

- 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.
- 4.4 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.
- 4.5 WCMAS will collect, process and retain, amongst others, the personal information of the member and his / her dependants contained in the authorisation form, the documents provided in terms of 4.9 and the claims from service providers as well as benefit payments and clinical information relevant to the authorisation form, claims and benefits.
- 4.6 The personal information will be collected and processed by WCMAS and its representatives for the purpose of assessment and processing the amendment to information, 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.
- 4.7 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.
- 4.8 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 member and his / her dependants and for other lawful, historical, statistical and research purposes.
- 4.9 The supporting documentation listed below **must** accompany this EFT authorisation, failure of which will result in a rejection of this form by WCMAS (tick the relevant block if the documents referred to are attached to this authorisation form):
- Proof of banking details (either a bank stamped statement, a confirmation letter from the bank indicating the banking details or a cancelled cheque none of which should be older than 3 months.)
 - Copy of ID
- 4.10 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
- 4.10 Complaints regarding compliance with the PoPI Act can be addressed to WCMAS or the Information Regulator when established.
- 4.11 Contact details for the Council for Medical Schemes:
Share call number: 086 112 3267
Website: www.medicalschemes.com
Complaints division: complaints@medicalschemes.com

5. Declaration by practice / member (on behalf of all dependants)

- I, the undersigned, hereby:
- 5.1 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 4 above. I specifically consent on my own behalf as well as on behalf of my dependants (as appropriate) to the processing of such information by WCMAS and its representatives as set out in section 4.
 - 5.2 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
 - 5.3 Confirm that I have attached true copies of documentation provided.
 - 5.4 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.
 - 5.5 Confirm that I have read and understood all the information contained in this EFT authorisation form.
 - 5.6 Declare that all the information provided is true and correct to the best of my knowledge and belief.
 - 5.7 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.
 - 5.8 Applicable to members only: I hereby authorise my employer to deduct from my salary each month the specified contributions and other debt owed to the Scheme and to pay the money to the Scheme on my behalf as the case may be.

PLEASE EMAIL THIS FORM BACK TO BILLINGS@WCMAS.CO.ZA

Doctor / Member Signature

Date

Witness

Witness

FOR OFFICE USE ONLY

Members:	Telephone confirmation	Practices:	BHF file
	Call log number:		Check successful:
	Check successful:		Telephone confirmation
			Call log number:
			Check successful: