STATUTORY NOTICE

Provider and Representative disclosures in terms of the Financial Advisory and Intermediary Services Act, No. 37 of 2002 (FAIS Act)

The FAIS Act was enacted for your benefit. Completemed Healthcare Consultants (Pty) Ltd is an approved Financial Services Provider (FSP). Please note that this disclosure does not form part of the insurance contract with the service providers we are contracted to. As a long-term or short-term insurance policyholder, or prospective policyholder, or a medical scheme member you have the right to the following information:

1. The Financial Service Provider

Completemed Healthcare Consultants (Pty) Ltd was established in 2001, Registration Number 2001/012686/07. As a licensed Financial Service Provider (FSP) in terms of the FAIS Act, Completemed Healthcare Consultants (Pty) Ltd accepts responsibility for the actions of its representatives acting within their mandates in rendering services as defined by the FAIS Act and Codes of Conduct promulgated in terms of the Act.

Company Name	Completemed Healthcare Consultants (Pty) Ltd
Ownership structure	Completemed Healthcare Consultants (Pty) Ltd is a wholly owned subsidiary of Sanlam Life Insurance Limited
Capacity	Independent Intermediary
Council for Medical Schemes Accreditation	ORG 1214
FSB Registration Number	3373
Financial Services Board Accreditation	2001/012686/07
Office Address	Sanlam, 2 Strand Road, Bellville, 7530
Postal Address	PO Box 1, Sanlamhof, 7532, South Africa
Telephone	0860 122340
E-mail	info@completemed.co.za
Website	www.completemed.co.za

2. The Representatives

Our representatives meet the fit and proper requirements as prescribed by the FAIS legislation.

As an authorised FSP we are licensed to render financial services in respect of the following financial Product Categories:

Health Service Benefits, Short Term Insurance (Personal Lines)

3. Insurance Product Providers

We are contracted with the following Insurance Companies:

Total Risk Administrators, Stratum, Xelus, Sirago and African Unity Health

4.Medical Scheme Product Providers

We are contracted with the following Medical Schemes:

Bonitas Medical Fund, Discovery Health Medical Scheme, Fedhealth Medical Scheme, KeyHealth Medical Scheme, Liberty Medical Scheme, Medihelp Medical Scheme, Medshield Medical Scheme, Momentum Health Medical Scheme, Profmed Medical Scheme, Resolution Health Medical Scheme, Sizwe Medical Scheme, Spectramed Medical Scheme, Topmed Medical Scheme

5. Indemnity cover held

Yes, Amount: R1, 050,000,000, Insurer: Various Lloyd's of London Syndicates / Stalker Hutchison Admiral and other South African Insurance markets

6.Shareholding of more than 10% in any Insurer

In the Sanlam Group, Completemed is a wholly-owned subsidiary of Sanlam Life Insurance Limited, and is authorized to provide financial services on a number of medical schemes, including Bonitas and Fedhealth,

Sanlam Limited holds shares in Medscheme that administers the scheme business of Bonitas and Fedhealth.

7. Remuneration of more than 30% from any Medical Scheme

Name of Medical Schemes from which the FSP received more than 30% of total remuneration during the past calendar year (if any)

Topmed Medical Scheme

8. Compliance related queries

For any compliance matter relating to FAIS or the Policyholder Protection Rules you may contact our Compliance Officer.

Please put any complaint in writing and address it to any of the following:

	Internal	**External**
Name	Riana van Zyl	Egbert Fouche
Company	Completemed Healthcare Consultants (Pty) Ltd	Sanlam Life Insurance Ltd
Postal address	PO Box 1, Sanlamhof, 7532	PO Box 1, Sanlamhof, 7532
Telephone	021 947-4793	021 947-5460
Facsimile	021 957-2529	021 947-9636
E-mail	riana.vanzyl@completemed.co.za	egbert.fouche@sanlam.co.za

If the matter is not resolved to your satisfaction, you may address your queries to the Ombud for Financial Services Providers or the Council of Medical Schemes.

Ombud for FSP	Telephone	012 762 5000 / 012 470 9080
	Fax	086 764 1422
	E-mail	info@faisombud.co.za
	Website	https://www.faisombud.co.za
CMS	Telephone	0861 123 267/ 012 431 0500
	Fax	012 430 7644
	E-mail	complaints@medicalschemes.com
	Website	https://www.medicalschemes.com

9. Your rights

9.1 Your right to know the impact of the decision you elect to make

The representative or insurer dealing with you must inform you of:

- The premium you may be paying and the nature and extent of the benefits you may receive.
- The possible impact of this purchase on your finances.
- The possible impact of this purchase on your other policies (affordability). The contract terms of the product you intend to purchase.

9.2 Your right when being advised to replace an existing policy

You may not be advised to cancel a policy to enable you to purchase a new policy or amend an existing policy, unless:

The intermediary identifies the policy as a replacement policy.
The implications of the cancellation of the policy are disclosed to you, such as:

- The influence on your benefits under the policy to be replaced.
- The additional costs incurred with the replacement.

The insurer or medical scheme which issued the original policy may contact you to discuss the matter with their representative.

9.3 Your right to be informed by the insurer / medical scheme

The medical scheme / insurer will forward you documentation confirming policy or member details, which may also include:

The name of the insurer / medical scheme
The product(s) being purchased
The cost in Rands of the transaction and specifically:

- Waiting periods, if any
- Loadings, if any
- Late Joiner Penalties, if any
- Exclusions, if any
- The amount of commission and other remuneration being paid to the intermediary,
- Contact number and address of compliance officers of the insurer or product provider.
- Waiting periods, if any

In the case of policies in an investment element, the ongoing expense and any other fees and charges payable.

9.4 Your right to cancel the transaction

In most cases you have the right to cancel a policy in writing within 30 days after receipt of the documentation from the insurer or medical scheme. Please bear in mind that you may not exercise this right if you have already claimed under the policy.

9.5 Other important issues

- It is important that you are sure that the product or transaction meets your needs and that you feel you have all the information you need before making a decision.
- It is recommended that you discuss with the intermediary, medical scheme or insurer the possible impact of the proposed transaction on your finances, your other policies or your broader insurance portfolio.
- Where paper forms are required, it is advisable to sign them once they are fully completed. Feel free to make notes regarding verbal information, and to ask for written confirmation or copies of documents.
- During any client contact the representative has to explain the aim and intention of the contact to you.
- In cases where a financial service was delivered to you orally you may request written confirmation within a reasonable time.
- The representative of the company may not request or induce the client in any manner to waive any right or benefit conferred on the client by or in terms of any provision of the FAIS General Code of Conduct.
- The company undertakes to reveal any conflict or possible conflict in interest in terms of any advice or interaction with you.

10. Your obligations

With the completion and submission of any transactional requirement(s):

- You have to ensure, in those instances where the representative completes any transactional requirement(s) on your behalf, that the information is accurate and complete,
- You have to reveal all material facts accurately and comprehensively,
- You have to be aware of the possible consequences of misrepresentation, withholding facts or presenting incorrect information.

11. Disclaimer

The information attached to this quotation, and in particular the benefit comparison, consists of a key benefit and financial and demographic summary of the scheme options only and does not replace the benefits contained in the Rules of the schemes summarised as such.

Nor does it propose to be a comprehensive or factually correct listing of the benefits or all the benefits of the various products and in all instances the Rules of the Schemes shall prevail in case of any discrepancy..

Although care has been taken to represent the benefits and limitations of the products accurately, no liability is accepted for any incorrect information or any decision taken on the strength of the information given.

12. Remuneration

Should you be an existing client or appoint our company as your Intermediary, a monthly ongoing fee is payable by the Medical Scheme to the FSP. This fee is legislated and is determined by the Department of Health from time to time and is currently limited to 3% of the total monthly contribution or R80.00 plus VAT, whichever is the lesser.

Gap cover commision: Recurring commission of 20% (including VAT) payable monthly on premiums received.

I hereby acknowledge that I understand the contents of this notice.

Client Name _____ **Signature** _____ **Date** _____

GLOSSARY OF TERMS AND ABBREVIATIONS

NHRPL	**National Health Reference Price List**
	The tariff and applicable rules for specific services or supplies provided, based on the 2006 NHRP List published by the Council for Medical Schemes, with annual inflationary increases determined by the Department of Health.
MSA	**Medical Savings Account**
	A savings facility attached to certain Scheme Options to which members contribute monthly, which is limited to a maximum of 25% of total monthly contributions. Normally a credit equal to 12x the monthly savings contribution is available upfront.
PP/DSP	**Preferred Provider/Designated Service Provider**
	A service provider with whom the Scheme has negotiated preferential rates, or who is part of a preferred provider network.
PMB	**Prescribed Minimum Benefits**
	A list of 270 conditions or group of conditions and 26 chronic illness conditions as listed in Annexure A of the Medical Schemes Act for which any Scheme is obliged to provide members certain minimum benefits in the form of diagnosis, treatments and services.
CDL	**Chronic Disease List**
	A specified list of 26 chronic conditions forming part of the Prescribed Minimum Benefits in respect of which all schemes are obliged to cover in full according to the specific Scheme or Option treatment plans and protocols.
LJP	**Late Joiner Penalty**
	A contribution loading imposed on persons older than 35 who were not members or dependants of a medical scheme from a date before 1 April 2001. The loading is based on the Risk portion of the contribution and is calculated according to the years without cover after the age of 35, with credit given for years of cover after the age of 21, according to the following scales: 1-4 years - 5% 5-14 years - 25% 15-24 years - 50% 25+ years - 75%.
SPG	**Self-Payment Gap**
	A period during which a member will be required to fund a certain portion of day-to-day claims from his/her own pocket after the Medical Savings Account is depleted and when the Option has an Above Threshold Benefit.

OAL	**Overall Annual Limit**
	An upper limit, normally expressed as a Rand amount, to which claims are restricted during a benefit year for Hospital claims only or all claims incurred by the member and paid by the Scheme.
ATB	**Above Threshold Benefit**
	A benefit forming part of certain Scheme Options that provides continued cover for day-to-day claims and accessed after depletion of a members\' MSA, together with reaching a specified Threshold in accumulated legitimate claims, expressed as a Rand amount.
Major Medical benefits	Inured benefits for services other than day-to-day benefits, such as hospitalsation and the treatment/procedures performed whilst a beneficiary is hospitalised.
Formulary	A defined list of medicine used in the treatment of various diseases.
General Waiting Period	A period in which a Beneficiary is not entitled to claim any benefits. A general waiting period of 3 months will usually be applicable if a member was not previously a member of a registered medical scheme, or was a member of a medical scheme for more than two years and the change of medical scheme was not as a result of a change of employment, or if the period between the termination of membership of a previous scheme and joining a new scheme is more than ninety days.
Condition-specific Waiting Period	A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve (12) month period ending on the date on which an application for membership was made. A 12 month condition-specific waiting period will usually be applicable if a member was not previously a member of a registered medical scheme, or was a member of a medical scheme for less than two years and the change of medical scheme was not as a result of a change of employment, or if the period between the termination of membership of a previous scheme and joining a new scheme was more than ninety days.
p/b	per beneficiary
p/f	per family
p/a	per annum