2008

SUMMARY OF ANNUAL FINANCIAL STATEMENTS
OPSOMMING VAN FINANSIËLE STATE

VISION	We are a well respected medical scheme of choice and a leader in the innovative provision of excellent, technology enabled and cost-effective services by valuing long-term trust relationships with our responsible members and strategic partners.
MISSION	Our mission is to restore, promote and maintain health ensuring long-term growth, sustainability and peace-of-mind for our members.

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A copy of the complete set of Annual Financial Statements is available on request from TeleMed or on the website at www.telemed.co.za.

corporate profile

THEN AND NOW

Since 1922, TeleMed, an open market, South African medical scheme, has delivered affordable, appropriate and quality private healthcare to a growing and diverse membership.

This year, TeleMed not only celebrates 87 successful years in the medical scheme industry, but also the long-standing relationships it has established and nurtured with members, healthcare providers and suppliers along the way.

Historically, TeleMed operated as a closed scheme providing secure and dependable service to employees of the Post and Telecommunications industry.

In1996, it recognised that consumer expectations and market trends had evolved and decided to show its mettle by entering the competive open medical scheme environment.

Based on its reputation as a stable and reliable medical scheme that delivers exceptional customer service, it used its vast experience to skillfully transform its operations and craft an appealing product range that offers members the freedom to manage their benefits according to lifestyle as well as enjoy uncompromising personal service.

Having pitted its strengths against major players within a robust and highly competitive market, TeleMed's flexibility and vigour to deliver on its promises of value-based medical cover and individual attention, has positioned it as one of the top medical schemes in the country.

THE PERFECT FIT

TeleMed's business focus is not restricted to niche sectors of the population, such as the most affluent or even first time buyers, but attracts anyone looking for sound cover at a sensible price.

The primary purpose of purchasing healthcare cover is to insure against unknown and unexpected future medical expenses.

Even those who are young and healthy, or whose annual medical requirements are marginal, are acutely aware that medical cover is a necessity and not a luxury. With company subsidised medical benefits no longer the norm, most people either individually research the many benefit options available, or consult an intermediary or independent broker to do so on their behalf.

Whilst we all concede that monthly medical scheme premiums consume a large chunk of personal income, the choice of medical scheme and option is, in most cases, governed by available funds versus individual circumstances and healthcare needs.

In addition, potential members and employer groups tend to favour schemes offering options with modest annual contribution increases, that pay claims on time with no fuss and that stringently manage administration costs.

Although the importance of having medical cover is undisputed, members often feel that the specific benefits they pay for are either irrelevant or insufficient for their particular medical conditions or healthcare requirements.

TeleMed has therefore structured its Platinum, Gold, Gold Select, Silver and Bronze options with this in mind.

Apart from offering extensive in-hospital benefits across all options, the appeal of TeleMed's Flexpenditure and Flexfunder medical savings accounts is that they offer members the freedom and flexibility to control where and how they spend their benefits to deliver the perfect fit for their specific lifestyles.

OUR PEOPLE - THE SPECIAL TOUCH

We live in a relatively impersonal world and, as a result, we often doubt the assurance of receiving special attention.

TeleMed's undertaking to care for its members because it says it will is part of the company ethos and a solemn promise. Members are considered part of the Scheme's healthcare family and TeleMed employees afford them the individual attention, compassion, confidentiality and consideration they expect and deserve.

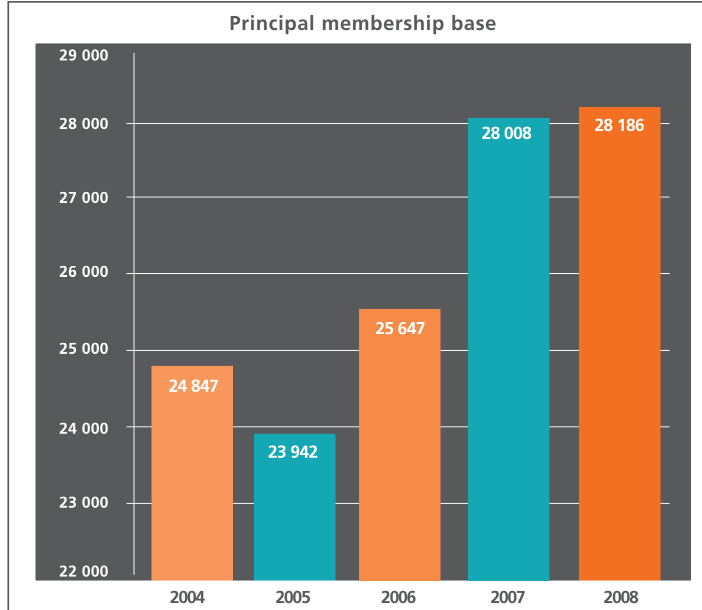
TeleMed's staff appointments are based on skill and inclination and, in addition to training, mentoring and continual review, employees are encouraged to further empower themselves through learning and hands-on experience.

FACTS AND STATS

Looking after our members entails:

- 62 184 lives covered
- An average of R846 million in benefits paid per year
- 4 977 553 claim lines processed per year
- Annually receiving 89% electronic and 11% paper claims
- 1 194 807 member visits to service providers in a single year
- An annual average of 287 139 phone calls attended to by our qualified contact centre agents
- A 7-day turn-around time to pay our service providers
- An average of 69 190 e-mails received monthly
- Over 1 000 births within a six month period

The graph below illustrates TeleMed's steady membership growth from 2005 - 2008.



VALUE DRIVEN

Customer focused product offerings and service delivery

Employees are motivated to achieve the vision of the organisation and value diversity

Focus on rewarding members for managing their health and wellbeing

A pro-active and innovative approach to sustain and grow our business

Service excellence is the foundation of everything we do

We are ethical and trustworthy – we deliver on our promises

CHAIRMAN'S REPORT

As I write this report we have just finalised our first quarterly review, January to March 2009, in which TeleMed's financial performance was discussed with the Actuary. I am pleased to report that there has been a remarkable improvement in our solvency ratio since the end of December, with 1% to over 10%, and all indications are that we can expect continued improvement during the course of 2009.

Additionally, we noted positive feedback from the Chairman of our Audit Committee and the auditors about the healthy co-operative relationships that exist among our new management team. As Chairman, I am therefore upbeat about the future and any impending challenges.

Our CEO, Leon La Grange and his management team have worked exceptionally hard and I can confirm that we have fortunately entered calmer waters where there is no longer a need to review and expend time and energy dealing with matters from our recent past.

The fundamental challenges facing TeleMed in the current volatile economic climate remain prominent and require the Board's continued attention and commitment. One important recurring concern is Telkom's cyclical restructuring strategy that negatively impinges upon employment and our membership base. These developments also mean that our already relatively high average membership age increases and bring inflationary pressures to bear on membership contributions. As a result, the Board must continually seek methods to manage rising health costs more effectively and stringently to sustain the viability of the Scheme.

TeleMed's circumstances are not dissimilar to other players in the medical scheme industry and often unpopular decisions need to be made to ensure that members, especially the older ones, are still able to afford to pay contributions whilst being assured of receiving optimal healthcare services. Unfortunately changes to streamline costs and guarantee effective service often involve restricting the choice of service provider and treatment options.

A number of medical schemes and administrators have decided to consolidate their operations to broaden their risk pools. TeleMed's Board has also, for several years, identified and investigated this option as a route to broaden its risk pool. As there is limited growth in the number of people who are financially able to purchase healthcare cover, one of our key strategies is to consider merging with schemes of similar ethos and values to best protect the long-term interests of our many loyal members. We are actively pursuing this possibility and trust that we will be able to report progress on this initiative during 2009.

One of the government's key focal areas is to provide access to and improve healthcare service to a multitude of people who have previously not been well served. Affordability is an important factor in these endeavours and could lead to significant changes in the supply and funding of healthcare in future. I believe that a partnership with one or more schemes will strengthen our ability to face forthcoming challenges.

As highlighted in the governance statement in the Annual Financial Report, last year was turbulent and resulted in a fair amount of change. Following the resignation of Carel Stadler as CEO, the Board was in the fortunate position to urgently appoint Leon La Grange, then Chairman of the Board, as CEO from 18 June 2008. His primary tasks were to stabilise the working environment, strengthen governance practices and internal controls and improve TeleMed's relationship with the Council for Medical Schemes. I am pleased to report that good progress has been made in all key areas over the past nine months.

I would like to express my sincere appreciation to my fellow trustees for their loyal and dedicated service to TeleMed and for the trust they displayed in my abilities by electing me as Chairman at the end of July last year. It is indeed an honour to serve the membership of TeleMed in this new capacity. A heartfelt thank you also to our many devoted and responsible members - your continued interest and support is vital and highly appreciated.

Finally, I wish to extend my thanks to TeleMed's management team for making my task so much easier as a result of their support and hard work. Thank you to Leon La Grange for five years of steadfast service as trustee and Chairman of the Board. Undoubtedly the experience serves him well in his new capacity as CEO.

Ben Bets
Chairman: TeleMed Board of Trustees
21 April 2009

chairman's report

VOORSITTERSVERSLAG

Ek skryf hierdie verslag net na die finalisering van ons eerste kwartaalverslag, van Januarie tot Maart 2009, waarin TeleMed se finansiële prestasie met die Aktuaris bespreek is. Dis vir my 'n vreugde om verslag te kan lewer oor die merkwaardige verbetering in ons solvensieverhouding wat sedert die einde van Desember, met 1% tot 10% gestyg het, met alle aanduidings in plek dat ons volgehoue verbetering in die loop van 2009 kan verwag.

Daarbenewens het ons positiewe terugvoer ontvang van die Voorsitter van ons Ouditkomitee en die ouditeure oor die gesonde, samewerkende verhoudings wat onder ons bestuurspan aanwesig is. As Voorsitter is ek dus optimisties oor die toekoms en enige uitdagings op hande.

Ons Hoof Uitvoerende Beampte, Leon La Grange en sy bestuurspan het besonder hard gewerk en ek kan bevestig dat ons gelukkig kalmer waters ingevaar het waar dit nie meer nodig is om sake uit ons onlangse verlede weer te bekyk en tyd en energie daaraan te bestee nie.

Die fundamentele uitdagings wat TeleMed in die huidige onbestendige ekonomiese klimaat in die gesig staar, bly prominent en vereis die Raad se voortgesette aandag en toewyding. Een belangrike terugkerende aangeleentheid is Telkom se sikliese herstruktureringstrategie wat werkverskaffing asook ons ledebasis negatief beïnvloed. Hierdie ontwikkelings beteken ook dat ons reeds relatief-hoë gemiddelde lidmaatouderdom toeneem, wat inflasionêre druk op lidbydraes teweegbring. Gevolglik moes die Raad voortdurend soek na wyses om stygende mediese kostes meer doeltreffend en strenger te bestuur ten einde die lewensvatbaarheid van die Skema te verseker.

TeleMed se omstandighede verskil nie van ander rolspelers in die mediese skema bedryf nie en ongewilde besluite moet dikwels geneem word om te verseker dat lede, veral die ouer lede, steeds kan bekostig om bydraes te betaal terwyl hulle seker is dat hulle optimale gesondheidsorgdienste kan ontvang. Veranderings aan rasionaliseringsonkostes en die waarborg van doeltreffende diens vereis ongelukkig dikwels dat die keuse van diensverskaffers en behandelingsopsies beperk moet word.

'n Aantal mediese skemas en administrateurs het besluit om hulle werksaamhede te konsolideer ten einde hulle risikopoel te verbreed. Die Raad van TeleMed het ook, vir 'n aantal jare, hierdie opsie geïdentifiseer en ondersoek dit as 'n roete na verbreding van sy risikopoel. Aangesien daar beperkte groei is in die aantal mense wat finansieel in staat is om gesondheidsorgdekking te bekostig, is een van ons sleutelstrategieë om te oorweeg om saam te smelt met skemas wat soortgelyke etos en waardes aanhang, om die langtermyn voordele van ons vele lojale lede te verseker. Ons is aktief besig om hierdie moontlikheid te ondersoek en vertrou dat ons tydens 2009 oor vordering met hierdie inisiatief sal kan rapporteer.

Een van die regering se sleutelfokusareas is om toegang te verskaf en gesondheidsorgdienste te verbeter vir 'n menigte mense wat vantevore nie goeie diens ontvang het nie. Bekostigbaarheid is 'n belangrike faktor in hierdie pogings en mag lei tot betekenisvolle veranderings in die voorsiening en befondsing van gesondheidsorg in die toekoms. Ek glo dat 'n vennootskap met een of meer skemas ons vermoë sal versterk om toekomstige uitdagings te hanteer.

Soos benadruk in die stelling van die bestuur in die Jaarlikse Finansiële Verslag, was verlede jaar stormagtig en het dit 'n taamlike hoeveelheid veranderings teweeggebring. Na die bedanking van Carel Stadler as HUB, was die Raad gelukkig geposisioneer om Leon La Grange, toe Raadsvoorsitter, dringend te kon aanwys as HUB vanaf 18 Junie 2008. Sy primêre take was om die werksomgewing te stabiliseer, bestuurspraktyke en interne kontrole te versterk en om TeleMed se verhouding met die Raad op Mediese Skemas te verbeter. Dit is vir my 'n vreugde om te kan rapporteer dat goeie vordering die afgelope nege maande in al die sleutelareas gemaak is.

Ek betoon graag my innige waardering vir mede-trustees wat lojale en toegewyde diens aan TeleMed gelewer het en vir die vertroue wat hulle getoon het in my vermoëns toe ek as Voorsitter verkies is teen einde Julie verlede jaar. Dit is voorwaar 'n eer om die lede van TeleMed in hierdie nuwe hoedanigheid te kan dien. Diepgrondige dank ook aan soveel van ons toegewyde en verantwoordelike lede - voortgesette belangstelling en ondersteuning is lewensbelangrik en word op prys gestel.

Laastens bedank ek graag die bestuurspan van TeleMed wat met hulle ondersteuning en harde werk my taak soveel makliker gemaak het. Dankie aan Leon La Grange vir vyf jaar van standvastige diens as trustee en Voorsitter van die Raad. Die ondervinding sal verseker handig te pas kom in sy nuwe hoedanigheid as HUB.

Ben Bets
Voorsitter: TeleMed Raad van Trustees
21 April 2009

message from the CEO

MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

If there is one word that aptly categorises the year for TeleMed, it would be change!

There were major changes to the management structure, with several of the Executives resigning during the year to pursue other opportunities and culminating in the resignation of the CEO in June 2008.

At the time of joining the Scheme, following my appointment as CEO by the Board of Trustees, it was necessary to restructure the management hierarchy in order to swiftly eliminate internal anxiety, as well as operational and other uncertainties, that normally accompany a period of upheaval. The result was a "flat" reporting structure with managers assuming additional responsibility and accountability.

I am pleased to report that this strategy proved to be highly successful and the team has, in a relatively short time, achieved the desired objective of halting and even reversing the decline of TeleMed's financial situation. This defence of the bottom line, so to speak, resulted in the Scheme reporting its first surplus in its audited Annual Financial Statements in four years! From this firm base, the actuarial projections for 2009 onwards are very optimistic, with the prospect of the Scheme exceeding the 25% statutory reserve ratio requirements by 2011.

The Scheme also achieved an unqualified audit result from our external audit partner, PricewaterhouseCoopers, a stellar testament to management and staff commitment. I wish to express my gratitude to all of you for achieving these milestones.

As expected, delivering results such as these is never plain sailing and ultimately involved a major overhaul of operations, systems and contracts, as well as the firming up of the principles of managed healthcare. In some instances, it was also necessary to align service providers with TeleMed's mission and vision promises to its members and stakeholders.

During the year, management implemented Board approved strategies that focussed on actively retaining existing members and attaining a more conservative growth in new membership. Benefit design for 2009 concentrated on ensuring that options were self-sustaining, that the Scheme's reserve ratio grew and that TeleMed continued to offer affordable and attractive health cover that catered for our members' diverse healthcare requirements. Non-healthcare expenditure was revisited and unnecessary overheads were curtailed.

The delay in the approval of TeleMed's benefits by the Registrar detrimentally influenced the Scheme's membership base. The resultant uncertainty amongst brokers and corporate HR departments negatively impacted projected contribution income and occurred because a substantial number of members elected to, or were coerced by brokers, to leave the Scheme during December 2008.

All of this is now behind us and I can confidently say that with the dedication of the management team, support from the Board and staff of TeleMed and the invaluable expertise of, and commitment to excellence, by its diverse service provider partners, the Scheme is revitalised and continues to deliver characteristic, unprecedented health cover and service. Irrespective of the current economic climate, we look forward to a successful 2009.

Health greetings

Leon La Grange
Chief Executive Officer

BOODSKAP VAN DIE HOOF UITVOERENDE BEAMPTE

Indien een woord gekies moet word om TeleMed die afgelope jaar raak te beskryf, sal die woord verandering wees!

Daar was groot veranderings aan die bestuurstruktuur, met heelwat Uitvoerendes wat in die loop van die jaar bedank het om ander geleenthede op te volg, en dit het uitgeloop op die bedanking van die HUB in Junie 2008.

Toe ek na my aanstelling as HUB by die Skema se Raad van Trustees aangesluit het, was dit noodsaaklik om die bestuurshiërargie te herstruktureer om interne angstigheid asook operasionele en ander onsekerhede wat gewoonlik tydens 'n omwenteling opduik, vinnig uit te skakel. Die gevolg was 'n "plat" rapporteringstruktuur met bestuurders wat addisionele verantwoordelikheid en aanspreeklikheid aanvaar het.

Dis met vreugde wat ek terugvoer kan gee oor hierdie baie suksesvolle strategie, en die span het, in 'n relatiewe kort rukkie, die verlangde doelwit bereik om agteruitgang van TeleMed se finansiële toestand te stuit en selfs om te keer. Die verdediging van die sogenaamde voorlinie, het daartoe gelei dat die Skema oor sy eerste surplus in sy geöuditeerde Jaarlikse Finansiële State in vier jaar kan rapporteer! Vanuit hierdie stewige basis is die aktuariële projeksies vir 2009 vorentoe baie optimisties, met die moontlikheid dat die Skema die 25% statutêre reserwe ratio-vereistes teen 2011 sal bereik.

Die Skema het ook 'n ongekwalifiseerde ouditresultaat van ons eksterne ouditvennoot PricewaterhouseCoopers bereik, 'n uitsonderlike getuigskrif van bestuurs- en personeeltoewyding. Ek betuig graag my dank aan almal van julle wat hierdie mylpaal bereik het.

Soos verwag, is dit nooit maklik om sulke resultate te bereik nie en uiteindelik het dit 'n grootskaalse hersiening van operasies, sisteme en kontrakte behels, sowel as die versekering van die beginsels van gesondheidsorg. Dit was soms nodig om diensverskaffers in te trek by TeleMed se missie- en visiebeloftes aan sy lede en aandeelhouers.

In die loop van die jaar het die bestuur Raadstrategieë geïmplementeer wat gefokus was op die aktiewe behoud van bestaande lede en die bereiking van 'n meer konserwatiewe groei in nuwe lede. Voordele wat vir 2009 ontwerp is, het gekonsentreer daarop om te verseker dat opsies selfonderdhoudend was, dat die Skema se reserweverhouding gegroei het en dat TeleMed voortgegaan het om bekostigbare en aantreklike gesondheidsorgdekking te bied aan ons lede se diverse gesondheidsorgvereistes. Nie-gesondheidsorg uitgawes is hersien en onnodige onkostes is ingeperk.

Die oponthoud in die goedkeuring van TeleMed se voordele by die Registrateur het die Skema se ledebasis benadeel. Die gevolglike onsekerheid onder makelaars en korporatiewe Menslike Hulpbronneafdelings het negatief geïmpakteer op voorsiene bydrae-inkomste en het plaasgevind omdat 'n groot aantal lede gekies het of deur makelaars geforseer is, om die Skema in Desember 2008 te verlaat.

Dit is alles nou agter ons en ek kan vol vertroue skryf dat met die toewyding van die bestuurspan, ondersteuning van die Raad en personeel van TeleMed en die waardevolle kundigheid van, en toewyding aan uitnemendheid, van die diverse diensverskaffersvennote is die Skema verlewendig en gaan ons voort om kenmerkende, weergalose gesondheidsdekking en diens te lewer. Ongeag die huidige ekonomiese klimaat, sien ons uit na 'n suksesvolle 2009.

Gesondheidsgroete

Leon La Grange
Hoof Uitvoerende Beampte

STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES

The Board of Trustees is responsible for the preparation, integrity and fair presentation of the annual financial statements of TeleMed Medical Scheme. The annual financial statements presented on pages 29 to 50 have been prepared in accordance with International Financial Reporting Standards (IFRS) and in terms of the Medical Schemes Act 131 of 1998 as amended and its regulations and include amounts based on judgements and estimates made by management.

The Board of Trustees consider that in preparing the annual financial statements they have used the most appropriate accounting policies, consistently applied and supported by reasonable and prudent judgements and estimates and that all International Financial Reporting Standards that they consider to be applicable have been followed.

The Board of Trustees is satisfied that the information contained in the annual financial statements fairly represents the results of operations for the year and the financial position of the Scheme at year end. The Board of Trustees also prepared the other information included in the annual report and is responsible for both its accuracy and its consistency with the annual financial statements.

The Board of Trustees is responsible for ensuring that accounting records are kept. The accounting records disclose, with reasonable accuracy, the financial position of the Scheme to enable the Board of Trustees to ensure that the annual financial statements comply with the relevant legislation.

TeleMed Medical Scheme operated in a well-established, controlled environment, which is well documented and regularly reviewed. This incorporates risk management and internal control procedures which are designed to provide reasonable, but not absolute, assurance that assets are safeguarded and the risks facing the business are being controlled.

The going concern basis has been adopted in the preparation of the annual financial statements. The Board of Trustees has no reason to believe that the Scheme will not be a going concern for the foreseeable future, based on forecasts and available cash resources. These annual financial statements will indicate that the Scheme has turned around a deficit of R34,5 million in 2007 into a net gain of R7,3 million. This turnaround of a deficit trend into a surplus, as well as actuarial models for the next three years, supports the viability of the Scheme.

The Scheme's external auditors, PricewaterhouseCoopers Inc., are responsible for auditing the annual financial statements and their report appears on page 30.

The annual financial statements were approved by the Board of Trustees on 21 April 2009 and are signed on its behalf by:

BA Bets
Chairman

21 April 2009

DJ Fredericks
Trustee

L La Grange
Principal Officer

Board of Trustees

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES

The Trustees of TeleMed and the management team are fully committed to the principles and practice of fairness, openness, integrity and accountability in all TeleMed's dealings with its stakeholders. In addressing TeleMed's challenges the trustees fully realise that a critical balance of many conflicting demands must be achieved. This requires the highest level of governance and stewardship to be exercised at all times. The best sustainable overall interests of the members are uppermost in the board's mind and, in its governance role, the board fully supports, where applicable, the recommendations on corporate governance contained in the King II Report.

The composition of the Board of Trustees provides for seven of the eleven trustees to be elected by the members and therefore comfortably meets the legal requirement of 50% elected members. The other four trustees are appointed by the Board to enhance diversity of skills and representation. At present, there is a vacancy on the Board following the resignation of Mr Leon La Grange as a trustee and subsequent to his appointment as Chief Executive Officer and Principal Officer.

The Board of Trustees meets regularly and closely monitors the performance of our self-administered medical scheme and is actively supported by a number of board committees in critical performance areas. All the trustees have full access to the advice and services of the Chief Executive Officer and other members of the management team and, where appropriate, obtain independent professional advice at the expense of the Scheme.

TeleMed's ageing member profile has been a major concern for a number of years and the trustees have to pay special attention to product design to limit tariff increases to ensure that benefit options remain attractive to younger members. This has *inter alia* resulted in the introduction in 2007 of the Gold Select option, in partnership with ONECARE and PrimeCure, to facilitate the continued offering of affordable comprehensive cover to older members in particular.

The restrictions that apply to this option are generally not popular with the affected members, but the board was compelled to implement these changes to ensure the continued health of the Scheme.

These realities, coupled with the continued delay of the introduction of risk equalisation and other developments in the medical scheme industry, have demanded that the trustees seriously consider other strategies to broaden the risk pool. It has, for this reason, been an agreed strategy to consider active mergers with similar schemes to best protect the long-term interests of members.

Although membership has stabilised, Telkom's outsourcing strategy may pose further threats to the retention of younger economically active members and also emphasises the need for long-term planning and solutions. In order to protect the interests of our loyal members, the trustees are actively pursuing opportunities in this regard and it is hoped that real progress can be reported during the course of 2009.

TeleMed's solvency ratio has remained under pressure during 2008, but the trustees are pleased to report that the decline has been reversed and that the outlook for 2009 is continued improvement in this regard. TeleMed's non-healthcare costs of 9,7% (10.3% 2007) of contributions remains one of the lowest in the industry (industry average 15.7% for open schemes) and reflects that costs are being managed in a responsible manner for the benefit of the members.

As part of sound governance, the trustees regularly review TeleMed's strategy and performance, including the role and functioning of the Board and its sub-committees, delegation of authority, code of ethics, key policies, etc. Special attention is also given to trustee training. The Board uses the Balanced Scorecard approach to ensure that all critical business elements are addressed and performance monitored. Specific attention is also given to appropriate benchmarking.

Another key benchmarking tool compares TeleMed's normalised costs with that of the industry enabling focused managed healthcare initiatives, while regular surveys address general levels of satisfaction as well as more specific aspects of service.

The Scheme maintains internal controls and systems designed to provide reasonable assurance of the integrity and reliability of the financial statements and safeguards, verifies and maintains adequate accountability of its assets. Such controls are based on established policies and procedures and are

STATEMENT OF CORPORATE GOVERNANCE BY THE BOARD OF TRUSTEES
CONTINUED

implemented by trained personnel with the appropriate segregation of duties.

During the previous financial year the Registrar of Medical Schemes presented the Board of Trustees with an inspection report in which certain allegations were made including illegal payments to brokers. The Board had approved these payments in principle in 2006 based on the legal advice that payment to brokers for additional services was not illegal, but suspended these payments pending further investigation. In total an amount of R302 300 was paid to brokers for other services.

Subsequently the Board uncovered that some of the structures and mechanisms used by management did not conform to best risk management practices and could have exposed the Scheme to fraudulent practices. A forensic audit did not, however, find evidence of any self-enrichment by anyone involved with the Scheme. These mechanisms did, however, allow management to sidestep some of the reserved authorities of the Board. The Board, therefore, terminated the relevant contracts and broker payments in question.

Mr Carel Stadler, Chief Executive Officer, resigned in June 2008. The Board duly appointed Mr Leon La Grange, the then Chairman of the Board for a number of years, as the new Chief Executive Officer effective 18 June 2008, with the key mandate to restore relationships with the Council for Medical Schemes and further strengthen management practices and the internal controls of the Scheme. Mr Ben Bets was appointed as Chairman on 31 July 2008.

Except for the matter stated above, no other event or item has come to the attention of the Board of Trustees that indicated any material breakdown in the functioning of the key internal controls and systems during the year under review.

We are in fact pleased to report that the new management team, under the leadership of our new Chief Executive Officer, Mr Leon La Grange, has shown great determination to take ownership of the difficult task of managing the Scheme in the best interest of its members and has, in the process, also enhanced the sound application of the delegation of authority in a very responsible manner. The efforts of the management team are highly appreciated by the Board of Trustees.

BA Bets
Chairman

DJ Fredericks
Trustee

L La Grange
Principal Officer

21 April 2009

REPORT OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2008

1. Description of the medical scheme

1.1 Terms of registration

TeleMed is a non-profit, open medical scheme registered in terms of the Medical Schemes Act 131 of 1998, as amended.

1.2 Benefit options within TeleMed Medical Scheme

The Scheme offered five benefit options to employers and members of the public for the period under review. These are:

- **Bronze**
  A low-cost benefit option ideal for first time buyers or for those with moderate healthcare needs.

- **Silver**
  An appealing package for young, healthy families or individuals seeking to cater for any eventuality.

- **Gold**
  A wide range of cover at an affordable premium.

- **Gold Select**
  Healthcare services through contracted provider networks.

- **Platinum**
  A comprehensive option encompassing extensive benefits that rivals the best in the market.

1.3 Savings plan

In order to provide a facility for medical scheme members to set funds aside to meet future healthcare costs not covered in the benefit options, the trustees made the Silver option available to meet this objective.

Members pay an agreed sum, according to their earnings and limited to 25% of their gross contributions, into a savings account to help pay the member's portion of healthcare costs when they have exceeded their benefit limits, or if the benefits are not covered by the Scheme.

Unexpended savings accumulates for the long-term benefit of the member. Interest is not accrued or paid to members.

The liability to the members, in respect of the personal savings account, is reflected as a current liability in the annual financial statements and repayable in terms of Regulation 10 of the Act, as amended.

Savings contributions are refunded to the member when he or she leaves the Scheme or transfers to an option within the Scheme that does not have a savings option. The money will be transferred to the member within six months from the date of change or termination.

The savings account holder carries the risk in terms of the Rules of the Scheme.

1.4 Risk transfer arrangements

The Scheme has entered into risk transfer agreements with the following service providers:

- PrimeCure for the provision of all healthcare benefits for members on the Bronze option, as well as for a number of members on the Gold Select option.
- ONECARE for the provision of capitated health services for the balance of Gold Select option members.
- ER24 for the provision of emergency response and medical transportation.

Refer to Notes 13 and 14 of the unabridged Annual Financial Statements, available for inspection at the Schemes' registered offices, for further disclosure.

REPORT OF THE BOARD OF TRUSTEES
FOR THE YEAR ENDED 31 DECEMBER 2008

2. Trustees, management and key advisors

2.1 Board of Trustees in office during the year under review

BA Bets*
Member trustee
(Chairman)
Re-elected 22 June 2006
3 year term

GF Dempsey
Member trustee
(Deputy chairman)
Re-elected 29 April 2008
3 year term

JJ Bezuidenhout
Member trustee
Re-elected 22 June 2006
3 year term

F Vian
Member trustee
Elected 19 July 2007
3 year term

WJ Myburgh
Member trustee
Elected 19 July 2007
3 year term

NA Potgieter
Member trustee
Re-elected 29 April 2008
3 year term

DJ Fredericks
Appointed trustee
Reappointed 31 July 2008
2 year term

AI Minnaar
Appointed trustee
Reappointed 31 July 2008
2 year term

LA Louw
Appointed trustee
Reappointed 31 July 2008
2 year term

M Raath
Appointed trustee
Reappointed 31 July 2008
2 year term

** L La Grange resigned as Chairman on 17 June 2008 after which BA Bets acted as Chairman until his appointment on 31 July 2008.*

REPORT OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2008

2.2 Principal Officer

CP Stadler - Resigned
13 June 2008

L La Grange - Appointed
18 June 2008

2.3 Registered office and postal address

4 Third Street
Marlands
Germiston
1401

PO Box 303
Germiston
1400

2.4 Actuaries

The following Actuaries were contracted to evaluate the benefit options, pricing thereof, IBNR and Post-Retirement Healthcare liability:

The Health Monitor Company
Ground Floor
Block J
Central Park
400 16th Road
Midrand

Private Bag X17
Halfway House
1685

2.5 Auditors

PricewaterhouseCoopers Inc.
32 Ida Street
Menlo Park
0102

PO Box 35296
Menlo Park
0102

2.6 Investment managers

Coronation Fund Managers
(Financial Service Provider no. 548)
Coronation House
Boundary Terraces
1 Mariendahl Lane
Newlands
7700

PO Box 993
Cape Town
8000

3. Investment Policy of the medical scheme

The investment objectives of the Scheme is to ensure that the highest possible investment return is achieved by constantly monitoring market conditions and reacting to them. The policy prescribes investments only in call accounts or money market instruments for short-term surplus funds, or held-to-maturity investments and units in equity unit trusts or pooled equity managed funds for longer term surplus cash.

The Board of Trustees continues to invest funds in line with the requirements of the Medical Schemes Act 131 of 1998, as amended. There has been no change in policy during the current accounting year.

The Scheme invested in held-to-maturity investments, available-for-sale investments and cash instruments during 2008. This policy is reviewed annually, taking into consideration compliance with the Act, the risk of and returns on the various investment instruments and the surplus of available funds.

During the period of market volatility and collapse of the global economy and equity markets, the Scheme adopted a conservative approach and refrained from any further investments with an equity exposure.

4. Management of Insurance Risk

The primary insurance activity carried out by the Scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. This risk relates to the health of Scheme members. As such, the Scheme is exposed to the uncertainty surrounding the timing and severity of claims under the medical insurance contract. The Scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, management of risk transfer arrangements and the monitoring of emerging issues.

The Scheme uses several methods to assess and monitor insurance risk exposure for both specific and overall types of risk. These methods include internal risk measurement models, sensitivity and scenario analyses. The theory of probability is applied to the pricing and provisioning for a portfolio of medical insurance contracts. The principal risk is that the frequency and severity of claims are greater than expected.

Medical insurance events are, by their nature, random and the actual number and magnitude of events during any single year may vary

REPORT OF THE BOARD OF TRUSTEES
FOR THE YEAR ENDED 31 DECEMBER 2008

from those estimated using established statistical techniques. The assumptions used to extra-polate insurance assets and liabilities that materially effect the financial statements are provided in the notes to the annual financial statements.

5. Review of activities for the accounting year

5.1 Operational statistics

Please refer to the schedule on page 22.

5.2 Operating results

The results of the Scheme are detailed in the annual financial statements. The Board of Trustees believes that specific reference should be made to Paragraph 18 of this report regarding non-compliance with the Medical Schemes Act and its Regulations.

5.3 Solvency ratio

	2008 R	2007 R
Total members' funds as per balance sheet	89 640 075	82 289 903
Less: Revaluation reserves	(5 411 341)	(5 411 341)
Available-for-sale reserves	(669 529)	(667 142)
Accumulated funds as per Regulation 29	83 559 205	76 211 420
Gross contributions	918 897 109	817 961 245
Solvency ratio (Accumulated funds / Gross annual contribution income) x 100%	9.09%	9.32%

The Scheme did not achieve the solvency margin of 25% as required by the Medical Schemes Act. Refer to paragraph 18.1 of this report.

Although there was a slight decline of 0.23% in the solvency ratio, accumulated reserves increased by R7,3 million and gross annual contributions by R101 million. Membership growth of 0.6%, although positive, had a detrimental effect on the solvency ratio. Despite this, actuarial models indicate that the Scheme is a viable going concern.

REPORT OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2008

Review of activities for the accounting year

5.1 Operational statistics

	BRONZE		SILVER		GOLD		GOLD SELECT		PLATINUM		TOTAL SCHEME	
	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007
Number of members at the end of the accounting year	4 013	3 241	4 499	3 821	8 715	11 739	2 671	643	8 053	8 564	27 951	28 008
Average number of members for the accounting year	3 802	2 440	4 653	3 141	8 912	11 816	2 874	684	8 308	8 736	28 549	26 817
Average number of dependants for the accounting year	2 176	1 613	6 294	4 633	12 457	15 250	2 095	794	9 892	10 844	32 914	33 134
Average net contributions per member per month	R597	R637	R1 413	R1 512	R3 107	R2 590	R2 478	R2 351	R3 775	R3 264	R2 628	R2 500
Average net contributions per beneficiary per month	R379	R383	R601	R611	R1 296	R1 131	R1 433	R1 088	R1 723	R1 456	R1 221	R1 118
Average claims incurred per member per month	R525	R527	R1 721	R1 395	R2 329	R2 398	R2 989	R2 443	R3 490	R3 210	R2 394	R2 376
Average claims incurred per beneficiary per month	R334	R317	R732	R564	R971	R1 047	R1 729	R145	R1 593	R2 943	R1 112	R1 060
Average administration cost per member per month	R49	R15	R230	R212	R230	R211	R75	R52	R230	R211	R190	R189
Average administration cost per beneficiary per month	R31	R9	R98	R86	R96	R92	R44	R3	R105	R194	R88	R85
Average managed care: Management services per member	R0	R2	R598	R655	R657	R670	R199	R417	R767	R687	R546	R607
Average accumulated funds per member at 31 December	R2 927	R2 842	R2 927	R2 842	R2 927	R2 842	R2 927	R2 842	R2 927	R2 842	R2 927	R2 842
Beneficiaries per member at 31 December	1.58	1.69	2.44	2.34	2.38	2.28	1.69	2.15	2.17	2.23	2.15	2.20
Net claims as a percentage of net contributions	88.07%	82.76%	121.82%	92.26%	74.96%	92.57%	120.64%	104.00%	92.45%	98.36%	91.11%	95.05%
Managed care: Management services as a percentage of net contributions	0.00%	0.02%	3.53%	3.61%	1.76%	2.16%	0.67%	1.48%	1.69%	1.75%	1.73%	2.02%
Non-healthcare expenses as a percentage of net contributions	10.05%	2.32%	18.06%	14.01%	7.81%	8.16%	3.13%	2.22%	6.47%	6.47%	7.77%	7.58%
Average healthcare management expenses per beneficiary per month	-	0.08	21.20	22.05	22.82	24.38	9.59	2.06	29.19	52.48	21.13	22.61
Number of new members	2 082	1 703	1 179	1 465	276	21	2 197	674	116	15	5 850	3 878
Number of membership terminations	1 310	372	501	66	3 300	673	169	31	627	375	5 907	1 517
Average age per beneficiary	31	32	26	29	38	41	59	48	42	41	37	39
Pensioner ratio	5.68%	6.27%	1.83%	2.33%	12.35%	18.78%	51.92%	26.86%	14.49%	12.92%	13.29%	13.75%
Chronic profile	0.24%	0.04%	10.04%	10.94%	33.06%	38.03%	57.03%	37.99%	44.98%	41.78%	30.33%	32.23%

REPORT OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2008

5.4 Reserve accounts

Movements in the reserves as detailed in the Statement of Changes in Funds and Reserves.

There have been no unusual movements that the trustees believe should be brought to the attention of the members of the Scheme.

5.5 Outstanding claims provision

The basis of calculation and the movement of outstanding claims provision is discussed in Note 4 to the summarised annual financial statements and this is consistent with the previous year. The decrease of 23% can be attributed to the movement of a greater number of members onto risk transfer arrangements (24% vs 14% in 2007) as well as a marked improvement in claims payment efficiency.

6. Actuarial services

The Scheme's Actuaries have been consulted in the determination of contributions, benefit levels and outstanding claims provision as well as the post-retirement medical benefit liability.

7. Post balance sheet events

There have been no events that occurred subsequent to the financial year end that affect the annual financial statements and that the Board of Trustees believes should be brought to the attention of the members of the Scheme.

8. Investments in and loans to participating employers or members of the medical scheme and to other related parties

The Scheme holds no investments or loans in participating employers or other related parties.

9. Related party transactions

Refer to related parties disclosure in Point 10 of the notes to the summarised annual financial statements. Trustee remuneration is disclosed in Point 10 of the notes to the summarised annual financial statements.

10. Audit Committee

The Audit Committee was established in accordance with provisions of the Medical Schemes Act 131 of 1998, as amended. The Committee is mandated by the Board of Trustees by means of written terms of reference to its membership, authority and duties. The Committee consists of five members of which two are members of the Board of Trustees. The majority of members, including the Chairman, are not officers of the Scheme.

The Chairman of the Scheme, the Financial Manager, Internal Auditor and the External Auditors have unrestricted access to the Chairman of the Committee.

In accordance with the provisions of the Medical Schemes Act 131 of 1998, as amended, the primary responsibility of the Committee is to assist the Board of Trustees to carry out its duties relating to the Scheme's accounting policies, internal control systems and financial reporting practices. The Internal and External Auditors formally report to the Committee on critical findings arising from audit activities.

The Committee met five times during the year.

The Audit Committee comprises:

JFJ Scheepers (Chairman)
Independent member

L La Grange
Trustee member
Resigned 17 June 2008

DJ Fredericks
Trustee member

WJ Myburgh
Trustee member
Appointed 31 July 2008

IR Coetzee
Independent member

M Janse van Rensburg
Independent member
Appointed 10 April 2008

11. Investment Committee

An Investment Committee was established and is mandated by the members of the Board of Trustees by means of written terms of reference as to its membership, authority and duties. The Committee consists of two members of the Board of Trustees as well as the Chief Executive Officer and the Manager: Finance, IT and Member Administration. The Committee met three times during the year.

REPORT OF THE BOARD OF TRUSTEES
FOR THE YEAR ENDED 31 DECEMBER 2008

The Investment Committee comprises:

DJ Fredericks (Chairman)
Trustee member

WJ Myburgh
Trustee member

CP Stadler - Former CEO
Resigned 13 June 2008

R Lalla - Management
Resigned 31 May 2008

L La Grange - CEO
Appointed 31 July 2008

FR Olivier - Management
Appointed 31 July 2008

12. Action Committee

The primary responsibility of the Action Committee is to consider proposals to be tabled at the Board of Trustees meetings on an ongoing basis and act as the Board of Trustees' Remuneration Committee. The Committee met seven times during the year.

The Action Committee comprises:

BA Bets (Chairman)

JJ Bezuidenhout

GF Dempsey

M Raath
Appointed 31 July 2008

L La Grange
Resigned 17 June 2008

13. Human Resource Committee

The overall objective of the Human Resources Committee is to assist the trustees to discharge their duties relating to the attraction, retention and development of the Scheme's human resources.

The Human Resource Committee comprises:

GF Dempsey (Chairman)

NA Potgieter

F Vian

L La Grange - CEO

T du Toit - HR Manager

LJ Crowther - Learning and Compliance Manager
Appointed 31 July 2008

The Committee met three times during the year.

14. Managed Healthcare Committee

The overall objective of the Managed Healthcare Committee is to advise the Board on matters relating to the managed healthcare strategy and on methods to effectively address this key risk factor.

The Managed Healthcare Committee comprises:

LA Louw (Chairman)
Appointed 31 July 2008

GF Dempsey
Appointed 31 July 2008

JJ Bezuidenhout
Appointed 31 July 2008

L La Grange (CEO)
Appointed 31 July 2008

Dr WA Oosthuizen
Independent member

V Premnand - MHC Manager

The Committee met three times during the year.

15. Remuneration Committee

The overall objective of the Remuneration Committee is to determine and account for the remuneration of all TeleMed employees on behalf of the Board of Trustees in accordance with best corporate practice.

The Remuneration Committee comprises:

AI Minnaar (Chairman)
Appointed 31 July 2008

BA Bets
Appointed 31 July 2008

GF Dempsey
Appointed 31 July 2008

16. Dispute Committee

A Dispute Committee was established by the Board of Trustees by means of written terms of reference in respect of its membership, authorities and duties. The Committee adjudicates disputes that may arise between a member, prospective member, former member or person claiming against the Scheme by virtue of such member and the Scheme or an officer of the Scheme.

The Dispute Committee comprises:

C Harbottle (Chairman)
Independent member

E Prins
Independent member

M Morris
Independent member

REPORT OF THE BOARD OF TRUSTEES

FOR THE YEAR ENDED 31 DECEMBER 2008

17. Trustee and sub-committee meeting attendance

The schedule shows the meeting attendance by the Board of Trustees and Board Sub-Committee members. Trustee remuneration is disclosed under Point 10 of the notes to the summarised annual financial statements.

- **A** Total possible number of meetings could have attended
- **B** Actual number of meetings attended
- ***** Trustee
- **2** Management

TRUSTEE / SUB-COMMITTEE MEMBER	BOARD OF TRUSTEES		ACTION COMMITTEE		INVESTMENT COMMITTEE		AUDIT COMMITTEE		HUMAN RESOURCE COMMITTEE		MANAGED HEALTHCARE COMMITTEE		REMUNERATION COMMITTEE		DISPUTE COMMITTEE	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B
L La Grange*[2]	4*	4*	3*	3*	2[2]	2[2]	1*	1*			1*	1*	1*	1*		
BA Bets*	8	8	7	7							3	3	1	1		
JJ Bezuidenhout*	8	8	7	7												
GF Dempsey*	8	8	7	7					3	3	1	1	1	1		
DJ Fredericks*	8	3			3	3	5	1								
L Louw*	8	6									3	3				
AI Minnaar*	8	6											1	1		
NA Potgieter*	8	8							3	3						
W Myburgh*	8	7			3	3	2	2								
M Raath*	8	8	4	4												
F Vian*	8	8							3	3						
JFJ Scheepers							5	5								
IR Coetzee							5	5								
M Janse van Rensburg							5	5								
WJ Oosthuizen											3	2				
CP Stadler[2]					1	1			1	1						
FR Olivier[2]					3	3										
V Premnand[2]											3	3				
T du Toit[2]									3	3			1	1		
LJ Crowther[2]													1	1		
R Lalla[2]					1	0					1	1				
C Harbottle															0	0
E Prins															0	0
M Morris															0	0

AUDIT COMMITTEE REPORT

We are pleased to present our report for the financial year ended 31 December 2008 as required in terms of Clause 6 of the Audit Committee Charter.

Committee members and meeting attendance

The Audit Committee, constituted as required by Section 36 (10) of the Medical Schemes Act 1998, comprises the below listed members and meets at least three times per annum. During the current year five meetings were held.

MEMBER	MEETINGS ATTENDED
IR Coetzee Independent	5
DJ Fredericks Trustee	1
L La Grange Trustee	1
M Janse Van Rensburg Independent	5
WJ Myburgh Trustee	2
JFJ Scheepers Independent Chairman	5

The External Auditor, Chief Executive Officer, Executive: Finance and Risk Management as well as the Internal Auditor have a standing invitation to Audit Committee meetings and have attended most of the meetings during the year under review.

Audit Committee responsibility

The Audit Committee reports that it has adopted appropriate formal terms of reference as its charter (approved by the Board of Trustees), has regulated its affairs in compliance with this charter and has discharged its responsibilities as contained therein.

Internal audit function

The recommendation of the Audit Committee to outsource the Internal Audit function was accepted by the Board of Trustees. After a due tender process, adjudication of written proposals by several Chartered Accountant firms was done, based on the following criteria:

- price
- expertise / experience
- audit approach
- capacity / continuity
- BEE compliance in respect of ownership, gender and disability

It was recommended to the Board of Trustees that KPMG be appointed for a period of three years, to be reviewed on an annual basis.

KPMG presented its audit plan for 2008 on 18 July 2008 and submitted its first report to the Audit Committee on 19 September 2008.

The effectiveness of internal control

External audit management letters and reports and internal audit reports were reviewed to ensure that significant matters raised in the aforementioned management letters and reports were addressed and rectified on time.

Quality of management reports

The Committee is satisfied that the policies and procedures implemented by management were sufficient to ensure that the accounting and information systems and related controls are adequate and effective to enable the Board of Trustees to make informed decisions based on the said reports.

Going concern

In light of the declining solvency ratio as a result of losses made in recent years, a Sub-Committee discussed the issue of a going concern with Management and the Scheme's Actuary. Based on the revised forecast for 2009, as prepared by the Actuary, the Committee is of the opinion that there is no need for concern in respect of the following year.

Evaluation of financial statements

The audited annual financial statements of TeleMed were reviewed in conjunction with the management letter and report of the External Auditor. The Committee concurs and accepts the conclusions of the External Auditor and is of the opinion that these financial statements be approved and read together with the report of the External Auditor.

JFJ Scheepers
Chairman

independent auditor's report

INDEPENDENT AUDITOR'S REPORT

Report on the Summarised Financial Statements

The summarised financial statements set out on pages 29 to 50 have been derived from the financial statements of TeleMed Medical Scheme for the year ended 31 December 2008.

The summarised financial statements are the responsibility of the Scheme's trustees. Our responsibility is to express an opinion on whether the summarised financial statements are consistent, in all material respects, with the financial statements from which they were derived.

We have audited the annual financial statements of TeleMed Medical Scheme for the year ended 31 December 2008, from which the summarised financial statements were derived, in accordance with International Standards on Auditing.

In our report dated 30 April 2009, we expressed an unqualified opinion on the financial statements from which the summarised financial statements were derived.

In our opinion, the summarised financial statements are consistent, in all material respects, with the financial statements from which they are derived.

For a better understanding of the Scheme's financial position, its financial performance and cash flows for the period, and of the scope of our audit, the summarised financial statements should be read in conjunction with the financial statements from which the summarised financial statements were derived and our audit report thereon.

Report on other legal and regulatory requirements

As required by the Council for Medical Schemes, we report the following instances of non-compliance with the Medical Schemes Act, which we consider to be material:

We draw attention to Note 12 in the summarised financial statements which indicates that the Scheme did not comply with Section 33(2) of the Medical Schemes Act 131 of 1998, as some of the benefit options were not self-supporting in terms of membership and financial performance. Furthermore, Note 12 also indicates that the Scheme did not comply with Regulation 29(2) of the Medical Schemes Act 131 of 1998, as the Scheme failed to maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period of 25%.

PricewaterhouseCoopers Inc.

Director: J Prinsloo
Registered Auditor
Pretoria

13 May 2009

BALANCE SHEET

FOR THE YEAR ENDED 31 DECEMBER 2008

	2008 R	2007 R
ASSETS		
Non-current assets	31 164 716	31 776 238
Property, plant and equipment	9 038 787	9 542 306
Available-for-sale financial assets	22 125 929	22 233 932
Current assets	173 446 758	169 103 219
Held-to-maturity financial assets	94 315 007	92 316 088
Trade and other receivables	16 286 828	20 692 604
Cash and cash equivalents	62 844 923	56 094 527
Total assets	204 611 474	200 879 457
FUNDS AND LIABILITIES		
Members' funds	89 640 075	82 289 903
Accumulated funds	83 559 205	76 211 420
Revaluation reserves	5 411 341	5 411 341
Available-for-sale reserves	669 529	667 142
Non-current liabilities		
Post-retirement healthcare benefits	13 337 327	9 977 004
Current liabilities	101 634 072	108 612 550
Savings plan liability	27 445 953	26 725 855
Trade and other payables	24 656 426	30 352 732
Outstanding claims provision	48 294 892	50 791 741
Provisions	1 236 801	742 222
Total funds and liabilities	204 611 474	200 879 457

INCOME STATEMENT

FOR THE YEAR ENDED 31 DECEMBER 2008

	2008 R	2007 R
Net contribution income	900 241 094	804 407 742
Relevant healthcare expenditure	(820 244 681)	(768 629 047)
Net claims incurred	(851 382 520)	(770 105 648)
Claims incurred	(851 578 886)	(770 183 154)
Third party claim recoveries	196 366	77 506
Net income on other risk transfer arrangements	31 137 839	1 476 601
Recoveries from risk transfer arrangements	160 489 723	39 999 549
Risk transfer arrangement fees	(129 351 884)	(38 522 948)
Gross healthcare results	79 996 413	35 778 695
Managed healthcare expenses	(15 581 880)	(16 267 704)
Broker service fees	(4 823 213)	(3 093 031)
Administration expenses	(65 129 803)	(60 970 326)
Net impairment losses on healthcare receivables	(2 085 796)	(2 300 708)
Net healthcare results	(7 624 279)	(46 853 075)
Other income	15 612 111	13 562 402
Investment income	15 592 207	13 537 931
Sundry income	19 904	24 471
Other operating expenses	(640 047)	(1 236 940)
Asset management fees	(111 759)	-
Sundry expenses	(528 288)	(1 236 940)
Net surplus / (deficit) for the year	7 347 785	(34 527 613)

STATEMENT OF CHANGES IN FUNDS AND RESERVES

FOR THE YEAR ENDED 31 DECEMBER 2008

	ACCUMULATED FUNDS R	REVALUATION RESERVE R	AVAILABLE-FOR-SALE RESERVE R	TOTAL MEMBERS' FUNDS R
Balance as at 1 January 2007	110 739 033	5 411 341	-	116 150 374
Net deficit for the year	(34 527 613)	-	-	(34 527 613)
Unrealised gains on revaluation of available-for-sale investments (note 3)	-	-	667 142	667 142
Balance as at 31 December 2007	76 211 420	5 411 341	667 142	82 289 903
Balance as at 1 January 2008	76 211 420	5 411 341	667 142	82 289 903
Net gain for the year	7 347 785	-	-	7 347 785
Fair value adjustment on available-for-sale investments (note 3)	-	-	2 387	2 387
Balance as at 31 December 2008	83 559 205	5 411 341	669 529	89 640 075

CASH FLOW STATEMENT
FOR THE YEAR ENDED 31 DECEMBER 2008

	2008 R	2007 R
Cash flow from operating activities		
Cash flow utilised in operations before working capital changes	(5 269 096)	(44 906 027)
Working capital changes		
Decrease / (increase) in trade and other receivables	2 319 980	(11 876 241)
Increase in savings plan liability	720 098	1 743 554
(Decrease) / increase in trade and other payables	(2 335 982)	7 831 497
Increase in provisions	494 579	742 222
(Decrease) / increase in outstanding claims provision	(2 496 849)	13 791 741
Net cash utilised in operating activities	(6 567 271)	(32 673 254)
Cash flow from investment activities		
Purchase of property, plant and equipment	(387 381)	(1 717 425)
Additions to available-for-sale investments	-	(21 605 326)
Additions to held-to-maturity financial assets	(1 998 919)	(92 116 088)
Available-for-sale investment management fees	111 759	39 890
Investment income	15 592 207	13 537 931
Net cash generated / (utilised) in investment activities	13 317 666	(101 861 018)
Net increase / (decrease) in cash and cash equivalents	6 750 396	(134 534 273)
Cash and cash equivalents at beginning of year	56 094 527	190 628 800
Cash and cash equivalents at year end	62 844 923	56 094 527

notes to the
annual financial statements

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

1. Principal accounting policies

The principal accounting policies applied in the preparation of these annual financial statements are detailed below and are consistent with those of the previous year, unless otherwise stated.

1.1 Basis of preparation

The annual financial statements are prepared in accordance with International Financial Reporting Standards ("IFRS") and the Medical Schemes Act. IFRS comprise International Reporting Standards, International Accounting Standards and Interpretations originated by the International Financial Reporting Interpretations Committee (IFRIC) or the former Standing Interpretations Committee (SIC). The standards referred to are set by the International Accounting Standards Boards (IASB).

1.2 Basis of measurement

The financial statements have been prepared on the historical cost basis except for the following:

- Available-for-sale financial assets are measured at fair value
- Land and buildings are measured at fair value

1.3 Use of estimates and judgements

The preparation of annual financial statements, in conformity with IFRSs, requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Scheme's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the annual financial statements, are disclosed in the notes.

1.4 New accounting standards and International Financial Reporting Interpretation Committee (IFRIC)

Certain new standards, amendments and interpretations to existing standards have been published which are mandatory for the Scheme's accounting periods beginning on or after 1 January 2008. These are as follows:

(a) Standards, amendments and interpretations effective during 2008

IAS 1 - 'Presentation of financial statements - revised'. The changes made to IAS 1 requires that information in financial statements be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. This will enable an analysis of changes in a scheme's equity resulting from transactions with owners in their capacity as owners separately from 'non-owner' changes. The revisions include changes to the titles of some of the financial statements to reflect their functions more clearly. The new titles are not mandatory for use in financial statements.

Amendments to IAS 32 and IAS 1 - 'Amendment to IAS 32 financial instruments: presentation and IAS 1 presentation of financial statements - puttable financial instruments and obligations arising on liquidation'. The amendments require schemes to classify the following types of financial instruments as equity, provided they have particular features and meet specific conditions:

(a) puttable financial instruments (e.g. some shares issued by cooperative entities),

(b) instruments, or components of instruments, that impose an obligation on the Scheme to deliver to another party a pro rata share of the net assets of the Scheme only on liquidation (e.g. some partnership interests and some shares issued by limited life entities).

Additional disclosures are required in respect of the instruments affected by the amendments. Effective date 1 January 2009.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

IFRS 7 - Financial instruments: Disclosures. This amendment deals with presentation of finance costs.

IAS 8 - Accounting policies, changes in accounting estimates and errors. This amendment deals with the status of implementation guidance.

IAS 10 - Events after the reporting period. This amendment deals with dividends declared after the end of the reporting period.

IAS 16 - Property, plant and equipment. This amendment deals with recoverable amount of sale of assets held for rental.

IAS 18 - Revenue. This amendment deals with costs of originating a loan.

IAS 19 - Employee benefits. This amendment deals with curtailment and negative past service cost, plan administration costs, replacement of term 'fall due' and guidance on contingent liabilities.

IAS 20 - Account for government grants and disclosure of government assistance. This amendment deals with government loans with a below-market rate of interest and consistency of terminology with other IFRSs.

IAS 36 - Impairment of assets. This amendment deals with disclosure of estimates used to determine the recoverable amount.

IAS 38 - Intangible assets. This amendment deals with advertising activities, promotional activities and unit of production method of amortisation.

IAS 39 - Financial instruments: recognition and measurement. This amendment deals with reclassification of derivatives into or out of the classification of a fair value through profit or loss, designating and documenting hedges at the segment level and applicable effective interest rate on cessation of fair value hedge accounting. This amendment to the standard is effective for annual periods beginning on or after 1 January 2009.

IAS 40 - Investment property. This amendment deals with property under construction or development for future use as investment property, consistency of terminology with IAS 8 and investment property held under lease.

(b) Standards, amendments and interpretations effective during 2007 but irrelevant to the Scheme's operations

The following standards, amendments and interpretations to published standards are mandatory for accounting periods beginning on or after 1 January 2007 but are inapplicable to the Scheme's operations.

IFRIC 11, 'IFRS 2 - Group and treasury share transaction'

IFRIC 12, 'Service concession arrangements'

IFRIC 14, 'IAS 19 - The limit on a defined benefit asset, minimum funding requirements and their interaction'

IFRIC 16, 'Hedges of a net investment in a foreign operation'

(c) Interpretation of existing standards that are not yet effective and irrelevant to the Scheme's operations

The following interpretations to existing standards have been published and are mandatory for the Scheme's accounting periods beginning on or after 1 January 2009 or later, but are inapplicable to the Scheme's operations:

IAS 27. 'Consolidated and separate financial statements - revised'. IAS 27 (revised) requires the effects of all transactions with non-controlling interest to be recorded in equity if there is no change in control. They will no longer result in goodwill or gains and losses. The standard also specifies the accounting when control is lost. Any remaining interest

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in the Scheme is re-measured to fair value and a gain or loss is recognised in profit or loss. Effective date 1 July 2009. IAS 27 is inapplicable to the Scheme as there are no consolidated statements produced by the Scheme.

IFRS 3, 'Business combinations - revised'. The new standard continues to apply the acquisition method to business combinations, with some significant changes. For example, all payments to purchase a business are to be recorded at fair value on the acquisition date, with some contingent payments subsequently re-measured at fair value through income. Goodwill may be calculated based on the parent's share of net assets or it may include goodwill related to the minority interest. All transaction costs will be expended. Effective date 1 July 2009.

IAS 23 (Amendment), 'Borrowing costs' (effective from 1 January 2009). The Scheme is required to capitalise borrowing costs directly attributable to the acquisition, construction or production of a qualifying asset (one that takes a substantial period of time to get ready for use or sale) as part of the cost of that asset. The option to immediately expense borrowing costs will be removed. The Scheme will apply IAS 23 (Amended) from 1 January 2009, but it is currently inapplicable as there are no qualifying assets.

IFRS 8, 'Operating segments' (effective from 1 January 2009). IFRS 8 replaces IAS 14 and aligns segment reporting with the requirements of the US standard SFAS 131, 'Disclosures about segments of an enterprise and related information'. The new standard requires a 'management approach', under which segment information is presented on the same basis as that used for internal reporting purposes. The Scheme will apply IFRS 8 from 1 January 2009 but is currently inapplicable as the Scheme has no distinguishable business or geographical segments.

IFRIC 13, 'Customer loyalty programmes' (effective from 1 July 2008). IFRIC 13 clarifies that where goods or services are sold together with a customer loyalty incentive (for example, loyalty points for free products), the arrangement is a multi-element arrangement and the consideration received from the customer is allocated between the components of the arrangement in using fair values. IFRIC 13 is irrelevant as the Scheme does not operate loyalty programmes.

IFRIC 15, ' Agreements for the construction of real estate'. IFRIC 15 addresses diversity in accounting for real estate sales. IFRIC 15 clarifies the method of determining whether an agreement is within the scope of IAS 11 - construction contracts or IAS 18 - revenue and when revenue from construction should be recognised. The guidelines replace example 9 in the appendix to IAS 18. Effective date 1 January 2009. IFRIC 15 is irrelevant to the Scheme's operations because the Scheme does not have agreements for the construction of real estate.

IFRIC 16, 'Hedges of a net investment in a foreign operation'. IFRIC 16 provides guidance to identify the foreign currency risks that quality as a hedged risk (in the hedge of a net investment in a foreign operation). It secondly provides guidance on where, within a scheme, hedging instruments, that are hedges of a net investment in a foreign operation, can be held to qualify for hedge accounting. Thirdly, it provides guidance on how a scheme should determine the amounts to be reclassified from equity to profit or loss for both the hedging instrument and the hedged item. IFRIC 16 is irrelevant to the

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Scheme's operations because the Scheme does not have any investment in a foreign operation.

(d) Standard amendments to and interpretation of existing standards that are not yet effective and have not been adopted by the Scheme

The following standards, amendments to and interpretation of existing standards have been published and are mandatory for the Scheme's accounting periods beginning on or after 1 January 2009 or later, but have not yet been adopted.

IFRIC 14, 'IAS 19 - The limit on the defined benefit asset, minimum funding requirements and their interaction' (effective 1 January 2009).

IFRIC 14 provides guidance on assessing the limit in IAS 19 on the amount of surplus that can be recognised as an asset. It also explains how pension assets and liabilities may be affected by a statutory or contractual minimum funding requirement. The Scheme will apply IFRIC 14 from 1 January 2009, but it is not expected to have an impact on the Scheme's accounts.

IAS IR - 'Presentation of the financial statements' (effective 1 January 2009).

IAS 39R - 'Financial instruments: disclosure and presentation' (effective 1 July 2009).

IFRS 1 - 'First-time adoption of international financial reporting standards' and IAS 27 - 'Consolidated and separate financial statements: cost of an investment in a subsidiary, jointly controlled entity or associate'. The amendment allows first-time adopters to use a deemed cost of either fair value or the carrying amount under previous accounting practice to measure the initial cost of investment in subsidiaries, jointly controlled entities and associates in the separate financial statements. The amendment also removed the definition of the cost method from IAS 27 and replaced it with a requirement to present dividends as income in the separate financial statements of the investor.

IFRS 2 - 'Share based payment'. The amendment deals with two matters. It clarifies that vesting conditions are service conditions and performance conditions only. Other features of a share-based payment are not vesting conditions. It also specifies that all cancellations, whether by the entity or by other parties, should receive the same accounting treatment.

IFRS 5 - 'Non-current assets held for sale and discontinued operations'. This amendment deals with plans to sell the controlling interest in a subsidiary.

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2. Operating statistics per scheme option

2008	BRONZE R	SILVER R	GOLD R	GOLD SELECT R	PLATINUM R	TOTAL R
Gross contributions received	27 213 854	97 554 077	332 295 188	85 461 971	376 372 019	918 897 109
Less: Savings contributions	-	(18 656 015)	-	-	-	(18 656 015)
Net contributions received	27 213 854	78 898 062	332 295 188	85 461 971	376 372 019	900 241 094
Relevant healthcare expenditure	(23 967 823)	(96 111 425)	(249 100 238)	(103 098 490)	(347 966 705)	(820 244 681)
Risk claims incurred	(32 432 788)	(95 931 064)	(248 730 410)	(126 658 975)	(347 629 283)	(851 382 520)
Gross claims paid and reported	(32 432 788)	(96 631 064)	(256 830 410)	(126 658 975)	(350 029 283)	(862 582 520)
Decrease in outstanding claims provision	-	700 000	8 100 000	-	2 400 000	11 200 000
Claim recoveries from risk transfer arrangements	32 401 747	508 170	1 042 002	125 587 108	950 696	160 489 723
Expense on risk transfer arrangements	(23 936 782)	(688 531)	(1 411 830)	(102 026 623)	(1 288 118)	(129 351 884)
Gross underwriting	3 246 031	(17 213 363)	83 194 950	(17 636 519)	28 405 314	79 996 413
Broker service fees	(485 320)	(1 428 044)	(1 367 977)	(77 805)	(1 464 067)	(4 823 213)
Administration costs	(2 250 585)	(12 821 217)	(24 567 907)	(2 594 699)	(22 895 396)	(65 129 803)
Managed healthcare expenses	-	(2 784 618)	(5 850 841)	(571 856)	(6 374 565)	(15 581 880)
Net underwriting	510 126	(34 247 242)	51 408 225	(20 880 879)	(2 328 713)	(5 538 482)
Net impairment gain (loss)	(1 153 307)	62 138	(232 487)	(390 306)	(371 834)	(2 085 796)
Surplus / (deficit) from operations	(643 180)	(34 185 105)	51 175 738	(21 271 185)	(2 700 547)	(7 624 279)
Investment income	470 526	1 367 129	5 742 500	1 493 495	6 518 556	15 592 207
Sundry income	583	1 697	7 038	2 252	8 334	19 904
Other operating expenses	(32 005)	(64 080)	(229 419)	(61 541)	(253 001)	(640 047)
Surplus (deficit) for the year	(204 076)	(32 880 359)	56 695 856	(19 836 979)	3 573 342	7 347 785
Number of members at year end	4 013	4 499	8 715	2 671	8 053	27 951
Number of dependants at year end	2 320	6 465	12 003	1 845	9 440	32 073

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2007	BRONZE R	SILVER R	GOLD R	GOLD SELECT R	PLATINUM R	TOTAL R
Gross contributions received	18 645 338	70 554 662	367 289 984	19 296 539	342 174 722	817 961 245
Less: Savings contributions	-	(13 553 503)	-	-	-	(13 553 503)
Net contributions received	18 645 338	57 001 159	367 289 984	19 296 539	342 174 722	804 407 742
Relevant healthcare expenditure	(15 429 951)	(52 591 620)	(339 989 830)	(20 056 007)	(340 561 639)	(768 629 047)
Risk claims incurred	(16 743 089)	(52 659 179)	(340 236 492)	(19 497 554)	(340 661 892)	(769 798 206)
Gross claims paid and reported	(16 743 089)	(49 509 179)	(337 136 492)	(19 497 554)	(334 711 892)	(757 598 206)
Increase in outstanding claims provision	-	(3 150 000)	(3 100 000)	-	(5 950 000)	(12 200 000)
Claim recoveries from risk transfer arrangements	16 743 089	457 518	1 721 289	19 497 554	1 272 657	39 692 107
Expense on risk transfer arrangements	(15 429 951)	(389 959)	(1 474 627)	(20 056 007)	(1 172 404)	(38 522 948)
Gross underwriting	3 215 387	4 409 539	27 300 154	(759 468)	1 613 083	35 778 695
Broker service fees	(231 361)	(745 841)	(1 015 655)	(36 657)	(1 063 517)	(3 093 031)
Administration costs	(432 229)	(7 987 952)	(29 970 970)	(427 768)	(22 151 407)	(60 970 326)
Managed healthcare expenses	(3 705)	(2 057 219)	(7 919 853)	(285 492)	(6 001 435)	(16 267 704)
Net underwriting	2 548 093	(6 381 473)	(11 606 324)	(1 509 384)	(27 603 276)	(44 552 366)
Net impairment losses	(3 407 276)	(778 259)	(1 688 931)	(15 010)	(425 585)	(6 315 061)
Deficit from operations	(859 183)	(7 159 732)	(13 295 255)	(1 524 394)	(28 028 861)	(50 867 427)
Investment income						13 537 931
Other income						24 471
Other operating expenses						(1 236 940)
Deficit for the year						(38 541 965)
Number of members at year end	3 241	3 821	11 739	643	8 564	28 008
Number of dependants at year end	2 237	5 129	15 033	739	10 545	33 683

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

3. Available-for-sale investments

	2008 R	2007 R
Fair value at the beginning of the financial year	22 233 932	-
Net investments	-	21 605 326
Additions	-	21 600 000
Interest received	-	5 326
Investment management fees	(111 759)	(39 890)
Realised gains on disposal	1 370	1 354
Fair value adjustment on available-for-sale investments	2 387	667 142
Fair value at financial year end	22 125 929	22 233 932
The Scheme invested in the following fund:		
Coronation Domestic Absolute Portfolio	22 125 929	22 233 932
	22 125 929	22 233 932
The investments included above represent local investments in:		
Listed equities	12 494 512	15 442 292
Bonds	1 745 736	1 280 204
Money market instruments	7 885 681	5 511 436
	22 125 929	22 233 932

An investment register is available for inspection at the registered offices of the Scheme.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

4. Outstanding claims provision

2008	COVERED BY RISK TRANSFER ARRANGEMENTS	NOT COVERED BY RISK TRANSFER ARRANGEMENTS	TOTAL
Provision for outstanding claims incurred but not reported	10 294 892	38 000 000	48 294 892
Analysis of movements in outstanding claims			
Balance at beginning of year	1 591 741	49 200 000	50 791 741
Payments in respect of previous year	1 591 741	49 720 338	51 312 079
Over-provision in previous year	-	(520 338)	(520 338)
Adjustment for current year	8 703 151	11 200 000	2 496 849
Balance at year end	10 294 892	38 000 000	48 294 892
Analysis of outstanding claims provision			
Balance at beginning of year	1 591 741	49 200 000	50 791 741
Gross claims	1 591 741	49 907 582	51 499 323
Less: Estimated recoveries from personal savings accounts	-	(707 582)	(707 582)
Payments in respect of previous year	(1 591 741)	(49 720 338)	(51 312 079)
Transfer of over-provision to Income Statement	-	(520 338)	(520 338)
Adjustment for the current year	10 294 892	38 520 338	48 815 230
Provision for the current year	10 294 892	38 000 000	48 294 892

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

2007	COVERED BY RISK TRANSFER ARRANGEMENTS	NOT COVERED BY RISK TRANSFER ARRANGEMENTS	TOTAL
Provision for outstanding claims incurred but not reported	1 591 741	49 200 000	50 791 741
Analysis of movements in outstanding claims			
Balance at beginning of year	-	37 000 000	37 000 000
Payments in respect of previous year	-	40 801 217	40 801 217
Under-provision in previous year	-	(3 801 217)	(3 801 217)
Adjustment for current year	1 591 741	12 200 000	13 791 741
Balance at year end	1 591 741	49 200 000	50 791 741
Analysis of outstanding claims provision			
Balance at beginning of year	-	37 000 000	37 000 000
Gross claims	-	38 150 864	38 150 864
Less: Estimated recoveries from personal savings accounts	-	(1 150 864)	(1 150 864)
Payments in respect of previous year	-	(40 801 217)	(40 801 217)
Transfer of under-provision to Income Statement	-	(3 801 217)	(3 801 217)
Adjustment for the current year	1 591 741	53 001 217	54 592 958
Provision for the current year	1 591 741	49 200 000	50 791 741

No additional provision is required as a result of the liability adequacy test.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

4. Outstanding claims provision continued

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in neutral estimates of the most likely or expected outcome. The sources of data used as inputs for the assumptions are internal and comprise detailed studies that are carried out annually. There is additional emphasis on current trends and where, in previous years, insufficient information was available to facilitate a reliable best estimate of claims development, prudent assumptions are made.

Each notified claim is assessed on a separate, case by case basis with due regard to the claim circumstances, information available from managed care, management services and historical evidence of the size of similar claims. The provisions are based on information currently available. However, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items affecting the ultimate loss is difficult to estimate. Estimating the provision is compounded as claims differ by category, (i.e. in-hospital, chronic and above threshold benefits) and there are differences in the underlying insurance contracts, claim complexity, the volume, the individual severity of claims, determining the occurrence date of a claim and reporting lags.

The cost of outstanding claims at financial year end is estimated using the chain ladder model. The model extrapolates the development of paid and incurred claims, average cost per claim and ultimate claim numbers for each benefit year based upon observed development of previous years and expected loss ratio. Run-off triangles are used in situations where there are delays after treatment dates for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in the known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

The actual method or blend of method used varies according to the benefit year under review, categories of claims and observed historical claims development. The extent to which these methods use historical claims development information assumes that the historical claims development pattern will reoccur in future. There are reasons why this may not be the case, which insofar as they can be identified, have been allowed for by modifying the methods. Such reasons include:

- changes in processes that affect the development / recording of claims paid and incurred (such as changes in claim reserving procedures);
- economic, legal, political and social trends (resulting in different than expected levels of inflation and/or minimum medical benefits to be provided);
- changes to the medical requirement composition of members and their dependants; and
- random fluctuations, including the impact of large losses.

Assumptions

Assumptions that have the greatest effect on the measurement of the outstanding claims provision are the expected claims ratios for the most recent benefit years in respect of in-hospital, chronic and above threshold categories of claims. These ratios are used to assess the outstanding claims provisions for the 2008 and 2007 benefit years.

Changes to assumptions and sensitivities to changes in key variables

The table overleaf outlines the sensitivity of insured liability estimates to particular movements in assumptions used in the estimation process. It should be noted that this is a determination with no correlation between the key variables.

Where variables are considered to be immaterial, no impact has been assessed for significant changes to these variables. At present, the variables are not materially significant. However, should the levels of an individual variable change, amendment to the particular variable may be necessary.

An analysis of sensitivity around various scenarios within the general medical insurance business provides

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

an indication of the adequacy of the Scheme's estimation process. The Scheme believes that the liability for claims reported in the Balance Sheet is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions which could differ when claims arise.

4. Outstanding claims provision continued

Impact on reported deficit caused by changes in key variables

2008	2008 CLAIMS PAID FROM JAN - FEB 2009 R	ESTIMATE OF 2008 CLAIMS TO BE PAID AFTER MAR 2009 R	OUTSTANDING CLAIMS PROVISION R	% CHANGE IN OUTSTANDING CLAIMS PROVISION R
Base scenario	33 063 340	4 923 575	37 986 915	-
10% increase	33 063 340	5 415 933	38 479 273	1.30%
10% decrease	33 063 340	4 431 218	37 494 558	-1.30%

2007	2007 CLAIMS PAID FROM JAN - FEB 2008 R	ESTIMATE OF 2007 CLAIMS TO BE PAID AFTER MAR 2008 R	OUTSTANDING CLAIMS PROVISION R	% CHANGE IN OUTSTANDING CLAIMS PROVISION R
Base scenario	44 719 398	4 520 597	49 239 995	-
10% increase	44 719 398	4 972 657	49 692 055	0.92%
10% decrease	44 719 398	4 068 537	48 787 935	-0.92%

This analysis demonstrates a change in a specified variable with other assumptions remaining constant. The change in liability also represents the absolute change in surplus for the period. It should be noted that an increase in liability will result in a decrease in surplus and vice versa. These reasonable, possible changes in key variables do not directly affect reserves.

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

5. Net contribution income

	2008 R	2007 R
Gross contributions	918 897 109	817 961 245
Less:		
Savings contributions	(18 656 015)	(13 553 503)
Net contribution income	900 241 094	804 407 742

6. Net income on risk transfer arrangements

Managed care: Healthcare services (capitation contracts)

	2008 R	2007 R
Claims incurred in respect of related risk transfer arrangements		
Premiums / fees paid	129 351 884	38 522 948
Recoveries received	(160 489 723)	(39 999 549)
Net income on risk transfer arrangement	(31 137 839)	(1 476 601)

The following are the essentials of the risk transfer arrangements per contract:

The Emergency Room Company - ER24

Essential emergency response and medical transportation provided to members at a fixed cost per member, per month. The contract period was from 1 January 2008 to 31 December 2008.

ONECARE (Pty) Ltd

Provided an infrastructure enabling it to provide multi-disciplinary healthcare services on a managed care basis at agreed fixed premiums per member through a network of designated service providers. The contract period was from 1 January 2008 to 31 December 2008.

Prime Cure (Pty) Ltd

Provided an established infrastructure enabling it to provide multi-disciplinary healthcare services on a managed care basis at agreed fixed premiums per member through a network of designated service providers. The contract period was from 1 January 2008 to 31 December 2008.

The risk of the above contracts is carried by the Scheme. These contracts have been measured the same as in the past, i.e. fixed cost per member, per month. All the above contracts were renewed after expiry on 31 December 2008.

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7. Net impairment loss on healthcare receivables

	2008 R	2007 R
Contributions unable to be collected	(1 353 072)	(644 079)
Movement in impairment	(444 059)	(642 720)
Impairment recognised directly to the income statement	(909 013)	(1 359)
Irrecoverable members' and service providers' portions	(255 440)	(1 656 629)
Movement in impairment	(255 440)	(107 094)
Impairment recognised directly to the income statement	-	(1 549 535)
Irrecoverable savings plan account advances	(477 285)	-
Movement in impairment	(286 557)	-
Impairment recognised directly to the income statement	(190 728)	-
	(2 085 796)	(2 300 708)

8. Investment income

	2008 R	2007 R
Realised gains from available-for-sale investments (Note 3)	1 370	1 354
Interest received capitalised	2 115 007	12 282 923
Held-to-maturity investments	2 115 007	9 498 120
Interest income from cash and cash equivalents	-	2 784 803
Interest realised	13 475 830	1 253 654
Interest income from available-for-sale investments (Note 3)	-	5 326
Held-to-maturity investments	8 627 145	1 111 808
Interest income from cash and cash equivalents	4 848 685	136 520
	15 592 207	13 537 931

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

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9. Administration expenses

	2008 R	2007 R
Legal fees	192 161	72 457
Audit fees	681 264	658 581
Fees for current year	149 910	457 040
Fees for previous year	531 354	201 541
Computer expenses	7 038 591	6 892 216
Communication costs	761 022	1 227 315
Consultation fees	2 260 834	1 234 855
Internal audit fees	1 324 986	268 767
Other	935 848	966 088
Depreciation	890 900	860 162
Loyalty programme	2 392 850	2 509 100
Postage	1 930 747	1 803 642
Direct marketing and rebranding expenses	4 532 946	5 220 968
Marketing support services	2 334 541	4 445 454
Fidelity guarantee and indemnity insurance	30 321	95 154
Operating leases	2 294 077	2 211 467
Principal Officer's fees / expenses	14 497	200 857
Employee benefit costs	31 281 474	26 504 218
Salaries and related costs	24 086 242	19 722 195
Personnel training	99 179	1 023 371
Recruitment and support services	1 173 376	1 899 935
Pension and provident cost	2 562 354	2 439 740
Post-retirement healthcare benefits	3 360 323	1 418 977
Association fees	656 997	494 242
Telephone expenses	4 336 592	3 305 089
Board of Trustees remuneration / expenses	644 223	572 030
Other expenses	2 855 766	2 662 519
	65 129 803	60 970 326

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9. Administration expenses continued

Remuneration and consideration of Board of Trustees.

2008	FEES FOR BOARD AND COMMITTEE MEETINGS	FEES FOR HOLDING OFFICE	FEES FOR OTHER MEETING ATTENDANCE	ALLOWANCES	TOTAL REMUNERATION	TRAINING	CONFERENCE FEES	TRAVEL AND ACCOMMO-DATION	OTHER DISBURSEMENTS AND REIMBURSEMENTS	TOTAL CONSIDERATIONS
BA Bets (Chairman)	88 695	16 335	21 450	-	126 480	1 083	7 424	20 977	1 375	157 339
JJ Bezuidenhout	22 110	-	21 450	-	43 560	-	7 255	5 202	799	56 816
GF Dempsey	45 210	825	21 450	-	67 485	1 208	7 424	6 558	1 375	84 050
DJ Fredericks	9 405	1 650	4 290	-	15 345	-	-	952	237	16 534
L La Grange	42 900	15 345	13 365	-	71 610	-	7 424	22 632	1 573	103 240
N Potgieter	7 260	-	21 450	-	28 710	1 208	-	15 927	2 306	48 151
L Louw	8 250	825	16 170	-	25 245	-	-	2 901	386	28 532
A Minnaar	3 630	-	14 685	-	18 315	-	-	-	1 221	19 536
W Myburgh	23 100	3 300	18 150	-	44 550	1 208	-	6 278	1 221	53 257
M Raath	13 695	-	21 450	-	35 145	1 208	-	3 378	1 375	41 106
F Vian	6 353	-	21 450	-	27 803	1 208	-	5 277	1 374	35 662
Total	270 608	38 280	195 360	-	504 248	7 123	29 527	90 082	13 242	644 222

2007	FEES FOR BOARD AND COMMITTEE MEETINGS	FEES FOR HOLDING OFFICE	FEES FOR OTHER MEETING ATTENDANCE	ALLOWANCES	TOTAL REMUNERATION	TRAINING	CONFERENCE FEES	TRAVEL AND ACCOMMO-DATION	OTHER DISBURSEMENTS AND REIMBURSEMENTS	TOTAL CONSIDERATIONS
BA Bets	54 675	3 225	17 588	-	75 488	-	2 286	15 604	4 373	97 751
JJ Bezuidenhout	37 425	-	-	-	37 425	-	1 842	2 412	1 640	43 319
GF Dempsey	52 818	1 575	-	-	54 393	-	2 287	1 658	1 673	60 011
DJ Fredericks	28 650	-	-	-	28 650	-	-	7 539	582	36 771
L La Grange	127 957	17 625	7 875	-	153 457	-	2 287	35 967	1 673	193 384
J Laubscher	7 500	-	-	-	7 500	-	-	1 728	471	9 699
W Myburgh	17 490	3 630	-	-	21 120	-	-	3 371	-	24 491
M Raath	9 900	-	-	-	9 900	-	-	388	-	10 288
L Louw	11 250	-	-	-	11 250	-	-	288	834	12 372
MR Monamodi	9 675	-	-	-	9 675	-	-	896	1 674	12 245
T Borg-Jorgenson	3 675	-	-	-	3 675	-	-	-	445	4 120
A Minnaar	9 975	-	-	-	9 975	-	-	-	444	10 419
N Potgieter	27 975	-	-	-	27 975	-	2 286	8 307	1 658	40 226
F Vian	14 850	-	-	-	14 850	-	-	2 084	-	16 934
Total	413 815	26 055	25 463	-	465 332	-	10 989	80 242	15 466	572 030

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

10. Related party transactions

Key management personnel and their close family members

Key management personnel are people having the authority and responsibility for planning, directing and controlling the activities of the Scheme. Key management personnel include the Board of Trustees, the Principal Officer and the members of the Executive Committee. The disclosure deals with full-time personnel who receive compensation on a salaried basis (Principal Officer and Executive Committee members) as well as part-time personnel who are compensated on a fee basis (Board of Trustees).

Close family members include those of the Board of Trustees, Principal Officer and members of the Executive Committee.

The following related party transactions were noted for the period under review:

	2008 R	2007 R
Board of Trustees		
Remuneration and other considerations	644 222	572 030
Contributions to the Scheme	554 883	418 580
Claims	316 489	367 169
Chief Executive Officer's fees		
Previous	725 496	851 681
Current	531 958	-
Key management personnel		
Remuneration and other considerations (including employee benefit costs)	3 244 177	2 000 900
Contributions to the Scheme	231 889	75 262
Claims	119 940	139 047
Leave pay	268 485	296 885

All contributions received and benefits paid were in terms of the Rules of the Scheme.

The terms and conditions of the related party transactions were as follows:

Transaction	Nature of transactions and terms and conditions thereof
Contributions received	This constitutes the contributions paid by the related party, in his or her individual capacity, as a member of the Scheme. All contributions were at the same terms as applicable to third parties.
Claims incurred	This constitutes the claims by the related party, in his or her individual capacity, as a member of the Scheme. All claims were paid in terms of the Rules of the Scheme as applicable to third parties.

11. Contingent asset

Claims for third party debtors for benefits paid on behalf of the Scheme's members are disclosed as a contingent asset as the inflow of economic benefits is probable but not virtually certain. The estimated future economic benefits that could be derived from these third party claims debtors amounts to approximately R12 131 341 (2007: R6 450 368).

Claims paid on behalf of service providers for scheme members are disclosed as contingent assets as the inflow of economic benefits is probable but not virtually certain. The future economic benefits that could be derived from these third party claims debtors amounts to approximately R10 049 360 (2007: R10 704 360).

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 DECEMBER 2008

12. Non-compliance with the Medical Schemes Act 131 of 1998 and its regulations

12.1 Required solvency margin not achieved by the Scheme - Regulation 29 (2) of the Regulations to the Medical Schemes Act

Although the Scheme budgeted for a solvency margin of 13.42% at the end of 2008, a higher number of claims than expected were experienced on the Silver option as a result of a decision to exempt from underwriting young pregnant females wishing to join the option. The decision was reversed once management realised that claims were higher than anticipated. The impact was in the region of R30m and reduced the solvency with approximately 3% to 9.09%. The 2009 budget aims to increase solvency to the ratio as indicated in the business plan submitted to the Council for Medical Schemes.

12.2 Financial soundness of benefit options - Section 33 (2) of the Medical Schemes Act

The Silver option was designed, actuarialised and submitted to Council as a self-sustaining option. The high claims experienced, as explained in 12.1 above, resulted in an underwriting loss. The 2009 budget has addressed this and all indications are that the option will be self-sustaining from now onwards.

12.3 Non-compliance with Regulation 30 (2) which requires that investment in property must not exceed 2.5%

Regulation 30 (2) of the Medical Schemes Act which states that investment in property must not exceed 2.5% of the total assets as determined in terms of the regulation was not complied with. The percentage held in property by the Scheme amounts to 3.98% (Total assets R204 611 474) and therefore exceeds 2.5% as required by the Regulation of the Medical Schemes Act. This investment pertains to the building owned by the Scheme and used for the purpose of administration of the Scheme. No new investments were made in property during the year under review.

The Scheme will obtain approval of this investment from the Council for Medical Schemes.

12.4 Non-compliance with Regulation 6 (1) of the Act - Claims processed more than four months after service date

Regulation 6 (1) states that members have at least four months to submit claims for payment. Management has acknowledged the fact that stale claims were processed. This occurred because queries on claims often necessitate claims being referred back to members or service providers before payment can be made. Hence payment of claims may take place more than four months after service date. This is, however, provided for in Regulation 6 (3). Forced claims require mandatory authorisation by a senior staff member.

12.5 Non-compliance with Section 26 (7) of the Act - Contributions are not received within three days of becoming due

Late payments by members were identified. The Scheme has policies and procedure in place to suspend membership if a payment is not received within three days of the due date. This is to prevent the payment of claims.

12.6 Non-compliance with Sections 29 (d) and (n) of the Act - Member application form not signed

The Act refers to the manner in which contracts and other documents binding the Scheme shall be executed as well as the terms and conditions applicable to the admission of a person as a member of the Scheme. Management identified that an oversight had occurred and two application forms had not been signed. Controls are in place to prevent a recurrence.

12.7 Previous non-compliance with Section 65 and Regulation 28 of the Act - Advances to brokers

R236 349 of the R302 300 advanced to brokers as reported in 2007 has been recovered. The balance of R65 951 is currently being recovered in the form of regular monthly payments.

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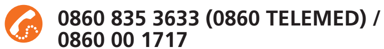

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Mediese Skema geregistreer kragtens Wet 131 van 1998
Medical Scheme registered under Act 131 of 1998