child. Please provide legal proof)

If over 18 years provide cellphone number

If your dependant is 23 years and older, are they:

Married? Yes ☐ No ☐ Financially dependent on you? Yes ☐ No ☐

Disabled? Yes ☐ No ☐ A student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐

How much does your dependant earn each month? **R**

4. Please select your Network Option

Comprehensive Network Option ☐ Restricted Network Option ☐

5. Preferred General Practioner (PGP) Nomination

Please nominate a PGP for each of your dependant/s here.

If you choose the Restricted Network Option we encourage you to nominate a PGP (or PGPs) from the restricted network of GPs so that you can use the same GP for your acute and chronic needs.

No.	Member's or dependant's first name and surname	ID number	PGP's name and surname	PGP's practice number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

About your PGP

- A PGP may be changed at the principal member's discretion once every six months
- Where a PGP is part of a group practice of general practitioners, members may visit any healthcare provider in the group practice, provided he or she practices under the same practice number as the group

- When the PGP is not available, the healthcare provider standing in (known as the locum) will automatically be considered as the PGP
- Consultations with a GP who is not the nominated PGP may attract deductible co-payments

6. Employer (for completion by Payroll and Benefits Centre team only)

Employer name | Employer number

Date of employment (D D M M Y Y Y Y) | Department name

Department number | Telephone

Email

Principal member's joining date (D D M M Y Y Y Y)

Income amount (Benefit value/Control amount) **R** .

(Contribution are deducted in accordance with the applicant's income and his or her number of eligible dependants in terms of the appropriate contribution table set out in the Scheme's rules which are amended from time to time).

Employer warranty

1. We warranty that the principal member detailed in section 1 is an employee of our organisation
2. The Scheme may ask us for an amount due for this member in the same way as it does for our other Sasolmed employees

Employer's authorised signatory

Name

7. Your banking details

Your claims refund

Please give us the details you would like to use:

Please note: we cannot accept credit card account details.

Bank name

Branch name | Branch code

Account number

Type of account | Cheque/Transaction/Transmission | Savings

Account holder

Account holder's physical address

If third party bank details, please insert the third party ID number.

ID number

If the third party bank account is not a personal bank account please indicate the type of account | Joint account | Company account | Trust account

Please provide proof of bank account. Refer to Annexure A at the back of the application form for the proof of bank account required

By signing below, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded.

- You understand that you may not transfer, assign, pledge or cede the payment or receipt of any benefit by or from the Scheme to any person and if you do or attempt to do so, the Scheme may withhold, suspend or discontinue the payment of such benefit.

You must inform us immediately if any of your banking details change.

Signature of account holder

Third Party Bank details

Please attach the relevant proof of bank account if you providing a third party bank account for claims refund.

Third party account (e.g. spouse, aunt, uncle, friend, father, son)

- Proof of the account (bank statement or bank letter not older than three months)
- A copy of the third party's (account holder) ID, Passport or Driver's Licence

- A copy of the main members ID, Passport or Driver's Licence

Joint account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the joint account holders

Company account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of the signatories who have authority to sign on behalf of the company
- A letter of authority stating that the account can be used including the details of the signatory and stating the membership details for which the bank account will be used. The letter must be dated, signed by an authorized person on behalf of the company
- A copy of the company's certificate of registration
- A copy of the principal members ID, Passport or Driver's Licence

Trust account

- Proof of account (bank statement or bank letter not older than three months)
- A copy of the ID, Passport or Driver's Licence of each of the trustees of the account
- A copy of the Trust's certificate of registration
- A copy of the Trust resolution. The resolution must be dated, signed by an authorised person on behalf of the Trust
- A copy of the principal members ID, Passport or Driver's Licence

If you are completing the request on behalf of the principal member, please include proof that you have obtained the necessary authority (example, Letter of Authority or Letter of Executorship).

8. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both. We may also use the information on the membership certificate to determine if we can apply waiting periods.

Main applicant

Name	Scheme name	Start date	End date	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

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

If any of your dependant/s applying for cover belonged to different medical schemes, please complete them below:

Dependant name	Scheme name	Start date	End date	Are they still a member?	Reason for leaving
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	
				Yes ☐ No ☐	

HIV and AIDS

If you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 002 134** within seven working days from the date we activate your Sasolmed membership. We treat this information in the strictest confidence. If you, or one or more of your dependants are HIV-positive, it is in your interest to register on the HIVCare Programme.

9. Terms and Conditions applicable to Sasolmed membership

Definitions

The Scheme refers to Sasolmed, registration number 1234, registered with the Council for Medical Schemes. Administrator refers to Discovery Health (Pty) Ltd, registration number 1997/013480/07, an authorised financial services provider, the administrator and managed healthcare organisation for and a subsidiary of the Discovery Group.

Do you agree that we may send you direct electronic marketing from time to time No, thank you ☐ Yes, I agree ☐

9.1. **Scheme rules for membership**

The rules of the Scheme record your rights and responsibilities for your membership. They may change from time to time. You may ask us for a copy of these rules at any time or view these rules on **sasolmed.co.za**.
When you sign this application, you confirm that you have read and understood these Terms and Conditions and you agree that you and those you apply for will be bound by these and Scheme rules.

Where applicable you also acknowledge and confirm that you and your employer, may communicate with us on this application and your membership of the Scheme.
Please speak to the Administrator if there is anything you do not understand.

9.2. **Who you are applying for**

You may apply to join the Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you as defined in the Scheme rules, as referred to above. For anyone to be treated as financially dependent for this application, you must have a responsibility to provide financially for that dependant. The Scheme or Administrator might ask you to give us proof of financial or legal responsibility. You may be called the principal member in our future communications to you.

9.3. **Acting for others**

You confirm you have the right to act for others. By signing this document, you confirm that; and/or

9.3.1. You have the right to apply for membership and to act for those you apply for in any matter relating to this application.

9.3.2. You have received permission from your spouse/partner and any dependant(s) over 18 to act for them in any matter relating to this application.

9.4. **Giving and getting information**

You must give true, correct and complete information

To consider your application for membership, the Scheme must learn more about you and those you apply for.
Information about you and those you apply for must be true, correct, and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application. We may ask those you apply for who are 18 and older for more information about themselves.

Your legal address

The Scheme or Administrator will send documents to you at the address you indicated as the communication channel you prefer to be contacted on. If it is necessary to send you any legal notices or summonses, our legal team will serve these at the physical address you have given, or at any other address you have given us. It is your responsibility to make sure we have the correct address for you.

The Scheme and Administrator may record telephone calls

The Scheme and Administrator may record telephone conversations with you and with those you apply for. The recordings and all information we get during the recordings will be processed and kept as required by law.

The Scheme and Administrator may get information about you from other relevant sources

The Scheme and Administrator may (at any time and on an ongoing basis) obtain your personal information from other relevant sources, including healthcare providers, contracted service providers, credit bureaus or industry regulatory bodies (“relevant sources”) and further process such information to consider your membership application, to conduct underwriting or risk assessments, to consider a claim for medical expenses, to profile and analyse risk or to investigate fraud, waste and/or abuse (including by healthcare providers, contracted service providers . We may (at any time and on an ongoing basis) verify with the relevant sources that your personal information is true, correct, and complete.

You give your permission that the Scheme and Administrator may get any information that is relevant to your application from your employer.

Tell the Scheme or Administrator immediately if your information changes

You must tell the Scheme or Administrator in writing if any of the information you gave, in your application for membership, changes between the day you sign this document and the day your membership starts. This includes information about your health and the health of those you apply for. We need advance notice of any administrative changes such as cancellation of membership, as we do not accept backdated changes.

When the Scheme may cancel your membership

The Scheme may cancel any membership if you and those you apply for:

- do not give us information that later turns out to be relevant to this application
- give us any information that is not true, correct, and complete
- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document, and the day cover starts

Providing false information may lead to criminal charges being brought against you. You will have to pay any amount owing to the Scheme as a result of this cancellation.

9.5. **About becoming a member**

The Scheme might not pay for certain expenses immediately

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before the Scheme starts paying for any general or specific medical conditions. We will advise if any waiting periods apply. Please speak to the Administrator with regard to any waiting periods applicable to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time

As the principal member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month to avoid suspension of benefits. The Scheme has the right to amend monthly contributions and benefits from time to time with prior notification.

9.6. **Repaying money owed to the Scheme**

The Scheme has the right at any time to collect from you any amount that you owe. We will notify you if there is any amount that you owe to the Scheme.

Signature of principal member _____ Date D D M M Y Y Y Y

10. Sasolmed Privacy Statement 2026

When you engage with Sasolmed, you are entrusting us with your personal information. We are committed to protecting your right to privacy and keeping your information safe. Our Privacy Statement tells you how we collect, use and share your personal information, including personal information about your spouse, employees, dependants, beneficiaries and life assureds, where applicable. To view and read our Privacy Statement, please follow this link:**https://www.sasolmed.co.za/assets/medical-schemes/saslomed/general/sasolmed-privacy-statement.pdf**