



Contact details

Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

Permission to make certain information available to other third party

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 Anglovaal Medical Scheme, including its administrator (currently Discovery Health (Pty) Ltd), as well as those entities who do not have a direct relationship with Anglovaal Medical Scheme.

Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, 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). The Administrator take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administrative delays, please make sure this form is completed in full.
3. Incomplete forms will not be considered as valid consent.
4. Provide a copy of your nominated third party's identity document or valid passport.
5. Please fax the completed form to **011 539 5217** or email it to **consent@avgms.co.za**.
6. 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.
7. For more information about how and why we use your information, please view our Privacy Statement: <https://www.avgms.co.za/portal/anglovaal/privacy>

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

1. About yourself (member)

Membership number	<input type="text"/>
ID or passport number	<input type="text"/>
Member's name	<input type="text"/>
Member's surname	<input type="text"/>

2. Permission to make certain information available to a third party 2020 - About the third party

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	<input type="text"/>
Surname	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>

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		
Biographical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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).

2.2. 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

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	Employer contact person	Employer contact person
Biographical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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).

2.3. 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

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		
Biographical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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. Your doctor

BHF Practice number

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Doctor's first name and surname

Please specify the type of information that your financial adviser, financial adviser house and/or employer contact 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.

Your doctor

Make all of the below available

Biographical information

<input type="checkbox"/>	D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
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Benefit information

<input type="checkbox"/>	D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
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Financial information

<input type="checkbox"/>	D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
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Medical information (Including Health Record containing pathology and radiology results and may include HIV-related information)

<input type="checkbox"/>	D	D	M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y
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(Refer to table 1 on page 4 for examples of these types of information).

*Please refer to the specific terms and conditions section under 'Discovery HealthID application consent' on the final page of this form.

2.5. Specific third party 1

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

Title

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Surname

First name(s) (as per identity document)

ID or passport number

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Email address

Contact number

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2.6. Specific third party 2

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

Title

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Surname

First name(s) (as per identity document)

ID or passport number

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Email address

Contact number

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2.7. Specific third party 3

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

Title

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Surname

First name(s) (as per identity document)

ID or passport number

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Email address

Contact number

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3. About the information we may provide to the third party

Please specify the type of information each specific third party may have access to and for how long the access should be valid. Should you not 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.

Third Party

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

Make all of the below available

	Specific party 1	Specific party 2	Specific party 3	From	To
Biographical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Benefit information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Financial information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y
Medical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D D M M Y Y Y Y	D D M M Y Y Y Y

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

Table 1

Examples of biographic information	Examples of benefit information	Examples of Financial information	Examples of Medical information
<ul style="list-style-type: none"> Membership number Date of birth ID number Postal and e-mail address Physical address Telephone numbers 	<ul style="list-style-type: none"> Plan type Limits Waiting period details Self-payment Gap 	<ul style="list-style-type: none"> Medical scheme tax certificate and tax summary Banking details Total contribution and breakdown 	<ul style="list-style-type: none"> Indicator of chronic condition/s Prescribed Minimum Benefit chronic condition details Confirmation of claims paid (excluding amounts and origin of payments) Claims transaction history, Hospital procedures, Procedure codes Procedures done in doctors' rooms paid from Hospital Benefit

4. Terms and conditions

- This document provides Anglovaal Medical Scheme, and its outsourced service providers, including the administrator, permission to make certain information available to the named third party or third parties selected in this form and reserves 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.
- You agree that by making this information available, Anglovaal Medical Scheme, and its outsourced service providers, including the administrator, are not responsible for any loss, whether direct, indirect or as a result of disclosing the information.
- You agree that the named third parties receiving this information may not hold Anglovaal Medical Scheme, and its outsourced service providers, including the administrator, responsible for any claims that result from the wrongful use or disclosure of the information by the named third parties.
- You agree that once you have provided permission, Anglovaal Medical Scheme, and its outsourced service providers, including the administrator, may give all the information that falls under the selected type of information to the named third parties.
- This permission will end on the dates specified. You agree that should you have not given an expiry date 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.

Signed at (town or city)

on

D	D	M	M	Y	Y	Y	Y
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Please print name

Signature of person providing permission