



THIRD PARTY CONSENT FORM 2024

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wcmas@wcmas.co.za
 C/o Susanna St & OR Tambo Rd
 P O Box 26, Emalaheni (Witbank), 1035
 Tel: 013 656 1407 Fax: 0866277795

Membership Number

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1. Principal member details

Member first full name and surname	Initials	
Identity / passport number (only foreigners to insert passport numbers)	Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F

2. Third party consent

Please provide consent to allow WCMAS to provide a third party with your personal information on their request by completing such third-party details below.

Full names:	Identity / passport number:	
Consent given From	Until	Until further notice
Postal Address	Residential Address	Relationship
		Cell phone:
		Tel: (H)
		Tel: (W)
		Fax:
(Code)	(Code)	E-mail address:

3. Protection of personal information

In accordance with the Protection of Personal Information Act No 4 of 2013(hereafter referred to as the PoPI Act) please take note of the following:

- 3.1 WCMAS and its representatives (e.g., third party administrator, duly authorised representatives of WCMAS, managed care organisation, etc.) will have access to all medical records and personal information of the principal member and his / her dependants, which includes children subject to parental control in terms of the law. WCMAS and said representatives will also be permitted to visit members or dependents (where applicable) at in-patient facilities where the member or dependent may receive treatment and where WCMAS deems this to be in the interest of the patient. WCMAS will keep all such information confidential and will only disclose the personal information to its representatives and other third parties, if required for the assessment and payment of benefits, collection of monies owed by the member or service providers to WCMAS or as otherwise authorised in terms of the law.
- 3.2 The rights of the member or his / her dependant (i.e. data subject) are detailed in section 5 of the PoPI Act.
- 3.3 Personal information is defined in the PoPI Act as information relating to an identifiable living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to:
 - Information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person;
 - Information relating to the education or the medical, financial, criminal or employment history of the person;
 - Any identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier or other particular assignment to the person;
 - The biometric information of the person;
 - The personal opinions, views or preferences of the person;
 - Correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;
 - The views or opinions of another individual about the person; and
 - The name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person.
- 3.4 WCMAS and its representatives will collect the personal information of the member and his / her dependants directly from the member, his / her dependants, health care providers that have provided health care services to the member and his / her dependants and other relevant sources for the purposes set out below.
- 3.5 WCMAS will collect process and retain, amongst others, the personal information of the member and his / her dependants contained in the consent form and the claims from service providers as well as benefit payments and clinical information relevant to the membership application, claims and benefits.
- 3.6 The personal information will be collected and processed by WCMAS and its representatives for the purpose of assessment and processing the application for membership, underwriting, determination of benefit entitlements, provision of medical scheme benefits, assessment of claims, reimbursement of claims, risk management, collection of monies owed to WCMAS, compliance with the Medical Schemes Act and the registered rules of WCMAS and any related matters.
- 3.7 The member undertakes to update his / her personal information as soon as reasonably practicable after changes have occurred. This will ensure that the records of WCMAS contain information that is accurate and up to date.

3.8 The personal information of the member and his / her dependants will be retained as part of the records of WCMAS for as long as required by the Medical Schemes Act, the Scheme Rules, the South African Revenue Service, the Protection of Personal Information Act and any other applicable legislation for as long as is necessary in order to provide medical scheme services to the members and his / her dependants and for other lawful, historical, statistical and research purposes.

3.9 The supporting documentation listed below **must** accompany this consent form, failure of which will result in a rejection of this consent form by WCMAS. (tick the relevant block if the documents referred to are attached to this consent form):

Information required in the above consent form:

- Copies of identity documents of the principal member
- Copies of identity documents of the person for whom consent is given.

3.10 The name and address of the party responsible for safekeeping of the information is detailed as follows:

Witbank Coalfields Medical Aid Scheme

Physical address: 2nd Floor WCMAS Building; C/o Susanna & OR Tambo road; Emalahleni; 1034

Postal address: P O Box 26; Emalahleni, 1035

3.11 Complaints regarding compliance with the PoPI Act can be addressed to WCMAS or the Information Regulator when established.

3.12 Contact details for the Council for Medical Schemes:

Share call number: 086 1123267

Website: www.medicalschemes.com

Complaints division: complaints@medicalschemes.com

4. Declaration by member (on behalf of all dependants)

I, the aforementioned member, hereby:

4.1 Grant permission on my own behalf as well as on behalf of my dependants (if applicable):

4.1.1 to any medical practitioner, person or party who may be in possession of or obtain information concerning my/our health status, treatment received or anticipated, as well as any other relevant health information including my/our HIV status, to divulge such information to WCMAS or its representative (e.g. third party administrator, managed care organisation, etc.) on request, also after my death or the death of any of my dependants. I understand that the health information may and on occasion shall be used to evaluate the allocation and payment of benefits for certain diseases;

4.1.2 that a duly authorised representative of WCMAS may visit me or any dependent where applicable at any facility where I am an in-patient, at such reasonable time and for such reasonable reason as it may deem appropriate, and with due consideration of my best interests and may have access to all my medical records.

4.2 Guarantee that to the extent that it may be required by law that I have the necessary consent from my dependants to provide the authorisation as set out in this section

4.3 Confirm that I understand that WCMAS will process personal information (which includes the collection, use and retention of such information) about me and my dependants as set out in section 3 above. I specifically consent on my own behalf as well as on behalf of my dependants to the processing of such information by WCMAS and its representatives as set out in section 3.

4.4 Confirm that I understand that it is my responsibility to update my information with WCMAS that has changed as soon as reasonably practicable after the change has been effected

4.5 Confirm that I have attached true copies of documentation provided.

4.6 Confirm that I am aware of my right to request changes to my personal information as included in the records of WCMAS in accordance with the PoPI Act.

4.7 Confirm that I have read and understood all the information contained this affidavit.

4.8 Declare that all the information provided is true and correct to the best of my knowledge and belief.

4.9 Declare that any false statement in this affidavit may result in my membership and that of my dependants being terminated or rejected, as the case may be.

4.10 Acknowledge that, in instances where a broker or any other person completed this form on my behalf, I will remain liable for the information disclosed herein.

Member Signature

Date

Commissioner of Oaths

Stamp: Commissioner of Oaths